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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 07-01-2019 , and ending 06-30-2020

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

C Name of organization
Presence Central and Suburban Hospitals Network

Doing business as
SEE SCHEDULE O

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
C/O TAX DEPARTMENT PO BOX 45998

City or town, state or province, country, and ZIP or foreign postal code
ST LOUIS, MO 631455998

F Name and address of principal officer:
KEITH PARROTT
C/O TAX DEPARTMENT PO BOX 45998
ST LOUIS, MO 631455998

D Employer identification number
36-4195126

E Telephone number
(314) 733-8000

G Gross receipts \$ 799,430,104

H(a) Is this a group return for subordinates?
☐ Yes ☒ No
H(b) Are all subordinates included?
☐ Yes ☐ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶ 0928

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

J Website: ▶ SEE SCHEDULE O

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

L Year of formation: 1997

M State of legal domicile: IL

Part I

Summary

Activities & Governance

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

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

3 Number of voting members of the governing body (Part VI, line 1a) 3 7

4 Number of independent voting members of the governing body (Part VI, line 1b) 4 6

5 Total number of individuals employed in calendar year 2019 (Part V, line 2a) 5 0

6 Total number of volunteers (estimate if necessary) 6 779

7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 804,639

7b Net unrelated business taxable income from Form 990-T, line 39 7b 354,064

Revenue

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

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

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

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

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

Prior Year

Current Year

404,473 39,575,260

814,419,606 755,902,183

6,932,821 38,906

9,527,055 3,435,791

831,283,955 798,952,140

Expenses

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

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

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

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

16b Total fundraising expenses (Part IX, column (D), line 25) ▶0

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

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

19 Revenue less expenses. Subtract line 18 from line 12

256,066 235,923

275,597,573 0

0

526,179,095 848,253,457

802,032,734 848,489,380

29,251,221 -49,537,240

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

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

Beginning of Current Year

End of Year

430,679,416 520,201,301

107,296,904 416,001,132

323,382,512 104,200,169

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
TONYA MERSHON VICE PRESIDENT, TAX
Type or print name and title

2021-05-13
Date

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN

Firm's name ▶

Firm's EIN ▶

Firm's address ▶

Phone no.

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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2019)

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:

ROOTED IN THE LOVING MINISTRY OF JESUS AS HEALER, WE COMMIT OURSELVES TO SERVING ALL PERSONS WITH SPECIAL ATTENTION TO THOSE WHO ARE POOR AND VULNERABLE. OUR CATHOLIC HEALTH MINISTRY IS DEDICATED TO SPIRITUALLY-CENTERED, HOLISTIC CARE WHICH SUSTAINS AND IMPROVES THE HEALTH OF INDIVIDUALS AND COMMUNITIES. WE ARE ADVOCATES FOR A COMPASSIONATE AND JUST SOCIETY THROUGH OUR ACTIONS AND OUR WORDS.

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 \$ 532,182,670 including grants of \$ 235,923) (Revenue \$ 756,102,082)
See Additional Data






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

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

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

4e Total program service expenses ▶ 532,182,670

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	No
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	
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	No
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI. 	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX 	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X 	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional 	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
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	No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? 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	No
b	A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV	28b	No
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	No
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	29	No
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	No
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	No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? 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 ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a 287	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c Yes	

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

Form **990** (2019)

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

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

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a	Yes
10b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	Yes
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	No
11b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
12b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
12c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	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?		
15a	The organization's CEO, Executive Director, or top management official	15a	No
15b	Other officers or key employees of the organization	15b	No
	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
16b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	Yes

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-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:
 Sara O'Brien 4600 EDMUNDSON ROAD ST LOUIS, MO 631343806 (314) 733-8000

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			
(1) MARK HANSON ESQ CHAIR	1.0 2.0	X		X				0	0	0
(2) THOMAS HUBERTY MD VICE CHAIR	1.0 1.0	X		X				0	0	0
(3) DAVID J BORDO MD DIRECTOR	0.0 50.0	X						0	407,123	25,453
(4) JAY BERGMAN DIRECTOR	1.0 1.0	X						0	0	0
(5) MARSHA LADENBURGER RN DIRECTOR (END 7/2019)	1.0 1.0	X						0	0	0
(6) PATRICIA FOLTZ DIRECTOR	1.0 1.0	X						0	0	0
(7) STEVE TALTY MD DIRECTOR	1.0 0	X						0	0	0
(8) THOMAS RUSSE DIRECTOR	1.0 1.0	X						0	0	0
(9) DANA L GILBERT PRESIDENT	0.0 50.0			X				0	516,647	26,829
(10) EARL J BARNES II TREASURER (START 11/2019)	0.0 50.0			X				0	514,654	1,716
(11) JULIE P ROKNICH SECRETARY	0.0 50.0			X				0	243,411	18,059
(12) PAUL E BELTER TREASURER (END 11/2019)	0.0 50.0			X				0	1,098,169	26,068
(13) RICHARD D CARTER CFO, AMITA HEALTH (START 4/2020)	0.0 50.0			X				0	0	0
(14) CHRISTOPHER S SHRIDE FORMER KEY EMPLOYEE (END 12/2018)	0.0 50.0				X			0	377,624	28,881
(15) BETTINA A JOHNSON FORMER OFFICER (END 12/2018)	0.0 50.0						X	0	316,363	17,045
(16) CONNIE J NOLTEMEYER FORMER KEY EMPLOYEE (END 12/2014)	0.0 50.0						X	0	147,979	10,628
(17) MICHAEL L BROWN FORMER KEY EMPLOYEE (END 12/2018)	0.0 50.0						X	0	461,896	13,430

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

[illegible]

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)	0	4,787,882	218,164

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 ► 0

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

Section B. Independent Contractors

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

(A)	(B)	(C)
Name and business address	Description of services	Compensation
ALVERNO CLINICAL LABORATORIES LLC 26051 NETWORK PLACE CHICAGO, IL 606731260	LABORATORY SERVICES	8,271,217
AMERICAN ANESTHESIOLOGY ASSOCIATES OF IL PO BOX 281034 ATLANTA, GA 303841034	ANESTHESIA SERVICES	1,383,149
CARDIAC SURGERY ASSOCIATES SC 2650 WARRENVILLE ROAD DOWNERS GROVE, IL 605152075	MEDICAL SERVICES	1,074,890
JOINT DYNAMICS LLC 505 WEXFORD COURT ST CHARLES, IL 60175	MEDICAL SERVICES	692,000
ANESTHESIA ASSOCIATES LTD 2540 HANFORD LN AURORA, IL 605026969	ANESTHESIA SERVICES	535,110

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 ► 21

Form 990 (2019)		Page 9					
Part VIII		Statement of Revenue					
Check if Schedule O contains a response or note to any line in this Part VIII <input type="checkbox"/>							
		(A)	(B)	(C)	(D)		
		Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514		
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	772,873				
	e Government grants (contributions)	1e	38,801,002				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,385				
	g Noncash contributions included in lines 1a - 1f:\$	1g					
	h Total. Add lines 1a-1f ▶	39,575,260					
Program Service Revenue	2a Net Patient Service Revenue	Business Code					
		621990	752,290,551	752,254,384	36,167		
	b Pharmacy Revenue	446110	1,521,013	1,294,683	226,330		
	c Rental Income from Affiliates	531120	1,465,348	1,465,348			
	d Services to Affiliates	561000	511,357	511,357			
	e Income from Joint Ventures	900099	113,914	-193,426	307,340		
	f All other program service revenue.		0	0	0		
	g Total. Add lines 2a-2f. ▶	755,902,183					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		27,125			27,125	
	4 Income from investment of tax-exempt bond proceeds ▶						
	5 Royalties ▶						
	6a Gross rents	(i) Real	(ii) Personal				
		6a	1,133,427				
		b Less: rental expenses	6b	364,838			
		c Rental income or (loss)	6c	768,589	0		
	d Net rental income or (loss) ▶		768,589			768,589	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		7a		13,017			
		b Less: cost or other basis and sales expenses	7b		1,236		
		c Gain or (loss)	7c	0	11,781		
	d Net gain or (loss) ▶		11,781			11,781	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a					
		b Less: direct expenses	8b				
	c Net income or (loss) from fundraising events ▶						
	9a Gross income from gaming activities. See Part IV, line 19	9a					
		b Less: direct expenses	9b				
	c Net income or (loss) from gaming activities ▶						
	10aGross sales of inventory, less returns and allowances	10a	233,896				
b Less: cost of goods sold		10b	111,890				
c Net income or (loss) from sales of inventory ▶		122,006				122,006	
Miscellaneous Revenue		Business Code					
11aCafeteria/Vending Revenue	722514	1,970,302		8,612		1,961,690	
b Leased Employees	561300	119,531		119,531			
c Building Support services	811000	72,467		72,467			
d All other revenue		382,896	199,899	34,192		148,805	
e Total. Add lines 11a-11d ▶		2,545,196					
12 Total revenue. See instructions ▶		798,952,140	755,532,245	804,639		3,039,996	

Form 990 (2019)

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	229,923	229,923		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	6,000	6,000		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages				
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management	569	569		
b Legal	46,647		46,647	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	155		155	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	37,170,196	27,203,054	9,967,142	0
12 Advertising and promotion	219,522	126,101	93,421	
13 Office expenses	1,799,789	613,615	1,186,174	
14 Information technology	234,022	192,725	41,297	
15 Royalties				
16 Occupancy	21,054,769	19,310,923	1,743,846	
17 Travel	102,548	43,577	58,971	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	171,513	108,262	63,251	
20 Interest	13,414,807		13,414,807	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	34,114,303	31,288,811	2,825,492	
23 Insurance	13,145,727		13,145,727	
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 Wage & Benefit Allocation	250,212,017	200,162,530	50,049,487	
b Professional Fee to Affiliate	168,230,328		168,230,328	
c Medical Supplies	138,253,508	118,761,439	19,492,069	
d UBI Tax Expense	139,546		139,546	
e All other expenses	169,943,491	134,135,141	35,808,350	0
25 Total functional expenses. Add lines 1 through 24e	848,489,380	532,182,670	316,306,710	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year	
Assets	1	Cash—non-interest-bearing		13,504	1	13,504	
	2	Savings and temporary cash investments		7,029,296	2	1,543,360	
	3	Pledges and grants receivable, net			3		
	4	Accounts receivable, net		114,777,242	4	98,294,502	
	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		0	5	0	
	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)		0	6	0	
	7	Notes and loans receivable, net			7		
	8	Inventories for sale or use		20,269,186	8	19,008,904	
	9	Prepaid expenses and deferred charges		77,716	9	2,899,514	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	368,099,101			
	b	Less: accumulated depreciation	10b	57,199,860	282,797,638	10c	310,899,241
	11	Investments—publicly traded securities			11		
	12	Investments—other securities. See Part IV, line 11		0	12		
	13	Investments—program-related. See Part IV, line 11		1,539,961	13	270,832	
	14	Intangible assets		413,315	14	562,077	
	15	Other assets. See Part IV, line 11		3,761,558	15	86,709,367	
16	Total assets. Add lines 1 through 15 (must equal line 34)		430,679,416	16	520,201,301		
Liabilities	17	Accounts payable and accrued expenses		2,895,142	17	60,259,438	
	18	Grants payable			18		
	19	Deferred revenue		2,314,727	19	0	
	20	Tax-exempt bond liabilities			20		
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21		
	22	Loans and other payables to 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		0	22	0	
	23	Secured mortgages and notes payable to unrelated third parties			23		
	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		102,087,035	25	355,741,694	
	26	Total liabilities. Add lines 17 through 25		107,296,904	26	416,001,132	
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.						
	27	Net assets without donor restrictions		323,382,512	27	104,200,169	
	28	Net assets with donor restrictions			28		
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> 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		323,382,512	32	104,200,169	
33	Total liabilities and net assets/fund balances		430,679,416	33	520,201,301		

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI ☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	798,952,140
2	Total expenses (must equal Part IX, column (A), line 25)	2	848,489,380
3	Revenue less expenses. Subtract line 2 from line 1	3	-49,537,240
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	323,382,512
5	Net unrealized gains (losses) on investments	5	2,674
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	1,462,114
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-171,109,891
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	104,200,169

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
1 Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	Yes	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

Form 990 (2019)

Form 990, Part III, Line 4a:

PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK OPERATED 4 ACUTE CARE HOSPITALS. AMITA HEALTH ST. MARY'S HOSPITAL IS A 178-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY. DURING JULY 1, 2019 - JUNE 30, 2020, AMITA HEALTH ST. MARY'S HOSPITAL TREATED 5,074 ADULTS AND CHILDREN FOR A TOTAL OF 19,198 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES FOR 108,183 OUTPATIENT VISITS, WHICH INCLUDED 2,664 OUTPATIENT SURGERIES AND 24,296 EMERGENCY ROOM VISITS. AMITA HEALTH ST. JOSEPH MEDICAL CENTER IS A 478-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY. DURING JULY 1, 2019 - JUNE 30, 2020, AMITA HEALTH ST. JOSEPH MEDICAL CENTER TREATED 17,040 ADULTS AND CHILDREN FOR A TOTAL OF 83,764 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES FOR 287,163 OUTPATIENT VISITS, WHICH INCLUDED 5,335 OUTPATIENT SURGERIES AND 54,560 EMERGENCY ROOM VISITS. AMITA HEALTH ST. JOSEPH HOSPITAL - ELGIN IS A 184-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY. DURING JULY 1, 2019 - JUNE 30, 2020, AMITA HEALTH ST. JOSEPH HOSPITAL - ELGIN TREATED 5,709 ADULTS AND CHILDREN FOR A TOTAL OF 31,385 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES FOR 114,220 OUTPATIENT VISITS, WHICH INCLUDED 2,163 OUTPATIENT SURGERIES AND 22,544 EMERGENCY ROOM VISITS. AMITA HEALTH MERCY MEDICAL CENTER IS A 267-BED HOSPITAL CAMPUS PROVIDING SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY. DURING JULY 1, 2019 - JUNE 30, 2020, AMITA HEALTH MERCY MEDICAL CENTER TREATED 6,845 ADULTS AND CHILDREN FOR A TOTAL OF 33,893 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES FOR 137,539 OUTPATIENT VISITS, WHICH INCLUDED 1,692 OUTPATIENT SURGERIES AND 32,562 EMERGENCY ROOM VISITS. SEE SCHEDULE H FOR A NON-EXHAUSTIVE LIST OF COMMUNITY BENEFIT PROGRAMS AND DESCRIPTIONS. As part of the Ascension Catholic health ministry, the filing organization served in support of Ascension's commitment to both care for patients and communities and support caregivers and other associates through the challenges of the COVID-19 global pandemic in FY20.

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
Presence Central and Suburban Hospitals Network

Employer identification number
36-4195126

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

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

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

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) 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 ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						
18	Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

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

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

Part IV

Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations			
1 <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 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: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

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

Facts And Circumstances Test

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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
Presence Central and Suburban Hospitals Network

Employer identification number
36-4195126

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ 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 ► \$

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

Cat. No. 52283D

Schedule D (Form 990) 2019

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:

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Temporarily restricted endowment ▶

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

	Yes	No
3a(i)		
3a(ii)		
3b		

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	0	23,750,000		23,750,000
b Buildings	0	230,160,526	23,251,255	206,909,271
c Leasehold improvements	0	2,946,143	548,512	2,397,631
d Equipment	0	67,270,294	31,034,689	36,235,605
e Other	0	43,972,138	2,365,404	41,606,734
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				310,899,241

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) Other Receivables	1,793,086
(2) Physician Guarantee Asset	45,928
(3) Estimated 3rd Party Payor Settlements	2,551,321
(4) Right of Use Operating Lease Asset	37,551,534
(5) Due from Affiliates	44,766,697
(6) Savings Plan Receivable	801
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) ▶	86,709,367

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	
See Additional Data Table	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	355,741,694

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: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

Form 990, Schedule D, Part X, - Other Liabilities

1. (a) Description of Liability	(b) Book Value
Estimated 3rd Party Payor Settlement	81,010,148
Recovery Tail Liability	4,181,552
Accrued Real Estate Tax Liability	1,215,977
Current Portion Lease Liabilities	245,309
Other Liabilities	2,010,311
Due to Affiliates	107,432,953
Long Term Operating Lease Liability	37,856,377
CARES Relief Funds	11,132,104
Medicare Advance Payments	110,656,963

Supplemental Information

Return Reference	Explanation
Schedule D, Part X, Line 2 FIN 48 (ASC 740) footnote	THE SYSTEM ACCOUNTS FOR UNCERTAINTY IN INCOME TAX POSITIONS BY APPLYING A RECOGNITION THRESHOLD AND MEASUREMENT ATTRIBUTE FOR FINANCIAL STATEMENT RECOGNITION AND MEASUREMENT OF A TAX POSITION TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. THE SYSTEM HAS DETERMINED THAT NO MATERIAL UNRECOGNIZED TAX BENEFITS OR LIABILITIES EXIST AS OF JUNE 30, 2020.

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
Presence Central and Suburban Hospitals Network

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

Employer identification number
36-4195126

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			27,052,176		27,052,176	3.19 %
b Medicaid (from Worksheet 3, column a)			191,127,354	128,251,845	62,875,509	7.41 %
c Costs of other means-tested government programs (from Worksheet 3, column b)					0	0 %
d Total Financial Assistance and Means-Tested Government Programs	0	0	218,179,530	128,251,845	89,927,685	10.60 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).	65	22,198	810,268	35,107	775,161	0.09 %
f Health professions education (from Worksheet 5)	10	9,682	2,329,319	63,178	2,266,141	0.27 %
g Subsidized health services (from Worksheet 6)					0	0 %
h Research (from Worksheet 7)	1		444		444	0 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	19	886	417,035		417,035	0.05 %
j Total. Other Benefits	95	32,766	3,557,066	98,285	3,458,781	0.41 %
k Total. Add lines 7d and 7j	95	32,766	221,736,596	128,350,130	93,386,466	11.01 %

Part II

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing	1	24	1,224		1,224	0 %
2 Economic development					0	0 %
3 Community support	2	261	10,452		10,452	0 %
4 Environmental improvements	1		9,000		9,000	0 %
5 Leadership development and training for community members					0	0 %
6 Coalition building	2		974		974	0 %
7 Community health improvement advocacy					0	0 %
8 Workforce development	1	1	1,208		1,208	0 %
9 Other					0	0 %
10 Total	7	286	22,858	0	22,858	0 %

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

1 Yes

2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

2 5,691,596

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 0

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)

5 313,801,138

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

6 399,484,313

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

7 -85,683,175

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

Section C. Collection Practices

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

9a Yes

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

9b Yes

Part IV

Management Companies and Joint Ventures

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 KANKAKEE VALLEY DIALYSIS CENTER	DIALYSIS CENTER	50 %		50 %
2 DREYER MERCY AMBULATORY SURGERY CENTER	AMBULATORY SURGERY CENTER	40 %		60 %
3 CENTER FOR DIGESTIVE HEALTH	DIGESTIVE HEALTH SERVICES	10 %		90 %
4 PRESENCE SAINT JOSEPH HOSPITAL ORTHOPEDIC CLINICAL CO-MANAGEMENT COMPANY LLC	MANAGEMENT OF ORTHOPEDIC SERVICE LINE	20 %		80 %
5				
6				
7				
8				
9				
10				
11				
12				
13				

Schedule H (Form 990) 2019

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)

	Other (describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	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)
AMITA HEALTH SAINT JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

1

Community Health Needs Assessment

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

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

AMITA HEALTH SAINT JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

AMITA HEALTH SAINT JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

AMITA HEALTH SAINT JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

2

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

AMITA HEALTH MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

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

AMITA HEALTH MERCY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

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

AMITA HEALTH MERCY MEDICAL CENTER

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

3

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

AMITA HEALTH SAINT JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

AMITA HEALTH SAINT JOSEPH HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

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

AMITA HEALTH SAINT JOSEPH HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
AMITA HEALTH SAINT MARY'S HOSPITAL**Name of hospital facility or letter of facility reporting group****Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):**

4

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>https://www.amitahealth.org/about-us/community-benefit/</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

AMITA HEALTH SAINT MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0</u> % and FPG family income limit for eligibility for discounted care of <u>600.0</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

AMITA HEALTH SAINT MARY'S HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

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

AMITA HEALTH SAINT MARY'S HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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.

[illegible]

Part V **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? **21**

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

Part VI Supplemental Information

Provide the following information.

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

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

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7 Costing Methodology used to calculate financial assistance	The cost of providing charity care, means-tested government programs, and other community benefit programs is estimated using internal cost data, and is calculated in compliance with Catholic Health Association ("CHA") guidelines. The organization uses a cost accounting system that addresses all patient segments (for example, inpatient, outpatient, emergency room, private insurance, Medicaid, Medicare, uninsured, or self pay). The best available data was used to calculate the amounts reported in the table. For the information in the table, a cost-to-charge ratio was calculated and applied.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part II Community Building Activities	<p>COMMUNITY BUILDING ACTIVITIES INCLUDE PROGRAMS THAT IMPROVE THE COMMUNITY'S HEALTH AND SAFETY BY ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS, SUCH AS POVERTY, HOMELESSNESS AND ENVIRONMENTAL HAZARDS. PARTICIPATION IN COLLABORATIVE COMMUNITY EFFORTS TO PROMOTE PUBLIC HEALTH INITIATIVES IS ALSO INCLUDED, SUCH AS ENGAGEMENT IN COALITIONS AND ADVOCACY FOR HEALTH IMPROVEMENT. THESE ACTIVITIES STRENGTHEN THE COMMUNITY'S CAPACITY TO PROMOTE THE HEALTH AND WELL-BEING OF ITS RESIDENTS BY OFFERING THE EXPERTISE AND RESOURCES OF THE HEALTH CARE ORGANIZATION. HOSPITAL MINISTRIES ENGAGE IN A VARIETY OF COMMUNITY-BUILDING ACTIVITIES WHICH ULTIMATELY IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE ARE PRIVILEGED TO SERVE, EVEN THOUGH THEY ARE NOT SPECIFIC HEALTH ACTIVITIES. EXAMPLES OF COMMUNITY BUILDING ACTIVITIES INCLUDE: -THE WORK OF ALL OF OUR HOSPITALS IN SUPPORT OF DISASTER READINESS AND EMERGENCY PREPAREDNESS. THIS WORK GOES ABOVE AND BEYOND ANY LICENSURE REQUIREMENTS TO PROACTIVELY ENSURE THAT OUR COMMUNITIES ARE SAFE AND PREPARED IF A DISASTER SHOULD PRESENT ITSELF. -COMMUNITY SUPPORT: DONATIONS FROM OUR MINISTRIES TO ORGANIZATIONS ADDRESSING THE ROOT CAUSES OF HEALTH PROBLEMS. -COALITION BUILDING: WITH THE GOAL OF MAKING COMMUNITIES A THRU WORKING WITH LOCAL LEGISLATORS ON POLICY, SYSTEMS AND ENVIRONMENTAL CHANGES. -WORKFORCE DEVELOPMENT: PARTNERING WITH LOCAL SCHOOLS TO ALLOW LOCAL TEEN PARTICIPANTS THE OPPORTUNITY TO USE THEIR TIME AND TALENTS FOR THOSE IN NEED, WHILE PROVIDING THEMSELVES WITH EXCELLENT EXPOSURE TO MANY HEALTH-RELATED CAREERS, AS WELL AS BUSINESS COMMUNICATIONS AND EARLY CHILDHOOD TEACHING.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 2 Bad debt expense - methodology used to estimate amount	AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE AND REASONABLE EFFORTS TO COLLECT FROM THE PATIENT HAVE BEEN EXHAUSTED, THE CORPORATION FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST-DUE PATIENT BALANCES WITHIN COLLECTION AGENCIES, SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY ASCENSION HEALTH. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH THE CORPORATION'S POLICIES. AFTER APPLYING THE COST-TO-CHARGE RATIO, THE SHARE OF THE BAD DEBT EXPENSE FOR JULY 1, 2019 THROUGH JUNE 30, 2020 WAS \$31,852,201 AT CHARGES, (\$5,691,596 AT COST).

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 3 Bad Debt Expense Methodology	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK has a very robust financial assistance program; therefore, no estimate is made for bad debt attributable to financial assistance eligible patients.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 4 Bad debt expense - financial statement footnote	THE ORGANIZATION IS PART OF THE ASCENSION HEALTH ALLIANCE'S CONSOLIDATED AUDIT IN WHICH THE FOOTNOTE THAT DISCUSSES THE BAD DEBT (IMPLICIT PRICE CONCESSIONS) EXPENSE IS LOCATED IN FOOTNOTE #2, PAGES 16-18.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 8 Community benefit & methodology for determining medicare costs	A COST TO CHARGE RATIO IS APPLIED TO THE ORGANIZATION'S MEDICARE EXPENSE TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE ORGANIZATION'S MEDICARE COST REPORT. ASCENSION HEALTH AND ITS RELATED HEALTH MINISTRIES FOLLOW THE CATHOLIC HEALTH ASSOCIATION (CHA) GUIDELINES FOR DETERMINING COMMUNITY BENEFIT. CHA COMMUNITY BENEFIT REPORTING GUIDELINES SUGGEST THAT MEDICARE SHORTFALL IS NOT TREATED AS COMMUNITY BENEFIT.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b Collection practices for patients eligible for financial assistance	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK FOLLOWS THE ASCENSION GUIDELINES FOR COLLECTION PRACTICES RELATED TO PATIENTS QUALIFYING FOR CHARITY OR FINANCIAL ASSISTANCE. A PATIENT CAN APPLY FOR CHARITY OR FINANCIAL ASSISTANCE AT ANY TIME DURING THE COLLECTION CYCLE. ONCE QUALIFYING DOCUMENTATION IS RECEIVED THE PATIENT'S ACCOUNT IS ADJUSTED. PATIENT ACCOUNTS FOR THE QUALIFYING PATIENT IN THE PREVIOUS SIX MONTHS MAY ALSO BE CONSIDERED FOR CHARITY OR FINANCIAL ASSISTANCE. ONCE A PATIENT QUALIFIES FOR CHARITY OR FINANCIAL ASSISTANCE, ALL COLLECTION ACTIVITY IS SUSPENDED. COLLECTION POLICIES ARE THE SAME FOR ALL PRESENCE HEALTH HOSPITALS. PATIENTS ARE NOTIFIED OF THE FINANCIAL ASSISTANCE POLICY AT THE TIME OF REGISTRATION VIA POSTED NOTIFICATIONS AND ON EVERY ACCOUNT STATEMENT THAT IS SENT TO THEM. THIS INFORMATION IS AVAILABLE IN ALL LANGUAGES SPOKEN BY AT LEAST 1,000 HOUSEHOLDS OF LIMITED ENGLISH PROFICIENCY IN THE AREA SERVED BY THE HOSPITAL ENTITY, PER FINAL RULE 501(R) GUIDELINES. PATIENTS MAY APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THE REVENUE CYCLE. PER THE PROVISION FOR FINANCIAL ASSISTANCE POLICY, THE COLLECTION PROCESS IS AS FOLLOWS: 1. PRE-LITIGATION REVIEW: PRIOR TO AN ACCOUNT BEING AUTHORIZED FOR THE FILING OF SUIT FOR NON-PAYMENT OF A PATIENT BILL, A FINAL REVIEW OF THE ACCOUNT WILL BE CONDUCTED AND APPROVED BY THE FINANCIAL COUNSELING REPRESENTATIVE (OR DESIGNEE) TO MAKE SURE THAT NO APPLICATION OF FINANCIAL ASSISTANCE WAS EVER RECEIVED AND THAT THERE EXISTS OBJECTIVE EVIDENCE THAT THE PATIENT DOES HAVE SUFFICIENT FINANCIAL MEANS TO PAY ALL OR PART OF HIS/HER BILL. PRIOR TO A COLLECTIONS SUIT BEING FILED, THE SELF-PAY COLLECTIONS DIRECTOR MUST REVIEW AND APPROVE. 2. RESIDENTIAL LIENS: NO HOSPITAL WILL PLACE A LIEN ON THE PRIMARY RESIDENCE OF A PATIENT WHO HAS BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE, FOR PAYMENT OF THE PATIENT'S UNDISCOUNTED BALANCE DUE. FURTHER, IN NO CASE WILL ANY HOSPITAL EXECUTE A LIEN BY FORCING THE SALE OR FORECLOSURE OF THE PRIMARY RESIDENCE OF ANY PATIENT TO PAY FOR ANY OUTSTANDING MEDICAL BILL. 3. NO USE OF BODY ATTACHMENTS: NO HOSPITAL WILL USE BODY ATTACHMENT TO REQUIRE ANY PERSON, WHETHER RECEIVING FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS OR NOT, TO APPEAR IN COURT. 4. COLLECTION AGENCY REFERRALS: EACH HOSPITAL FINANCE ACCOUNTING WILL ENSURE THAT ALL COLLECTION AGENCIES USED TO COLLECT PATIENT BILLS PROMPTLY REFER ANY PATIENT WHO INDICATES FINANCIAL NEED, OR OTHERWISE APPEARS TO QUALIFY FOR FINANCIAL ASSISTANCE/CHARITY CARE DISCOUNTS, TO A FINANCIAL COUNSELOR TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR SUCH A CHARITABLE DISCOUNT. IN CASES WHERE A PATIENT HAS BEEN BILLED BUT IS LATER DETERMINED TO QUALIFY UNDER THE FINANCIAL ASSISTANCE POLICY WITHIN THE APPLICATION PERIOD, THE CHARGE IS REVERSED AND THE APPROPRIATE AMOUNT APPLIED TO CHARITY, AND THE PATIENT IS PROVIDED A REFUND IF THE FINAL PATIENT RESPONSIBILITY IS LESS THAN THE PATIENT ALREADY PAID. FOR MORE INFORMATION ABOUT PRESENCE HEALTH'S FINANCIAL ASSISTANCE PROGRAM, VISIT https://www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16a FAP website	- AMITA HEALTH SAINT JOSEPH MEDICAL CENTER: Line 16a URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH MERCY MEDICAL CENTER: Line 16a URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT JOSEPH HOSPITAL: Line 16a URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT MARY'S HOSPITAL: Line 16a URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ;

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16b FAP Application website	- AMITA HEALTH SAINT JOSEPH MEDICAL CENTER: Line 16b URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH MERCY MEDICAL CENTER: Line 16b URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT JOSEPH HOSPITAL: Line 16b URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT MARY'S HOSPITAL: Line 16b URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ;

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16c FAP plain language summary website	- AMITA HEALTH SAINT JOSEPH MEDICAL CENTER: Line 16c URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH MERCY MEDICAL CENTER: Line 16c URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT JOSEPH HOSPITAL: Line 16c URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ; - AMITA HEALTH SAINT MARY'S HOSPITAL: Line 16c URL: www.amitahealth.org/patient-resources/pay-your-bill/financial-assistance/ ;

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2 Needs assessment	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK JOINS FORCES WITH LOCAL COMMUNITY ORGANIZATIONS TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY. COMMUNITY HEALTH NEEDS ASSESSMENTS (CHNAS) ARE COMPLETED FOR THE INDIVIDUAL COUNTIES WE SERVE WITH COMMUNITY PARTNERS EVERY 3 YEARS AS REQUIRED. TO SUPPLEMENT THE CHNA, PRESENCE HOSPITALS ALSO REVIEW AND ANALYZE INPATIENT AND EMERGENCY DEPARTMENT UTILIZATION ON AN ANNUAL BASIS TO UNCOVER ANY NEW COMMUNITY HEALTH TRENDS. IN ADDITION TO ASSESSING THE HEALTH NEEDS, PRESENCE HOSPITAL MINISTRIES ALSO COMPLETE MEDICAL STAFF DEVELOPMENT PLANS. THE PLANS ARE CONDUCTED BY EXTERNAL CONSULTANTS, WHO PROVIDE AN INDEPENDENT ASSESSMENT OF THE NEED FOR PHYSICIANS BY SPECIALTY WITHIN THE HOSPITAL'S PRIMARY SERVICE AREA AS DEFINED BY STARK REGULATIONS. IDENTIFYING COMMUNITY NEEDS IS JUST ONE STEP IN THE CHNA PROCESS. THE MOST CRITICAL STEP IS PRIORITIZING AND ALIGNING EXPERTISE TO MAKE AN IMPACT ON THE IDENTIFIED NEEDS. TO FACILITATE THIS PROCESS, THE BOARD OF DIRECTORS OF EACH HOSPITAL MINISTRY HAS APPOINTED A COMMUNITY LEADERSHIP BOARD THAT IS ULTIMATELY RESPONSIBLE FOR THE OVERSIGHT AND DIRECTION OF THE COMMUNITY BENEFIT INITIATIVES. ON A TRIENNIAL BASIS THIS ADVISORY BOARD, WHICH IS MADE UP OF COMMUNITY MEMBERS, APPROVES THE HOSPITAL'S IMPLEMENTATION STRATEGY PURSUANT TO AUTHORITY DELEGATED BY THE HOSPITAL MINISTRY'S BOARD OF DIRECTORS. THIS PLAN IDENTIFIES THE PRIORITIES AND ACTIONS THAT WILL TAKE PLACE TO TRANSFORM COMMUNITY HEALTH.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3 Patient education of eligibility for assistance	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK IS COMMITTED TO DELIVERING EFFECTIVE, SAFE, PERSON-CENTRIC, HEALTHCARE TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. AS A NONPROFIT HEALTH SYSTEM, IT IS OUR MISSION AND PRIVILEGE TO PLAY THIS IMPORTANT ROLE IN OUR COMMUNITY. STAFF SCREEN UNINSURED PATIENTS AND IF FOUND POTENTIALLY ELIGIBLE FOR A GOVERNMENT FUNDING SOURCE, PROVIDE ASSISTANCE AND/OR RESOURCES TO THE PATIENT AND THEIR FAMILY. IF A PATIENT IS NOT ELIGIBLE FOR A PAYMENT SOURCE, PRESENCE HEALTH'S FINANCIAL ASSISTANCE POLICY COVERS PATIENTS WHO LACK THE FINANCIAL RESOURCES TO PAY FOR ALL OR PART OF THEIR BILLS. ELIGIBILITY FOR FINANCIAL ASSISTANCE IS BASED UPON THE ANNUAL FEDERAL POVERTY GUIDELINES; PRESENCE HEALTH HOSPITALS PROVIDE FINANCIAL ASSISTANCE FOR THOSE WHO EARN UP TO 600% OF THE FEDERAL POVERTY LEVEL. PRESENCE HEALTH HOSPITALS WIDELY PUBLICIZE THEIR: - FINANCIAL ASSISTANCE POLICY - FINANCIAL ASSISTANCE APPLICATION - FINANCIAL ASSISTANCE POLICY SUMMARY - BILLING AND COLLECTIONS POLICY - AMOUNT GENERALLY BILLED (AGB) CALCULATION - LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY VIA THE HOSPITAL FACILITY'S WEBSITE - https://www.amitahealth.org/patient-resources/pay-your-bill/price-estimates/financial-assistance-documents PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK MAKE PAPER COPIES OF THE: - FINANCIAL ASSISTANCE POLICY - FINANCIAL ASSISTANCE APPLICATION - FINANCIAL ASSISTANCE POLICY SUMMARY - BILLING AND COLLECTIONS POLICY - AMOUNT GENERALLY BILLED CALCULATION - LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY. THE PAPER COPIES ARE MADE READILY AVAILABLE AS PART OF THE INTAKE, DISCHARGE AND CUSTOMER SERVICE PROCESSES. UPON REQUEST, PAPER COPIES CAN ALSO BE OBTAINED BY MAIL AND BY EMAIL. PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK INFORMS THEIR PATIENTS OF THE FINANCIAL ASSISTANCE POLICY VIA A NOTICE ON PATIENT BILLING STATEMENTS, INCLUDING THE PHONE NUMBER AND WEB ADDRESS WHERE MORE INFORMATION MAY BE FOUND AND VERBALLY DURING PATIENT REGISTRATION ENCOUNTERS. PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK INFORMS THEIR PATIENTS OF THE FINANCIAL ASSISTANCE POLICY VIA SIGNAGE DISPLAYED IN THE EMERGENCY ROOM AND ADMISSIONS AREAS.</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community information	<p>Saint Joseph Medical Center AMITA HEALTH SAINT JOSEPH MEDICAL CENTER RESIDES IN WILL COUNTY Y, WHICH TOTAL POPULATION IS APPROXIMATELY 692,661 AS OF 2017. A MAJORITY OF THESE WILL CO UNTY RESIDENTS RESIDE IN JOLIET, PLAINFIELD, BOLINGBROOK, AND ROMEOVILLE. WILL COUNTY IS P REDOMINANTLY URBAN, WITH 96.07% OF THE TOTAL POPULATION LIVING IN URBAN AREAS. GEOGRAPHICA LLY, SOUTHERN WILL COUNTY IS LARGELY RURAL. THE MEDIAN AGE OF WILL COUNTY IS 36.2 YEARS, A ND THE COUNTY'S POPULATION IS SLIGHTLY YOUNGER THAN ILLINOIS' POPULATION. THE POPULATION O F FOREIGN-BORN RESIDENTS IN WILL COUNTY INCREASED SLIGHTLY BETWEEN 2011 AND 2016 (AN INCRE ASE OF 2,767 RESIDENTS). CURRENTLY, THE FOREIGN-BORN POPULATION CONSTITUTES 11.7% OF THE W ILL COUNTY POPULATION. IN 2016, THE MAJORITY OF WILL COUNTY'S POPULATION WAS WHITE (74.2%) , FOLLOWED BY BLACK/AFRICAN AMERICAN (11.2%), ASIAN (5.1%), AND AMERICAN INDIAN/ALASKA NAT IVE (0.2%). THE MEDIAN HOUSEHOLD FAMILY INCOME IN 2018 WAS \$97,733 IN WILL COUNTY WHICH HI GHER THAN ILLINOIS. HOWEVER, THERE ARE GEOGRAPHICAL INEQUITIES THAT EXIST IN INCOME WITH L OWER MEDIAN IN THE 60433 & 60432 (BOTH JOLIET) ZIP CODES AS WELL AS AMONG THE HISPANIC & L ATINO POPULATIONS. AMITA HEALTH SAINT JOSEPH MEDICAL CENTER SERVICE AREA IS DEFINED BY ZIP CODES BELOW: SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 60435 JOLIET 60436 JOLIET 60544 PLAINFIELD 60433 JOLIET 60431 JOLIET 60432 JOLIET 60434 JOLIET 60585 PLAINFIELD 60586 PLA INFIELD 60403 CREST HILL 60404 SHOREWOOD SERVICE AREA: SECONDARY MARKET - ZIP CODE CITY 60 451 NEW LENOX 60481 WILMINGTON 60450 MORRIS 60410 CHANNAHON 60446 ROMEOVILLE 60447 MINOOKA 60416 COAL CITY 60408 BRAIDWOOD 60421 ELWOOD 60441 LOCKPORT 60448 MOKENA 60442 MANHATTAN 60423 FRANKFORT 60440 BOLINGBROOK 60424 GARDNER 60439 LEMONT 60407 BRACEVILLE 60474 SOUTH WILMINGTON 60491 HOMER GLEN St. Mary's Hospital AMITA HEALTH ST. MARY'S HOSPITAL IS LOCATE D WITHIN KANKAKEE COUNTY. ACCORDING TO THE US CENSUS BUREAU, KANKAKEE HAS GROWN STEADILY O VER THE YEARS. HOWEVER, FROM 2010 TO 2015 THE POPULATION HAS DECREASED SLIGHTLY. THE TOTAL POPULATION FOR KANKAKEE WAS PROJECTED TO REACH 110,024 IN 2018. KANKAKEE COUNTY IS MAINLY URBAN WITH 75.4% OF THE TOTAL POPULATION (85,703 PEOPLE) LIVING IN URBAN AREAS. A MAJORIT Y OF KANKAKEE COUNTY RESIDENTS RESIDE IN THE CENTRAL PART OF THE COUNTY. THE MEDIAN AGE OF KANKAKEE COUNTY IS 37.6 YEARS, WHICH IS SIMILAR TO THE MEDIAN POPULATION OF ILLINOIS (37. 9). IN 2018, THE FOREIGN-BORN POPULATION CONSISTS OF NEARLY 5% OF THE KANKAKEE COUNTY POPU LATION. THE MAJORITY OF KANKAKEE COUNTY RESIDENTS ARE WHITE (79.7%) WHICH IS HIGHER THAN T HE WHITE POPULATIONS IN THE ILLINOIS (71.67%) AND US (72.75%). FIFTEEN PERCENT OF THE POPU LATION IS BLACK, IS SLIGHTLY HIGHER THAN THE ILLINOIS (14.23%) AND US (12.67%). TEN PERCENT OF THE POPULATION IS HISPANIC OR LATINO, WHICH HAS INCREASED FROM 8.2% IN 2010. IN 2017, THE MEDIAN FAMILY INCOME IS SIGNIFICANTLY LESS IN KANKAKEE COUNTY (\$56,543) THAN THE INCO ME FOR ILLINOIS RESIDENTS, AND SLIGHTLY LESS THAN THE US POPULATION. THE MEDIAN FAMILY INC OME IS HIGHEST AMONG WHITE NON-HISPANICS, AND LOWEST AMONG BLACKS. THE MEDIAN FAMILY INCOM E IS HIGHEST AMONG FAMILIES MARRIED WITH CHILDREN, AND LOWEST AMONG SINGLE FEMALES WITH CH ILDREN. AMITA HEALTH ST. MARY'S HOSPITAL SERVICE AREA IS DEFINED BY ZIP CODES BELOW: SERVI CE AREA: PRIMARY MARKET - ZIP CODE CITY 60901 KANKAKEE 60914 BOURBONNAIS 60915 BRADLEY 609 54 MOMENCE 60950 MANTENO SERVICE AREA: SECONDARY MARKET - ZIP CODE CITY 60964 SAINT ANNE 6 0927 CLIFTON 60922 CHEBANSE 60940 GRANT PARK 60970 WATSEKA 60941 HERSCHER 60913 BONFIELD 6 0938 GILMAN 60911 ASHKUM 60955 ONARGA 60944 HOPKINS PARK 60951 MARTINTON 60930 DANFORTH 60 910 AROMA PARK 60912 BEAVERVILLE 60919 CABERY 60961 REDDICK 60917 BUCKINGHAM 60935 ESSEX 6 0928 CRESCENT CITY 60481 WILMINGTON 60468 PEOTONE 60420 DWIGHT 60958 PEMBROKE TOWNSHIP Mer cy Medical Center AURORA, WHERE AMITA HEALTH MERCY MEDICAL CENTER RESIDES, IS THE SECOND L ARGEST CITY IN ILLINOIS AND ACCOUNTS FOR MOST OF THE HOSPITAL'S PRIMARY SERVICE AREA. A TO TAL OF 530,839 PEOPLE LIVE IN THE 519.36 SQUARE MILE REPORT AREA DEFINED FOR KANE COUNTY A CCORDING TO THE U.S. CENSUS BUREAU AMERICAN COMMUNITY SURVEY 2014-18 5-YEAR ESTIMATES. NEA RLY 73% OFF THE POPULATION IN KANE COUNTY IS WHITE, FOLLOWED BY OTHER RACE AT 14.7% IN 201 8. NEARLY 32% OF THE POPULATION IS HISPANIC OR LATINO ETHNICITY. THE MEDIAN AGE IS 37 YEAR S WHICH IS SIMILAR TO THAT OF ILLINOIS. NEARLY 18% OF THE POPULATION IS FOREIGN-BORN IN KA NE COUNTY WHICH IS SIGNIFICANTLY HIGHER THAN ILLINOIS (14.0%) AND THE UNITED STATED (13.4%) IN 2018. NINETY-SIX PERCENT OF THE POPULATION RESIDES IN URBAN AREAS OF THE COUNTY. IN 2 018, THE MEDIAN FAMILY INCOME IS \$90,558, WHICH IS HIGHER THAN ILLINOIS AND THE UNITED STA TES. THERE ARE GEOGRAPHICAL DISPARITIES THAT EXIST WITH LOWER INCOMES IN THE AURORA AND EL GIN. MARRIED COUPLES WITH OR WITHOUT CHILDREN EARN THE MOST INCOME IN KANE COUNTY WHILE SI NCE MALES WITH CHILDREN EARN THE LEAST. ASIAN AND</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community information	<p>NON-HISPANIC WHITE POPULATIONS EARN THE MOST WHILE BLACK POPULATIONS, OTHER RACE POPULATIONS AND HISPANIC POPULATIONS EARN THE LEAST. AMITA HEALTH MERCY MEDICAL CENTER'S SERVICE AREA IS DEFINED BY ZIP CODES BELOW: SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 60506 AURORA 60505 AURORA 60542 NORTH AURORA 60538 MONTGOMERY 60504 AURORA 60507 AURORA 60502 AURORA SERVICE AREA: SECONDARY MARKET - ZIP CODE CITY 60510 BATAVIA 60543 OSWEGO 60560 YORKVILLE 60548 SANDWICH 60545 PLANO 60174 SAINT CHARLES 60554 SUGAR GROVE 60134 GENEVA 60552 SOMONA UK 60503 AURORA 60511 BIG ROCK 60520 HINCKLEY 60119 ELBURN 60115 DEKALB 60541 NEWARK St. Joseph Hospital AMITA HEALTH SAINT JOSEPH HOSPITAL RESIDES IN KANE COUNTY. A TOTAL OF 530,839 PEOPLE LIVE IN THE 519.36 SQUARE MILE REPORT AREA DEFINED FOR KANE COUNTY ACCORDING TO THE U.S. CENSUS BUREAU AMERICAN COMMUNITY SURVEY 2014-18 5-YEAR ESTIMATES. NEARLY 73% OF THE POPULATION IN KANE COUNTY IS WHITE, FOLLOWED BY OTHER RACE AT 14.7% IN 2018. NEARLY 32 % OF THE POPULATION IS HISPANIC OR LATINO ETHNICITY. THE MEDIAN AGE IS 37 YEARS WHICH IS SIMILAR TO THAT OF ILLINOIS. NEARLY 18% OF THE POPULATION IS FOREIGN-BORN IN KANE COUNTY WHICH IS SIGNIFICANTLY HIGHER THAN ILLINOIS (14.0%) AND THE UNITED STATES (13.4%) IN 2018. NINETY-SIX PERCENT OF THE POPULATION RESIDES IN URBAN AREAS OF THE COUNTY. IN 2018, THE MEDIAN FAMILY INCOME IS \$90,558, WHICH IS HIGHER THAN ILLINOIS AND THE UNITED STATES. THERE ARE GEOGRAPHICAL DISPARITIES THAT EXIST WITH LOWER INCOMES IN THE AURORA AND ELGIN. MARRIED COUPLES WITH OR WITHOUT CHILDREN EARN THE MOST INCOME IN KANE COUNTY WHILE SINGLE MALES WITH CHILDREN EARN THE LEAST. ASIAN AND NON-HISPANIC WHITE POPULATIONS EARN THE MOST WHILE BLACK POPULATIONS, OTHER RACE POPULATIONS AND HISPANIC POPULATIONS EARN THE LEAST. AMITA HEALTH SAINT JOSEPH HOSPITAL'S SERVICE AREA IS DEFINED BY ZIP CODE BELOW: SERVICE AREA: PRIMARY MARKET - ZIP CODE CITY 60123 ELGIN 60120 ELGIN 60124 ELGIN 60121 ELGIN 60110 CARPENTERSVILLE 60177 SOUTH ELGIN 60140 HAMPSHIRE 60118 DUNDEE SERVICE AREA: SECONDARY MARKET - ZIP CODE CITY 60102 ALGONQUIN 60103 BARTLETT 60174 SAINT CHARLES 60014 CRYSTAL LAKE 60107 STRAMWOOD 60142 HUNTLEY 60098 WOODSTOCK 60050 MCHENRY 60051 MCHENRY 60156 LAKE IN THE HILLS 60175 SAINT CHARLES 60136 GILBERTS 60134 GENEVA 60013 CARY 60152 MARENGO 60135 GENOA 60109 BURLINGTON 60012 CRYSTAL LAKE 60180 UNION</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 Promotion of community health	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK ARE FAITH-BASED MINISTRIES THAT PROVIDE SERVICES BASED UPON THE ETHICAL AND RELIGIOUS DIRECTIVES OF THE CATHOLIC CHURCH. PRESENCE HEALTH HOSPITALS ENHANCE THE PUBLIC HEALTH OF OUR COMMUNITIES BY: 1. ENSURING OUR MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS. 2. ALL OF OUR HOSPITALS ARE ACCREDITED AND IN GOOD STANDING WITH THE JOINT COMMISSION ACCREDITATION OF HEALTHCARE ORGANIZATIONS. 3. ENSURING OUR BOARD OF DIRECTORS IS DIVERSE AND ABLE TO PROVIDE EXPERTISE, AND MADE UP OF INDEPENDENT MEMBERS OF THE COMMUNITIES WE SERVE. OUR BOARD MEMBERS MUST FOLLOW A CONFLICT OF INTEREST POLICY. 4. REINVESTING SURPLUS FUNDS INTO THE ORGANIZATION TO IMPROVE PATIENT CARE THROUGH NEW PROGRAMS AND TECHNOLOGY. 5. PROVIDING FINANCIAL ASSISTANCE, SLIDING SCALE DISCOUNTS AND HAS COLLECTION PRACTICES THAT ARE IN COMPLIANCE WITH STATE AND FEDERAL GUIDELINES. IN ADDITION, WE FOLLOW THE FINANCIAL ASSISTANCE AND CHARITY GUIDELINES OF THE CATHOLIC HEALTH ASSOCIATION. 6. PARTICIPATING IN ALL GOVERNMENT SPONSORED HEALTH CARE PROGRAMS, MEDICARE, MEDICAID, CHAMPUS, TRICARE, SCHIP AND OTHERS. 7. PROVIDING EMERGENCY ROOM SERVICES IN ALL OF OUR COMMUNITIES AND PROVIDING TRAINING TO LOCAL FIRE DEPARTMENTS AND AMBULANCES. OUR EMERGENCY ROOM PARTICIPATES WITH LOCAL POLICE AND FIRE DEPARTMENTS IN DISASTER DRILLS. 8. STAFFING BOARD CERTIFIED EMERGENCY ROOM PHYSICIANS IN OUR EMERGENCY ROOM AND URGENT CARE SERVICES. WE TREAT PATIENTS ACCORDING TO EMTALA GUIDELINES AND SERVE ALL PATIENTS REGARDLESS OF ABILITY TO PAY. IN ADDITION, WE ARE COMMITTED TO DETERMINING THE NEEDS OF OUR COMMUNITIES AND CREATING WAYS TO MEET THOSE NEEDS. THE OBLIGATION TO REACH OUT TO THOSE IN NEED AND IMPROVE HEALTH FLOWS DIRECTLY FROM OUR CATHOLIC IDENTITY AND THE HERITAGE OF OUR FOUNDING CONGREGATIONS. IN EACH OF THE COMMUNITIES WE SERVE, WE WORK WITH OTHERS - INCLUDING CHARITABLE ORGANIZATIONS, COMMUNITY HEALTH PROVIDERS, ELECTED OFFICIALS, BUSINESS LEADERS, SCHOOLS, CHURCHES, AND RESIDENTS - TO LOOK AT THE OVERALL HEALTH OF THE COMMUNITY AND IDENTIFY THE GREATEST NEEDS. WE THEN MAKE A PLAN AND DEVELOP STRATEGIES TOGETHER WITH OUR COMMUNITIES TO ADDRESS THE HIGHEST PRIORITY HEALTH NEEDS. THE HIGHEST PRIORITY NEEDS AND THE PROGRAMS WE'VE DEVELOPED TO MEET THESE NEEDS ARE IDENTIFIED ARE IDENTIFIED IN PART V SECTION C IN THE DESCRIPTION FOR PART V SECTION B LINE 11.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 Affiliated health care system	<p>PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK BECAME AN AFFILIATE OF ASCENSION HEALTH AND JOINED AMITA HEALTH WHEN IT WAS ACQUIRED BY ASCENSION HEALTH ON MARCH 1, 2018. PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK'S AFFILIATES ARE LARGE MULTI-FACETED, INTEGRATED, NOT-FOR-PROFIT MINISTRIES INCLUDING HOSPITAL AND NON-HOSPITAL MINISTRIES (PHYSICIAN GROUP PRACTICES, HOSPITAL ORGANIZATIONS, RESEARCH, AND HOME HEALTH,). THESE MINISTRIES WORK TOGETHER TO CARE FOR PATIENTS, JOINED BY COMMON SYSTEMS AND A PHILOSOPHY OF SERVING AS A HEALING PRESENCE WITH SPECIAL CONCERN FOR OUR NEIGHBORS ESPECIALLY THOSE WHO ARE VULNERABLE. THIS COMMUNITY BENEFIT HAPPENS THROUGH ITS FOCUS ON PATIENT CARE, EDUCATION AND RESEARCH. THE ORGANIZATIONS WORK TOGETHER TO SERVE THEIR COMMUNITIES AT THE LOCAL, REGIONAL, STATE AND NATIONAL LEVEL. ASCENSION HEALTH ALLIANCE, D/B/A ASCENSION (ASCENSION), IS A MISSOURI NONPROFIT CORPORATION FORMED ON SEPTEMBER 13, 2011. ASCENSION IS THE SOLE CORPORATE MEMBER AND PARENT ORGANIZATION OF ASCENSION HEALTH, A CATHOLIC NATIONAL HEALTH SYSTEM CONSISTING PRIMARILY OF NONPROFIT CORPORATIONS THAT OWN AND OPERATE LOCAL HEALTHCARE FACILITIES, OR HEALTH MINISTRIES, LOCATED IN 20 OF THE STATES AND THE DISTRICT OF COLUMBIA. ASCENSION IS SPONSORED BY ASCENSION SPONSOR, A PUBLIC JURIDIC PERSON. THE PARTICIPATING ORGANIZATIONS/ENTITIES OF ASCENSION SPONSOR ARE THE DAUGHTERS OF CHARITY OF ST. VINCENT DE PAUL, ST. LOUISE PROVINCE; THE CONGREGATION OF ST. JOSEPH; THE CONGREGATION OF THE SISTERS OF ST. JOSEPH OF CARONDELET; THE CONGREGATION OF ALEXIAN BROTHERS OF THE IMMACULATE CONCEPTION PROVINCE, INC. - AMERICAN PROVINCE; AND THE SISTERS OF THE SORROWFUL MOTHER OF THE THIRD ORDER OF ST. FRANCIS OF ASSISI - US/CARIBBEAN PROVINCE. AMITA HEALTH (WWW.AMITAHEALTH.ORG) IS A JOINT OPERATING COMPANY FORMED BY ASCENSION HEALTH AND ADVENTIST HEALTH SYSTEM SUNBELT HEALTHCARE CORPORATION OF WHICH ADVENTIST MIDWEST HEALTH, AND ALEXIAN BROTHERS HEALTH SYSTEM, ARE THE MEMBERS. AMITA HEALTH WELCOMED PRESENCE HEALTH TO THE ORGANIZATION IN MARCH 2018, MAKING AMITA HEALTH THE LARGEST HEALTH SYSTEM IN ILLINIOS. THROUGH ITS MEMBERS, AMITA HEALTH HAS OVER 25,000 ASSOCIATES COMMITTED TO DELIVERING THE MOST EFFICIENT, HIGHEST QUALITY, FAITH-BASED CARE AT NINETEEN ACUTE AND SPECIALTY CARE HOSPITALS AND AT MORE THAN 200 AMBULATORY/CLINIC LOCATIONS. AMITA HEALTH HAS AN EXTENSIVE PROVIDER NETWORK OF OVER 7,000 HOSPITAL-AFFILIATED PHYSICIANS, AND THE AMITA HEALTH MEDICAL GROUP CONSISTS OF OVER 800 MULTI-SPECIALTY EMPLOYED PHYSICIANS AND ASSOCIATE PRACTITIONERS, RANKING IT AMONG THE LARGEST REGIONAL MEDICAL GROUPS. AMITA HEALTH'S MISSION IS TO EXTEND THE HEALING MINISTRY OF JESUS BY RESPECTING THE FAITH TRADITIONS OF THE MANY INDIVIDUALS AND FAMILIES IT SERVES ACROSS SUBURBAN CHICAGO. WITH A SACRED MISSION OF EXTENDING THE HEALING MINISTRY OF CHRIST, ADVENTHEALTH (WWW.ADVENTHEALTH.COM) IS A CONNECTED SYSTEM OF CARE FOR EVERY STAGE OF LIFE AND HEALTH. MORE THAN 80,000 SKILLED AND COMPASSIONATE CAREGIVERS IN PHYSICIAN PRACTICES, HOSPITALS, OUTPATIENT CLINICS, SKILLED NURSING FACILITIES, HOME HEALTH AGENCIES AND HOSPICE CENTERS PROVIDE INDIVIDUALIZED, HOLISTIC CARE. A CHRISTIAN MISSION, SHARED VISION, COMMON VALUES, FOCUS ON WHOLE-PERSON HEALTH AND COMMITMENT TO MAKING COMMUNITIES HEALTHIER UNIFY THE SYSTEM'S 45 HOSPITAL CAMPUSES AND HUNDREDS OF CARE SITES IN DIVERSE MARKETS THROUGHOUT NINE STATES. THE COVERED AFFILIATES WITHIN AMITA HEALTH PROVIDE THE COMMUNITY WITH A FULL RANGE OF COMPREHENSIVE HEALTHCARE SERVICES AND ACCESS TO THE MOST ADVANCED MEDICAL TECHNOLOGY. THEIR HEALTHCARE PROFESSIONALS ARE PASSIONATE ABOUT DELIVERING EXCEPTIONAL HEALTHCARE AND ARE PROUD OF THE POWERFUL, CUTTING-EDGE TECHNOLOGY OFFERED BY THE SYSTEM. THE COVERED AFFILIATES WITHIN AMITA HEALTH ALSO OFFER A WIDE RANGE OF COMMUNITY HEALTH SERVICES, CORPORATE WELLNESS PROGRAMS, PREVENTIVE CARE AND EDUCATION. AS CHARITABLE ORGANIZATIONS, THEY RECOGNIZE THAT NOT EVERYONE CAN AFFORD ESSENTIAL MEDICAL SERVICES AND THAT THEIR MISSION IS TO SERVE THE COMMUNITY BY PROVIDING HEALTHCARE SERVICES AND HEALTHCARE EDUCATION. THEREFORE, IN KEEPING WITH AMITA HEALTH'S COMMITMENT TO SERVING ALL MEMBERS OF ITS COMMUNITY, FREE CARE AND/OR SUBSIDIZED CARE, CARE TO PERSONS COVERED BY GOVERNMENT PROGRAMS AT OR BELOW COST, AND HEALTH ACTIVITIES AND PROGRAMS TO SUPPORT THE COMMUNITY ARE CONSIDERED AND PROVIDED WHEN APPROPRIATE. THESE ACTIVITIES INCLUDE WELLNESS PROGRAMS, COMMUNITY EDUCATION PROGRAMS, SPECIAL PROGRAMS FOR THE ELDERLY AND MEDICALLY UNDERSERVED, AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES INCLUDING, BUT NOT LIMITED TO, EDUCATIONAL AFFILIATIONS, HEALTH SCREENINGS, COUNSELING PROGRAMS, CONTINUING MEDICAL EDUCATION (CME) PROGRAMS AND DONATIONS TO COMMUNITY GROUPS.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 7 State filing of community benefit report	IL

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

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		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	AMITA HEALTH SAINT JOSEPH MEDICAL CENTER 333 N MADISON STREET JOLIET, IL 60435 https://www.amitahealth.org/our-locations/hospitals/amita-health-saint-joseph-medical-center-joliet/ 0004838	X	X					X			
2	AMITA HEALTH MERCY MEDICAL CENTER 1325 NORTH HIGHLAND AVENUE AURORA, IL 60506 https://www.amitahealth.org/our-locations/hospitals/amita-health-mercy-medical-center-aurora/ 0004903	X	X					X			
3	AMITA HEALTH SAINT JOSEPH HOSPITAL 77 NORTH AIRLITE AVENUE ELGIN, IL 60123 https://www.amitahealth.org/our-locations/hospitals/amita-health-saint-joseph-hospital-elgin/ 0004887	X	X					X			
4	AMITA HEALTH SAINT MARY'S HOSPITAL 500 WEST COURT STREET KANKAKEE, IL 60901 https://www.amitahealth.org/our-locations/hospitals/amita-health-st-mary-s-hospital-kankakee/ 0004879	X	X					X			

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	To better target community resources on the service area's most pressing health needs, the hospital participated in a group discussion with organizational decision makers and community leaders to prioritize the significant community health needs while considering several criteria: alignment with Ascension Health strategies of healthcare that leaves no one behind; care for the poor and vulnerable; opportunities for partnership; availability of existing programs and resources; opportunities for partnership; addressing disparities of subgroups; availability of evidence-based practices; and community input. The significant health needs are a prioritized description of the significant health needs of the community as identified through the CHNA. See Schedule H, Part V, Line 7 for the link to the CHNA and Schedule H, Part V, Line 11 for how those needs are being addressed.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER. AMITA Health Saint Joseph Medical Center Joliet (AHSJMCJ) and members of the Will County Mobilizing through Action, Plannin g and Partnership (MAPP) Collaborative, a collaborative of the Will County Health Departme nt, local hospitals and community partners, worked together over 16 months (May 2018-Novem ber 2019) to build a comprehensive 2019 Community Health Needs Assessment (CHNA) for Will County. Using the Mobilizing for Action through Planning and Partnerships (MAPP) model for the CHNA, Will County MAPP Collaborative have engaged diverse groups of community residen ts and stakeholders and gathered robust data from various perspectives about health status and health behaviors. These prioritized health needs were selected in coordination with c ommunity residents and stakeholders through dedicated workgroups, focus groups, and 1,688 community survey responses. IN 2018, THE WILL COUNTY MAPP COLLABORATIVE CONVENED TO CONDUCT T THE FOURTH ITERATION OF THE MAPP PROCESS. MAPP IS A COMMUNITY-DRIVEN, STRATEGIC PLANNING FRAMEWORK THAT ASSISTS COMMUNITIES IN DEVELOPING AND IMPLEMENTING EFFORTS AROUND THE PRIO RITIZATION OF PUBLIC HEALTH ISSUES AND THE IDENTIFICATION OF RESOURCES TO ADDRESS THEM, AS DEFINED BY THE 10 ESSENTIAL PUBLIC HEALTH SERVICES. THE MAPP PROCESS HAS SIX PHASES WHICH INCLUDE FOUR ASSESSMENTS. COMMUNITY HEALTH STATUS ASSESSMENT THE COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) IS ONE OF FOUR ASSESSMENTS CONDUCTED AS A PART OF THE MAPP PROCESS. DURI NG THIS ASSESSMENT, INFORMATION REGARDING DEMOGRAPHICS, HEALTH STATUS, HEALTH BEHAVIORS, A ND SOCIAL DETERMINANTS IN THE COMMUNITY IS GATHERED AND ANALYZED. DATA IS COLLECTED FROM A VARIETY OF RESOURCES AND ANALYZED COMPARING LOCAL, STATE, AND NATIONAL BENCHMARKS WHEN AV AILABLE. THE CHSA WAS CONDUCTED MAY 2018 - JANUARY 2019. COMMUNITY THEMES AND STRENGTHS AS SESSMENT THE COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) AIMS TO GATHER COMMUNITY MEM BERS' PERCEPTIONS, THOUGHTS, OPINIONS, AND CONCERNS REGARDING QUALITY OF LIFE IN WILL COUN TY. THIS INPUT PROVIDES VALUABLE INSIGHT INTO THE ISSUES OF IMPORTANCE TO THE COMMUNITY. T HE CTSA WAS CONDUCTED MARCH-AUGUST 2019. FORCES OF CHANGE ASSESSMENT THE FORCES OF CHANGE ASSESSMENT (FOCA) AIMS TO IDENTIFY ALL THE FORCES AND ASSOCIATED OPPORTUNITIES AND THREATS THAT CAN AFFECT, EITHER NOW OR IN THE FUTURE, THE LOCAL PUBLIC HEALTH SYSTEM. FORCES MAY BE SOCIAL, ECONOMIC, POLITICAL, TECHNOLOGICAL, ENVIRONMENTAL, SCIENTIFIC, LEGAL, AND/OR ET HICAL IN NATURE. FORCES CAN BE TRENDS, FACTORS, OR EVENTS. THE FOCA WAS CONDUCTED FEBRUARY -MAY 2019. LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) WAS HELD VIA ELECTRONIC SURVEY AND WAS CONDUCTED IN MAY 2019.. THE LPHSA IS USED TO UNDERSTAND THE OVERALL STRENGTHS AND WEAKNESSES OF THE PUBLIC HEALTH SYSTEM BASED ON TH E 10 ESSENTIAL PUBLIC HEALTH SERVICES. THE WILL COUNTY MAPP COLLABORATIVE WAS FORMED FOLLO WING THE COMPLETION OF THE MAP

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>P PROJECT IN 2011. THE SECOND ITERATION OF THE MAPP PROCESS BEGAN IN SEPTEMBER 2012 AND WA S COMPLETED IN MAY 2014. THE THIRD ROUND OF THE MAPP PROCESS BEGAN IN JANUARY 2016 AND THE FOURTH ROUND BEGAN IN 2018 FOR COMPLETION IN LATE 2019. THE MAPP EXECUTIVE COMMITTEE MEET S QUARTERLY TO PROVIDE OVERSIGHT TO THE ONGOING MAPP PROCESS AND MAKE RECOMMENDATIONS TO T HE OVERALL OPERATIONS OF THE MAPP COLLABORATIVE. A PROGRAM COORDINATOR WAS APPOINTED IN MA RCH 2013. THE COORDINATOR IS A FULL-TIME STAFF MEMBER OF THE WILL COUNTY HEALTH DEPARTMENT , WITH PARTIAL FUNDING BY THE WILL COUNTY MAPP COLLABORATIVE. ACTION TEAMS WERE ESTABLISHE D AROUND THE IDENTIFIED PRIORITIES AND HAVE BEEN IMPLEMENTING ACTION PLANS AND STRATEGIES TO ADDRESS THOSE NEEDS. THE ACTION TEAMS ARE LED BY CHAIRS AND CO-CHAIRS FROM PARTNER ORGA NIZATIONS. MOST OF THE TEAMS MEET MONTHLY OR BI-MONTHLY AS NEEDED. ORGANIZATIONS INVOLVED IN THE MAPP EXECUTIVE COMMITTEE ARE LISTED BELOW. AMITA Health Aunt Martha's Health Servic es Catholic Charities Diocese of Joliet Chestnut Health Systems Easterseals Joliet Region, Inc. Edward-Elmhurst Hospital Governors State University Greater Joliet Area YMCA New Lif e Church Senior Services of Will County Silver Cross Hospital Stepping Stones, Inc. Three Rivers Manufacturers' Association United Way of Will County Valley View School District Wi ll County Board Will County Community Health Center Will County Executive's Office Will Co unty Health Department Will-Grundy Medical Clinic</p> <p>PRIORITIZATION OF STRATEGIC ISSUES ON SE PTEMBER 13, 2019, FORTY WILL COUNTY PUBLIC HEALTH STAKEHOLDERS PARTICIPATED IN A PLANNING SESSION AT AMITA HEALTH SAINT JOSEPH MEDICAL CENTER TO REVIEW KEY FINDINGS FROM THE FOUR M APP ASSESSMENTS, IDENTIFY CROSS-CUTTING THEMES AND POTENTIAL STRATEGIC ISSUES, AND PRIORIT IZE A SET OF STRATEGIC ISSUES. Together with our community stakeholders, we have identifie d the following prioritized health needs in our community: Behavioral Health and Substance Use, including prevention, treatment coordination, linkages, policy and education. Access to Health Care, enforcing coordination and linkage of services to ensure access to qualit y health services. Access to Food & Nutrition, creating healthy food access and linkages t hrough mapping, education and empowerment. Stabilization of the Built Environment, includi ng health services linkages, environmental evaluations for housing.</p>

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER. AMITA HEALTH SAINT JOSEPH MEDICAL CENTER PARTNERED WITH SILVER CROSS HOSPITAL, ADVENTIST BOLINGBROOK HOSPITAL AND EDWARD-elmhurst health.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER. -Aunt Martha's Health Services; -Catholic Charities Diocese of Joliet; -Chestnut Health Systems; -Easterseals Joliet Region, Inc.; -Governors State University; -Greater Joliet Area YMCA; -New Life Church; -Senior Services of Will County ; -Stepping Stones, Inc.; -Three Rivers Manufacturers' Association; -United Way of Will County; -Valley View School District; -Will County Board ; -Will County Community Health Center; -Will County Executive's Office; -Will County Health Department; -Will-Grundy Medical Clinic

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER. COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS. PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH MEDICAL CENTER. AMITA Health Saint Joseph Medical Center (SJMC) has developed an Implementation Strategy for the next three years that desc ribes the programs we are undertaking to address these prioritized health needs in our com munity. Prioritized Health Needs The following prioritized health needs will be addressed in the 2021-2023 (fiscal year) implementation strategy FOR THE TAX YEAR 2019 CHNA: Behavio ral Health and Substance Use Access to Health Care Access to Food & Nutrition Stabilizatio n of the Built Environment This implementation strategy was approved by the Presence Healt h Suburban Network Board on October 29, 2020. The collective monitoring, reporting progres s and revising will ensure the plan remains relevant and effective. Behavioral Health and Substance Use Strategy: Mental Health First Aid In response to a demonstrated system and s tate-wide need of addressing barriers to accessing and utilizing mental health services, A MITA Health Saint Joseph Medical Center Joliet and its community partners will continue to implement an evidence-based program, Mental Health First Aid (MHFA), to reduce the stigma associated with mental illness and improve the coordination of mental health care. MHFA t rains community residents and first responders to recognize, respond, and seek assistance for signs of mental illness and substance abuse. Anticipated Impact: By June 2023, AMITA H ealth Saint Joseph Medical Center Joliet and its community partners will have trained an additional 200 persons in Mental Health First Aid. Strategy: Warm Hand-off Program with Fam ily Guidance Centers In partnership with Family Guidance Center, a non-profit behavioral h ealth organization, continue the Warm Handoff Program for those AMITA Health Saint Joseph Medical Center Joliet patients with an identified substance use disorder. Family Guidance Center provides a full-time Certified Alcohol and Drug Counselor (CADC) on site at SJMC to identify patients suffering with SUD that might be looking for treatment options. Family Guidance specializes in finding appropriate inpatient or intensive outpatient treatment fo r those individuals who are uninsured or underinsured. Through the initiation of this prog ram in 2019, over 600 persons have been screened and nearly 58 persons have attended treat ment. Anticipated Impact: By June 2023, 150 patients screened through this partnership wil l have attended treatment (inpatient or outpatient) with Family Guidance Center or another SUD provider. Access to Health Care Strategy: Partnership with Will-Grundy Medical Clinic and Aunt Martha's Health & Wellness (FQHC) In order to increase and secure access to prim ary health care for those uninsured and underinsured, AMITA has partnered with Aunt Martha 's to ensure patients are assigned a medical home for post discharge care. In collaboratio n, Aunt Martha's provided on-site coordinators and phone liaisons to AMITA Health Saint Jo seph Medical Center, to round

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>in the emergency department as well as on inpatient units to coordinate primary care visit s for patients and sign patients up for Medicaid services or insurance on the federal exch anges. Additionally, AMITA Health provides clinic space within the Medical Center campus f or Aunt Martha's at a rental fee of only \$1 per year to ensure ease of access and the prov ision of quality health care for the low-income community. This location has over 9,500 vi sits in FY19 including over 4,600 unique patient visits. AMITA Health Saint Joseph Medical Center Joliet will continue to support and provide in-kind surgical and ancillary care fo r patients registered with the Will-Grundy Medical Clinic. The Clinic annually serves over 800 persons, who are the most economically vulnerable in our community and are not eligib le for government assistance. Anticipated Impact: By June 2023, over 50% of AHSJMCJ patien ts scheduled for post-discharge appointments with Aunt Martha's Health & Wellness will kee p their appointments. Access to Food and Nutrition Strategy: Rx Mobile Food Pantries & Mic ro Pantry In collaboration with Northern Illinois Food Bank (NIFB), continue the provision ing of the Rx Mobile Food Pantries and other food interventions in high need areas within the SJMC community. Work with community partner organizations to help promote the availabi lity of and locations of the pantries. Continue to refer patients from the outpatient diet ician and diabetes center to track health outcomes related to obtaining healthy foods. On average, each pantry truck serves 220 individuals with free healthy food options that they would normally not obtain on their limited incomes. Additionally, continue to support and stock the Micro Pantry on the SJMC campus, which provides 24/7 access to emergency food. A stocked pantry provides an average of 90 meals per day to those in need. Anticipated Imp act: Through June 2023, a monthly average of 220 persons will be provided with free health y food options through the Rx Mobile Food Pantry and other food interventions conducted by AHSJMCJ. Stabilizing the Built Environment Strategy: Health & Housing Collaboration Using established models of health and housing collaboration, work with the local Continuum of Care, the lead agency within a geographical area that coordinates homeless prevention and services, and other key community agencies to develop a multi agency collaborative. Suppor t the strategic planning of the local Continuum of Care to ensure homeless persons health factors and interactions within the local public health system are prioritized. Anticipate d Impact: By June 2023, in partnership with the Continuum of Care, establish a Health & Ho using Collaborative to increase care coordination of the homeless population in Will Count y. Summary of Progress FY20: In FY20, the following indicates the progress made on program ming conducted to address the identified health needs of the hospital from the 2017 & 2019 CHNA findings, as the 2019 CH</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>NA was approved during this the FY20 fiscal year. In addition to the strategic initiatives below, each hospital provided many additional health education initiatives, health focused events, in-kind services and cash donations to support and respond to the needs of the community. Prioritized Health Need: Preventing Chronic Diseases: Food Access SJMC continued to host its 24/7 emergency food pantry, a micro pantry, on its campus in FY20. Associate time was spent organizing, coordinating donations, and restocking the micro pantry that provides approximately 90 [IME1] meals per day. In FY2020, a new program, Rx Mobile Food Pantry, was initiated in partnership with Northern Illinois Food Bank to bring an on-site mobile food pantry truck to the hospital campus twice per month to provide free produce, meat and dairy. This initiative provided food to over 8,200 persons from July 2019-June 2020.</p> <p>Prioritized Health Need: Access to Dental & Health Care Through a commitment throughout AMITA Health, SJMC associates utilized the social determinant of health software, Aunt Bertha, to connect and refer patients to local resources such as food pantry, health clinics, utilities support and more. This systemic software is utilized at the patient's bedside as social needs arise that affect their health. Additionally, AMITA Health hosts Aunt Bertha on our external consumer website for community members to search for their own resources. In FY20, additional community partners were added to the resource portal and additional associates were trained on the platform. SJMC continued to provide in-kind clinic space to Aunt Martha's Health & Wellness, a federally qualified health center to ensure ease of access and the provision of quality health care for the low-income community. This location had over 9,500 visits in FY20 including over 4,600 unique patient visits. Additionally, SJMC and Aunt Martha's leadership meet to provide care coordination. In FY20, SJMC continued to support and provide in-kind surgical and ancillary care for patients registered with the Will-Grundy Medical Clinic. This free clinic serves over 800 persons annually, who are the most economically vulnerable in the community and are not eligible for government assistance. Prioritized Health Need: Behavioral Health In FY20, SJMC began a warm hand-off program in partnership with Family Guidance Centers. Through this effort, over 600 persons were screened and 58 persons attended treatment. AMITA Health has committed to providing free mental health first aid training and workshops in all our hospital communities. In FY20, SJMC provided training to 11 persons. Due to the COVID-19 pandemic, additional in-person trainings were put on hold.</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	To better target community resources on the service area's most pressing health needs, the hospital participated in a group discussion with organizational decision makers and community leaders to prioritize the significant community health needs while considering several criteria: alignment with Ascension Health strategies of healthcare that leaves no one behind; care for the poor and vulnerable; opportunities for partnership; availability of existing programs and resources; opportunities for partnership; addressing disparities of subgroups; availability of evidence-based practices; and community input. The significant health needs are a prioritized description of the significant health needs of the community as identified through the CHNA. See Schedule H, Part V, Line 7 for the link to the CHNA and Schedule H, Part V, Line 11 for how those needs are being addressed.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - AMITA HEALTH MERCY MEDICAL CENTER. THE CHNA PROCESS WAS INITIATED BY AMITA HEALTH MERCY MEDICAL CENTER AND AMITA HEALTH SAINT JOSEPH HOSPITAL IN COLLABORATION WITH T HE COMMUNITIES THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. ENGA GEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA P ROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. A MITA HEALTH MERCY MEDICAL CENTER SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT. THIS PROVIDED THE OPPORTUNITY FOR AMITA HEA LTH MERCY MEDICAL CENTER TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT. PART NERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUD ING DELNOR HOSPITAL, AMITA HEALTH SAINT JOSEPH HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERM AN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. COMMUNITY HEALT H IMPROVEMENT PLAN (CHIP) COMMITTEE TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND AMITA HEALTH MERCY MEDICAL CENTER REPRESENTA TIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE. TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUI STIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS. IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION. FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERIN G COMMITTEE WITH PUBLIC HEALTH EXPERTISE. THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNI NG PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEE T REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED . THE KANE COUNTY CHIP STEERING COMMITTEE MEMBERS ARE LISTED BELOW: -KANE COUNTY HEALTH DEPARTMENT -UNITED WAY OF ELGIN -AMITA HEALTH MERCY MEDICAL CENTER -AMITA HEALTH SAINT JOSEPH HOSPITAL -ADVOCATE SHERMAN HOSPITAL -FOX VALLEY UNITED WAY -INC BOARD -CADENCE HEALTH -R USH-COPLEY MEDICAL CENTER TO ESTABLISH PRIORITIES FOR THE IDENTIFIED NEEDS, AMITA HEALTH M ERCY MEDICAL CENTER ENGAGED IN A JOINT PRIORITIZATION EXERCISE WITH OTHER KANE COUNTY PART NER ORGANIZATIONS. ON MAY 10TH, 2018, THE KANE COUNTY HEALTH DEPARTMENT AND THE COLLABORAT ING HOSPITAL PARTNERS CONVENED A GROUP OF COMMUNITY STAKEHOLDERS (REPRESENTING A CROSS-SEC TION OF COMMUNITY-BASED AGENCIES AND ORGANIZATIONS) TO EVALUATE, DISCUSS AND PRIORITIZE HE ALTH ISSUES FOR COMMUNITY, BASED ON FINDINGS OF THIS COMMUNITY HEALTH NEEDS ASSESSMENT (CH NA). PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC) BEGAN THE MEETING WITH A PRESENTATION O F KEY FINDINGS FROM THE CHNA, HIGHLIGHTING THE SIGNIFICANT HEALTH ISSUES IDENTIFIED FROM T HE RESEARCH (SEE AREAS OF OPPO

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	RTUNITY ABOVE). FOLLOWING THE DATA REVIEW, PRC ANSWERED ANY QUESTIONS AND FACILITATED A GR OUP DIALOGUE, ALLOWING PARTICIPANTS TO ADVOCATE FOR ANY OF THE HEALTH ISSUES DISCUSSED. AF TERWARD, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF THE PRIORITIZATION EXERCISE THAT FOLLOW ED. TO SOLICIT INPUT FROM KEY INFORMANTS, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN T HE HEALTH OF THE COMMUNITY, AN ONLINE KEY INFORMANT SURVEY ALSO WAS IMPLEMENTED AS PART OF THIS PROCESS. A LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY KANE COUNTY HEALTH DEPAR TMENT AND COLLABORATING PARTNER ORGANIZATIONS; THIS LIST INCLUDED NAMES AND CONTACT INFORM ATION FOR PHYSICIANS, PUBLIC HEALTH REPRESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SE RVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS. POTENTIAL PARTICIPANTS WERE CHO SEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THE Y WORK, AS WELL AS OF THE COMMUNITY OVERALL. KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRO DUCING THE PURPOSE OF THE SURVEY AND PROVIDING A LINK TO TAKE THE SURVEY ONLINE; REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION. IN ALL, 157 COMMUNITY STAKEHOLDERS T OOK PART IN THE ONLINE KEY INFORMANT SURVEY. AMITA HEALTH MERCY MEDICAL CENTER WILL USE TH E INFORMATION FROM THIS COMMUNITY HEALTH NEEDS ASSESSMENT TO DEVELOP AN IMPLEMENTATION STR ATEGY TO ADDRESS THE SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY. WHILE THE HOSPITAL WILL LI KELY NOT IMPLEMENT STRATEGIES FOR ALL OF THE HEALTH ISSUES LISTED ABOVE, THE RESULTS OF TH IS PRIORITIZATION EXERCISE WILL BE USED TO INFORM THE DEVELOPMENT OF THE HOSPITAL'S ACTION PLAN TO GUIDE COMMUNITY HEALTH IMPROVEMENT EFFORTS IN THE COMING YEARS.

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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - AMITA HEALTH MERCY MEDICAL CENTER. KANE COUNTY HEALTH DEPARTMENT; UNITED WAY OF ELGIN; FOX VALLEY UNITED WAY; INC BOARD

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - AMITA HEALTH MERCY MEDICAL CENTER. COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS. PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - AMITA HEALTH MERCY MEDICAL CENTER - Part I. BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE, THE AREAS OF FOCUS FOR THE TAX YEAR 2017 IMPLEMENTATION STRATEGY PLAN THAT AMITA HEALTH MERCY MEDICAL CENTER WILL HELP ADDRESS INCLUDE: - MENTAL HEALTH - CHRONIC DISEASE - INCOME AND EDUCATION ALL SIGNIFICANT NEEDS IDENTIFIED IN THE TAX YEAR 2017 CHNA EXCEPT FOR INCOME & EDUCATION. AMITA HEALTH MERCY MEDICAL CENTER IS ACTIVELY PARTICIPATING ON THE KANE COUNTY INCOME & EDUCATION ACTION TEAM. AN ENVIRONMENTAL SCAN WAS COMPLETED IN 2018 TO BETTER TARGET ACTION TEAM ACTIVITIES. THERE ARE INITIATIVES PLANNED TO TARGET EARLY CAREER DEVELOPMENT FOR MIDDLE SCHOOL STUDENTS. AMITA HEALTH MERCY MEDICAL CENTER WILL CONTINUE TO SUPPORT AND COLLABORATE WITH THIS ACTION TEAM. FAITH COMMUNITY NURSING PROGRAM THE FAITH COMMUNITY NURSING (FCN) PROGRAM AT AMITA HEALTH MERCY MEDICAL CENTER INTEGRATES FAITH AND HEALTH IN ORDER TO SERVE THE HEALTH CARE NEEDS OF MEMBERS OF FAITH CONGREGATIONS AND THE COMMUNITY. THE FCN ROLE IS A SPECIALTY OF NURSING FOCUSED ON THE INTEGRATION OF THE SPIRITUAL DIMENSION INTO THE HEALTH SYSTEM THROUGH VISITS INVOLVING ADVOCACY, REFERRAL, WELLNESS EDUCATION AND NAVIGATION OF THE HEALTH SYSTEM. IN 2019, AMITA HEALTH MERCY MEDICAL CENTER PROVIDED FAITH COMMUNITIES WITH HEALTH INFORMATION AND RESOURCES INTEGRATING THE SPIRITUAL DIMENSION WITH EVIDENCE-BASED KNOWLEDGE TO ENHANCE DECISION MAKING FOR OPTIMAL HEALTHY CHOICES. THE FOLLOWING PARISHES WERE ENGAGED OUR LADY OF MARY CATHOLIC CHURCH, ST. KATHARINE DREXEL CATHOLIC CHURCH, BETHANY LUTHERAN CATHOLIC CHURCH, MAIN BAPTIST CHURCH, FOX VALLEY FAITH & HEALTH NETWORK. TOTAL PARTICIPANTS IN THE PROGRAM IN 2019 WERE 6,583. TAKE CHARGE OF YOUR HEALTH TAKE CHARGE OF YOUR HEALTH CHRONIC DISEASE SELF-MANAGEMENT PROGRAM IS A 6-WEEK PROGRAM WITH PARTICIPANTS EDUCATION WORKSHOP THAT IS EVIDENCE BASED CHRONIC DISEASE SELF MANAGEMENT PROGRAM DEVELOPED BY STANFORD SCHOOL OF MEDICINE PATIENT EDUCATION RESEARCH CENTER. THE PROGRAM PROVIDES INFORMATION AND TEACHES PRACTICAL SKILLS ON MANAGING CHRONIC HEALTH PROBLEMS. LIVE WELL, BE WELL PROGRAM GIVES PEOPLE THE CONFIDENCE AND MOTIVATION THEY NEED TO MANAGE THE CHALLENGES OF LIVING WITH CHRONIC DISEASE INCLUDING COMMUNICATION WITH PHYSICIANS, SYMPTOM MANAGEMENT, ACTION PLANNING & STRATEGIES FOR DISEASE PREVENTION. CAREGIVERS ARE ENCOURAGED TO ATTEND. IN 2019, AMITA HEALTH MERCY MEDICAL CENTER PROVIDED ACCESS TO TAKE CHARGE OF YOUR HEALTH WORKSHOPS FOR INDIVIDUALS DIAGNOSED WITH AT LEAST ONE CHRONIC DISEASE TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), LOCAL PHYSICIANS AND FAITH COMMUNITIES. TWENTY PARTICIPANTS WERE ENROLLED IN THIS PROGRAM IN FY2019. COMMUNITY WELLNESS PROGRAM THE COMMUNITY WELLNESS PROGRAM PROVIDES COMMUNITY EDUCATION AND SCREENING PROGRAMS ON A VARIETY OF HEALTH AND WELLNESS TOPICS BOTH IN THE COMMUNITY AND MAIN HOSPITAL LOCATION. COMPONENTS OF THE PROGRAM INCLUDE: BLOOD PRESSURE, BLOOD GLUCOSE, BLOOD LIPID, BO

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>DY-FAT AND BODY MASS INDEX (BMI) SCREENINGS. HEALTH EDUCATION TOPICS ON CHRONIC DISEASE IN CLUDE HYPERTENSION, STROKE, DIABETES, OBESITY AND HEART DISEASE. IN 2019, AMITA HEALTH MER CY MEDICAL CENTER PROVIDED INCREASED ACCESS TO HEALTH SCREENINGS SERVICES AND HEALTH EDUCA TION, INCLUDING WELLNESS AND CHRONIC DISEASE PREVENTION TO FAITH COMMUNITIES, AT LOCAL HEA LTH FAIR, AT LOCAL FOOD PANTRY'S AND AT FEDERALLY QUALIFIED HEALTH CENTER'S. SCREENING INC LUDED METABOLIC SCREENINGS ALONG WITH HEALTH EDUCATION ON CHRONIC DISEASE (STROKE, DIABETE S, HEART DISEASE, HIGH BLOOD PRESSURE) TO OVER 1,300 PERSONS. A-LIST DIABETES PREVENTION P ROGRAM A-LIST IS A DIABETES SCREENING AND EDUCATION PROGRAM THAT FOCUSES TO PREVENT THE ON SET OF TYPE 2 DIABETES. ESTABLISHED IN 2011, THE A-LIST: ACHIEVING GOOD HEALTH DIABETES PR EVENTION PROGRAM IS AN 8-WEEK PROGRAM THAT COMBINES DIABETES PREVENTION EDUCATION STRATEGI ES AND MEDICAL NUTRITION THERAPY CONCURRENTLY. PARTICIPANTS MUST HAVE AT LEAST ONE RISK FA CTOR FOR TYPE 2 DIABETES BUT MUST NOT BE DIAGNOSED UPON PROGRAM ENTRY. PARTICIPANTS MEET W ITH A DIABETES EDUCATOR FOR AN INDIVIDUAL INITIAL ASSESSMENT TO DETERMINE THE PLAN OF CARE . PARTICIPANTS WILL THEN ATTEND EIGHT 1.5-HOUR WORKSHOPS AND TWO INDIVIDUAL MEDICAL NUTRIT ION THERAPY SESSIONS. HEALTHY BEHAVIOR GOALS ARE SELECTED BY PARTICIPANTS AND A DIABETES E DUCATOR AT THE BEGINNING OF THE PROGRAM AND THEN TO BE RE-EVALUATED MIDWAY THROUGH THE PRO GRAM AND UPON PROGRAM COMPLETION OR AS NEEDED. IN 2019, 26 PERSONS PARTICIPATED IN A-LIST WITH 100% REPORTING INCREASED KNOWLEDGE ON DIABETES RISK FACTORS, NUTRITION AND DIABETES P REVENTION STRATEGIES. A1C ACHIEVER DIABETES MANAGEMENT PROGRAM THE A1C ACHIEVER DIABETES M ANAGEMENT PROGRAM IS A 2-3 MONTH DIABETES SELF-MANAGEMENT EDUCATION PROGRAM, WHICH HAS ACH IEVED EDUCATION RECOGNITION PROGRAM STATUS BY THE AMERICAN DIABETES ASSOCIATION AND FOLLOW THE NATIONAL STANDARDS FOR DIABETES SELF MANAGEMENT EDUCATION AND SUPPORT. PATIENTS ARE R EFERRED TO THE PROGRAM BY THEIR PRIMARY HEALTHCARE PROVIDER. THE PROGRAM INCLUDES AND INIT IAL ASSESSMENT, FOLLOWED BY A SERIES OF 5 CLASSES AND CONCLUDING WITH A FINAL ASSESSMENT. THE DIABETES EDUCATORS ARE NURSES, DIETITIANS AND PHARMACISTS. THE GOAL FOR THE PROGRAM IS TO ADOPT HEALTHIER BEHAVIORS WHICH WILL LEAD TO IMPROVED GLYCEMIC CONTROL. IN 2019, AMITA HEALTH MERCY MEDICAL CENTER OFFERED THE SELF-MANAGEMENT TRAINING AND EDUCATION TO COMMUNI TY WITH AN EMPHASIS ON THE UNDERSERVED. 80% DROPPED THEIR A1C SCORE AND 66% KEPT THEIR A1C SCORE LESS THAN 7%. ACTIVE SHOOTER RESPONSE COMMUNITY TRAINING IN RESPONSE TO THE ACTIVE SHOOTER EVENT THAT OCCURRED IN AURORA, IL IN FEBRUARY 2019, AMITA HEALTH MERCY MEDICAL CEN TER PARTNERED WITH THE AURORA POLICE DEPARTMENT (APD) OFFERING ALICE: ACTIVE SHOOTER RESPO NSE TRAINING TO SEVERAL LOCAL FAITH COMMUNITIES. ALICE (ALERT, LOCKDOWN, INFORM, COUNTER, EVACUATE) TRAINING PROVIDES PREPARATION AND A PLAN FOR INDIVIDUALS AND ORGANIZATIONS ON HO W TO MORE PROACTIVELY HANDLE T</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	HE THREAT OF AN AGGRESSIVE INTRUDER OR ACTIVE SHOOTER EVENT. ALICE TRAINING OPTION BASED T ACTICS HAVE BECOME THE ACCEPTED RESPONSE, VERSUS THE TRADITIONAL "LOCKDOWN ONLY" APPROACH. PROGRAM PARTICIPANTS INCREASED RECOGNITION OF ALICE OPTION-BASED TACTICS AND IMPROVED CON FIDENCE IN RESPONDING TO AN AGGRESSIVE INTRUDER OR ACTIVE SHOOTER EVENT. HAVING DEMONSTRAT ED ITS EFFECTIVENESS, THE PROGRAM CONTINUES TO EXPAND AND ADD BOTH PARTICIPANTS AND PARTNE RS IN THE FAITH COMMUNITY. IN 2019, 130 COMMUNITY PARTICIPANTS COMPLETED THE TRAINING HELD BY AMITA HEALTH MERCY MEDICAL CENTER. MENTAL HEALTH FIRST AID TRAINING IN RESPONSE TO A D EMONSTRATED SYSTEM AND STATE-WIDE NEED OF ADDRESSING BARRIERS TO ACCESSING AND UTILIZING M ENTAL HEALTH SERVICES, AMITA HEALTH MERCY MEDICAL CENTER INTRODUCED MENTAL HEALTH FIRST AI D (MHFA), TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL ILLNESS AND IMPROVE THE COORDINATION OF MENTAL HEALTH CARE THROUGHOUT A SIX COUNTY SERVICE AREA. COMMUNITY STAKEHOLDERS PARTNE RED IN THE DEVELOPMENT OF THE STRATEGY AND ITS IMPLEMENTATION THROUGHOUT THE PROCESS, RECR UITING TRAINEES, IDENTIFYING RESOURCES, AND DISSEMINATING FINDINGS. PROGRAM PARTICIPANTS I NCREASED RECOGNITION OF MENTAL HEALTH DISORDERS, INCREASED UNDERSTANDING OF APPROPRIATE TR EATMENTS, IMPROVED CONFIDENCE IN PROVIDING HELP TO OTHERS DURING CRISIS SITUATIONS, AND DE CREASED STIGMATIZING ATTITUDES. HAVING DEMONSTRATED ITS EFFECTIVENESS, THE PROGRAM CONTINU ES TO EXPAND AND ADD BOTH PARTICIPANTS AND PARTNERS. IN 2019, MENTAL HEALTH FIRST AID FOR PUBLIC SAFETY WAS INTRODUCED. THIS TRAINING IS AVAILABLE TO FIRST RESPONDERS. FORTY-FOUR P ERSONS ATTENDED MHFA TRAINING HELD BY AMITA HEALTH MERCY MEDICAL CENTER IN 2019.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 2	<p>Facility , 2 - AMITA HEALTH MERCY MEDICAL CENTER-PART 2. Summary of Progress FY20: In FY20 , the following indicates the progress made on programming conducted to address the identified health needs of the hospital, based on the most recent CHNA findings. In addition to the strategic initiatives below, each hospital provided many additional health education initiatives, health focused events, in-kind services and cash donations to support and respond to the needs of the community. Prioritized Health Need: Income & Education Through a commitment throughout AMITA Health, MMC associates utilized the social determinant of health software, Aunt Bertha, to connect and refer patients to local resources such as food pantry, health clinics, utilities support and more. This systemic software is utilized at the patient's bedside as social needs arise that affect their health. Additionally, AMITA Health hosts Aunt Bertha on our external consumer website for community members to search for their own resources. In FY20, additional community partners were added to the resource portal and additional associates were trained on the platform. In FY20, a micro pantry was added to the campus of MMC to assist those in poverty or low-income with an emergency food source. Associate time was spent organizing, coordinating donations, and restocking the pantry that provides approximately 90 [IME1] meals per day. MMC continued to provide a community garden on its campus with the annual produce yield being added to their micro pantry or donated to the Aurora Interfaith Food Pantry. MMC hosted Aurora University nursing student for their Community Health and Diabetes rotations, however, this was put on hold due to the restrictions that came about to address the pandemic. Faith Community Nurses from MMC worked in collaboration with local churches to host mobile food pantries as well as provide prepared meals to vulnerable community members. Prioritized Health Need: Mental Health AMITA Health has committed to providing free mental health first aid training and workshops in all our hospital communities. In FY20, MMC provided training to 19 community members in English and 22 in Spanish. Due to the COVID-19 pandemic, additional in-person trainings were put on hold. MMC continued to provide dedicated staff for 36 hours per week for the Behavioral Health Resource and Referral Call Center in FY20. This centralized resource and referral center addresses the diverse behavioral health needs of the community by directing callers to available community resources by a dedicated BHS counselor. MMC continued to serve on the FUSE (Frequent Users Systems Engagement) coalition to provide wrap around services to high utilizers of health, social and law enforcement services. Prioritized Health Need: Chronic Diseases In FY20, MMC continued to provide free diabetes prevention program to the community. Twelve persons participated with programming having to cease in the spring of 2020 due to COVID-19</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 2	estrictions. MMC provided a Diabetes Support Group that is open to any community member wh o has diabetes and family members or to anyone who wishes to learn more about diabetes and prevention. Different diabetes related educational presentations were provided along with healthy diabetes friendly recipes. In FY20 the support group served 16 participants. The support group was put on hold in the spring of 2020 due to COVID-19 restrictions. MMC cont inued to provide the Faith Community Nursing program to local churches and parishes to imp rove the health of the local community. In FY20, MMC provided over 4,800 health visits to 19 parishes and churches.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	To better target community resources on the service area's most pressing health needs, the hospital participated in a group discussion with organizational decision makers and community leaders to prioritize the significant community health needs while considering several criteria: alignment with Ascension Health strategies of healthcare that leaves no one behind; care for the poor and vulnerable; opportunities for partnership; availability of existing programs and resources; opportunities for partnership; addressing disparities of subgroups; availability of evidence-based practices; and community input. The significant health needs are a prioritized description of the significant health needs of the community as identified through the CHNA. See Schedule H, Part V, Line 7 for the link to the CHNA and Schedule H, Part V, Line 11 for how those needs are being addressed.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH HOSPITAL. THE CHNA PROCESS WAS INITIATED BY AMITA HEALTH SAINT JOSEPH HOSPITAL AND AMITA HEALTH MERCY MEDICAL CENTER IN COLLABORATION WITH THE COMMUNITIES THEY SERVE, THE KANE COUNTY HEALTH DEPARTMENT, DELNOR HOSPITAL, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANE COUNTY HEALTH DEPARTMENT FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. AMITA HEALTH SAINT JOSEPH HOSPITAL SERVED AS ONE OF EIGHT PARTNERS THAT PARTICIPATED IN THE KANE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT. THIS PROVIDED THE OPPORTUNITY FOR AMITA HEALTH SAINT JOSEPH HOSPITAL TO ACTIVELY PROVIDE EXPERTISE, INPUT, AND FINANCIAL SUPPORT. PARTNERS ALSO INVOLVED IN THIS PROCESS INCLUDED THE FOUR OTHER HOSPITALS IN KANE COUNTY INCLUDING DELNOR HOSPITAL, AMITA HEALTH MERCY MEDICAL CENTER, RUSH-COPLEY MEDICAL CENTER, SHERMAN HOSPITAL, AS WELL AS FOX VALLEY UNITED WAY AND THE UNITED WAY OF ELGIN. COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) COMMITTEE: TO PROVIDE COMMUNITY LEVEL OVERSIGHT FOR THE PROCESS, A DIVERSE GROUP OF COMMUNITY STAKEHOLDERS AND AMITA HEALTH SAINT JOSEPH HOSPITAL REPRESENTATIVES WERE INVITED TO PARTICIPATE ON THE CHIP STEERING COMMITTEE. TO ENSURE REPRESENTATIVE ENGAGEMENT, PERSONAL INVITATIONS WERE SENT TO ORGANIZATIONS REPRESENTING CULTURAL, LINGUISTIC, RACIAL, ETHNIC, AND OTHER MINORITY GROUPS. IN ADDITION, INDIVIDUALS WITH SPECIALIZED QUALIFICATIONS IN DEALING WITH SPECIAL POPULATIONS OR CLINICAL GROUPS WERE SOLICITED FOR THEIR PARTICIPATION. FINALLY, EFFORTS WERE MADE TO INCLUDE INDIVIDUALS ON THE CHIP STEERING COMMITTEE WITH PUBLIC HEALTH EXPERTISE. THOSE WHO COMMITTED TO THE ASSESSMENT AND PLANNING PROCESS BECAME THE EIGHT MEMBERS OF THE CHNA STEERING COMMITTEE, WHICH CONTINUES TO MEET REGULARLY TO PROVIDE FEEDBACK AND OVERSIGHT, ASSESS PROGRESS, AND MODIFY PLANS AS NEEDED. THE KANE COUNTY CHIP STEERING COMMITTEE MEMBERS ARE LISTED BELOW: KANE COUNTY HEALTH DEPARTMENT UNITED WAY OF ELGIN AMITA HEALTH MERCY MEDICAL CENTER AMITA HEALTH ST. JOSEPH HOSPITAL ADVOCATE SHERMAN HOSPITAL FOX VALLEY UNITED WAY INC BOARD CADENCE HEALTH RUSH-COPLEY MEDICAL CENTER TO ESTABLISH PRIORITIES FOR THE IDENTIFIED NEEDS, AMITA HEALTH SAINT JOSEPH HOSPITAL ENGAGED IN A JOINT PRIORITIZATION EXERCISE WITH OTHER KANE COUNTY PARTNER ORGANIZATIONS. ON MAY 10TH, 2018, THE KANE COUNTY HEALTH DEPARTMENT AND THE COLLABORATING HOSPITAL PARTNERS CONVENED A GROUP OF COMMUNITY STAKEHOLDERS (REPRESENTING A CROSS-SECTION OF COMMUNITY-BASED AGENCIES AND ORGANIZATIONS) TO EVALUATE, DISCUSS AND PRIORITIZE HEALTH ISSUES FOR COMMUNITY, BASED ON FINDINGS OF THIS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC) BEGAN THE MEETING WITH A PRESENTATION OF KEY FINDINGS FROM THE CHNA, HIGHLIGHTING THE SIGNIFICANT HEALTH ISSUES IDENTIFIED FROM THE RESEARCH. FOLLOWING THE DATA REVIEW

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	EW, PRC ANSWERED ANY QUESTIONS AND FACILITATED A GROUP DIALOGUE, ALLOWING PARTICIPANTS TO ADVOCATE FOR ANY OF THE HEALTH ISSUES DISCUSSED. AFTERWARD, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF THE PRIORITIZATION EXERCISE THAT FOLLOWED. TO SOLICIT INPUT FROM KEY INFORMANT S, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN THE HEALTH OF THE COMMUNITY, AN ONLINE K EY INFORMANT SURVEY ALSO WAS IMPLEMENTED AS PART OF THIS PROCESS. A LIST OF RECOMMENDED PA RTICIPANTS WAS PROVIDED BY KANE COUNTY HEALTH DEPARTMENT AND COLLABORATING PARTNER ORGANIZ ATIONS; THIS LIST INCLUDED NAMES AND CONTACT INFORMATION FOR PHYSICIANS, PUBLIC HEALTH REP RESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS. POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS OF THE COMMUNITY OVE RALL. KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRODUCING THE PURPOSE OF THE SURVEY AND PR OVIDING A LINK TO TAKE THE SURVEY ONLINE; REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION. IN ALL, 157 COMMUNITY STAKEHOLDERS TOOK PART IN THE ONLINE KEY INFORMANT SU RVEY. AMITA HEALTH SAINT JOSEPH HOSPITAL WILL USE THE INFORMATION FROM THIS COMMUNITY HEAL TH NEEDS ASSESSMENT TO DEVELOP AN IMPLEMENTATION STRATEGY TO ADDRESS THE SIGNIFICANT HEALT H NEEDS IN THE COMMUNITY. WHILE THE HOSPITAL WILL LIKELY NOT IMPLEMENT STRATEGIES FOR ALL OF THE HEALTH ISSUES LISTED ABOVE, THE RESULTS OF THIS PRIORITIZATION EXERCISE WILL BE USE D TO INFORM THE DEVELOPMENT OF THE HOSPITAL'S ACTION PLAN TO GUIDE COMMUNITY HEALTH IMPROV EMENT EFFORTS IN THE COMING YEARS.

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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH HOSPITAL. KANE COUNTY HEALTH DEPARTMENT; UNITED WAY OF ELGIN; FOX VALLEY UNITED WAY; INC BOARD

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH HOSPITAL. COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS. PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - AMITA HEALTH SAINT JOSEPH HOSPITAL-PART 1. BASED ON THE CHNA FINDINGS, INTERNAL RESOURCES, AND INTERNAL EXPERTISE, THE AREAS OF FOCUS FOR THE TAX YEAR 2017 IMPLEMENTATION STRATEGY PLAN THAT AMITA HEALTH SAINT JOSEPH HOSPITAL WILL HELP ADDRESS INCLUDE: - MENTAL HEALTH - CHRONIC DISEASE - INCOME AND EDUCATION ALL SIGNIFICANT NEEDS IDENTIFIED IN TAX YEAR 2017 CHNA ARE BEING ADDRESSED EXCEPT INCOME AND EDUCATION. IN LIEU OF A DIRECT STRATEGY TO ADDRESS THE NEED, AMITA HEALTH SAINT JOSEPH HOSPITAL JOINED THE ALIGNMENT FOR COLLABORATIVE EDUCATION COALITION IN 2018. THIS COLLABORATIVE IS FOCUSED ON THE COLLECTIVE IMPACT OF BUSINESSES AND THE SCHOOL COMMUNITIES. THEY ARE PARTNERING WITH ELGIN SCHOOL DISTRICT U-46 TO IMPROVE CAREER PATHWAYS, EARLY EDUCATION SUCCESS AND INCREASE TRAUMA EDUCATION. AMITA HEALTH SAINT JOSEPH HOSPITAL PROVIDED FUNDING TO ASSIST THE COLLABORATIVE IN THEIR EFFORTS IN DECEMBER 2018. TAKE CHARGE OF YOUR HEALTH TAKE CHARGE OF YOUR HEALTH CHRONIC DISEASE SELF-MANAGEMENT PROGRAM IS A 6-WEEK PROGRAM WITH PARTICIPANTS EDUCATION WORKSHOP THAT IS EVIDENCE BASED CHRONIC DISEASE SELF MANAGEMENT PROGRAM DEVELOPED BY STANFORD SCHOOL OF MEDICINE PATIENT EDUCATION RESEARCH CENTER. THE PROGRAM PROVIDES INFORMATION AND TEACHES PRACTICAL SKILLS ON MANAGING CHRONIC HEALTH PROBLEMS. LIVE WELL, BE WELL PROGRAM GIVES PEOPLE THE CONFIDENCE AND MOTIVATION THEY NEED TO MANAGE THE CHALLENGES OF LIVING WITH CHRONIC DISEASE INCLUDING COMMUNICATION WITH PHYSICIANS, SYMPTOM MANAGEMENT, ACTION PLANNING & STRATEGIES FOR DISEASE PREVENTION. CAREGIVERS ARE ENCOURAGED TO ATTEND. IN 2019, AMITA HEALTH SAINT JOSEPH HOSPITAL PROVIDED ACCESS TO TAKE CHARGE OF YOUR HEALTH WORKSHOPS FOR INDIVIDUALS DIAGNOSED WITH AT LEAST ONE CHRONIC DISEASE TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), LOCAL PHYSICIANS AND FAITH COMMUNITIES. TWENTY PARTICIPANTS WERE ENROLLED IN THIS PROGRAM IN FY2019. COMMUNITY WELLNESS PROGRAM THE COMMUNITY WELLNESS PROGRAM PROVIDES COMMUNITY EDUCATION AND SCREENING PROGRAMS ON A VARIETY OF HEALTH AND WELLNESS TOPICS BOTH IN THE COMMUNITY AND MAIN HOSPITAL LOCATION. COMPONENTS OF THE PROGRAM INCLUDE: BLOOD PRESSURE, BLOOD GLUCOSE, BLOOD LIPID, BODY-FAT AND BODY MASS INDEX (BMI) SCREENINGS. HEALTH EDUCATION TOPICS ON CHRONIC DISEASE INCLUDE HYPERTENSION, STROKE, DIABETES, OBESITY AND HEART DISEASE. IN 2019, AMITA PROVIDED INCREASED ACCESS TO HEALTH SCREENINGS SERVICES AND HEALTH EDUCATION, INCLUDING WELLNESS AND CHRONIC DISEASE PREVENTION TO FAITH COMMUNITIES, AT LOCAL HEALTH FAIR, AT LOCAL FOOD PANTRY'S AND AT FEDERALLY QUALIFIED HEALTH CENTERS. SCREENING INCLUDED METABOLIC SCREENINGS ALONG WITH HEALTH EDUCATION ON CHRONIC DISEASE (STROKE, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE) TO OVER 400 PERSONS. CDC NATIONAL DIABETES PREVENTION PROGRAM THE NATIONAL DIABETES PREVENTION PROGRAM (NATIONAL DPP) IS AN EVIDENCE- BASED LIFESTYLE CHANGE PROGRAM. PEOPLE AT RISK FOR TYPE 2 DIABETES PARTICIPATE IN THE PROGRAM AND WORK TO REDUCE THEIR R

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	ISK OF TYPE 2 DIABETES. HEALTHY BEHAVIOR GOALS ARE SELECTED BY PARTICIPANTS AND A DIABETES EDUCATOR AT THE BEGINNING OF THE PROGRAM AND THEN TO BE RE-EVALUATED MIDWAY THROUGH THE P ROGRAM AND UPON PROGRAM COMPLETION OR AS NEEDED. IN 2019, 36 PERSONS PARTICIPATED IN THE D PP PROVIDE BY AMITA HEALTH SAINT JOSEPH HOSPITAL. A1C ACHIEVER DIABETES MANAGEMENT PROGRAM THE A1C ACHIEVER DIABETES MANAGEMENT PROGRAM IS A 2-3 MONTH DIABETES SELF-MANAGEMENT EDUC ATION PROGRAM, WHICH HAS ACHIEVED EDUCATION RECOGNITION PROGRAM STATUS BY THE AMERICAN DIA BETES ASSOCIATION AND FOLLOW THE NATIONAL STANDARDS FOR DIABETES SELF MANAGEMENT EDUCATION AND SUPPORT. PATIENTS ARE REFERRED TO THE PROGRAM BY THEIR PRIMARY HEALTHCARE PROVIDER. T HE PROGRAM INCLUDES AND INITIAL ASSESSMENT, FOLLOWED BY A SERIES OF 5 CLASSES AND CONCLUDI NG WITH A FINAL ASSESSMENT. THE DIABETES EDUCATORS ARE NURSES, DIETITIANS AND PHARMACISTS. THE GOAL FOR THE PROGRAM IS TO ADOPT HEALTHIER BEHAVIORS WHICH WILL LEAD TO IMPROVED GLYC EMIC CONTROL. IN 2019, AMITA HEALTH SAINT JOSEPH HOSPITAL OFFERED THE SELF-MANAGEMENT TRAI NING AND EDUCATION TO COMMUNITY WITH AN EMPHASIS ON THE UNDERSERVED. 79% DROPPED THEIR A1C SCORE AND 67% KEPT THEIR A1C SCORE LESS THAN 7%. MENTAL HEALTH FIRST AID TRAINING IN RESP ONSE TO A DEMONSTRATED SYSTEM AND STATE-WIDE NEED OF ADDRESSING BARRIERS TO ACCESSING AND UTILIZING MENTAL HEALTH SERVICES, AMITA HEALTH SAINT JOSEPH HOSPITAL INTRODUCED MENTAL HEA LTH FIRST AID (MHFA), TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL ILLNESS AND IMPROVE THE COORDINATION OF MENTAL HEALTH CARE THROUGHOUT A SIX COUNTY SERVICE AREA. COMMUNITY STAKEHO LDERS PARTNERED IN THE DEVELOPMENT OF THE STRATEGY AND ITS IMPLEMENTATION THROUGHOUT THE P ROCESS, RECRUITING TRAINEES, IDENTIFYING RESOURCES, AND DISSEMINATING FINDINGS. PROGRAM PA RTICIPANTS INCREASED RECOGNITION OF MENTAL HEALTH DISORDERS, INCREASED UNDERSTANDING OF AP PROPRIATE TREATMENTS, IMPROVED CONFIDENCE IN PROVIDING HELP TO OTHERS DURING CRISIS SITUAT IONS AND DECREASED STIGMATIZING ATTITUDES. HAVING DEMONSTRATED ITS EFFECTIVENESS, THE PROG RAM CONTINUES TO EXPAND AND ADD BOTH PARTICIPANTS AND PARTNERS. IN 2019, MENTAL HEALTH FIR ST AID FOR PUBLIC SAFETY WAS INTRODUCED. THIS TRAINING IS AVAILABLE TO FIRST RESPONDERS. E IGHTY-EIGHT PERSONS ATTENDED MHFA TRAININGS HELD BY AMITA HEALTH SAINT JOSEPH HOSPITAL IN 2019. MENTAL HEALTH MENTAL HEALTH FIRST AID (MHFA): AN EVIDENCED-BASED PROGRAM AIMED AT RE DUCING THE STIGMA ASSOCIATED WITH MENTAL ILLNESS AND IMPROVES THE COORDINATION OF MENTAL H EALTH CARE THROUGHOUT A SIX COUNTY SERVICE AREA. PROGRAM PARTICIPANTS INCREASED RECOGNITIO N OF MENTAL HEALTH DISORDERS, INCREASED UNDERSTANDING OF APPROPRIATE TREATMENTS, IMPROVED CONFIDENCE IN PROVIDING HELP TO OTHERS DURING CRISIS SITUATIONS, AND DECREASED STIGMATIZIN G ATTITUDES. HAVING DEMONSTRATED ITS EFFECTIVENESS, THE PROGRAM CONTINUES TO EXPAND AND AD D BOTH PARTICIPANTS AND PARTNERS. CHRONIC DISEASE I'M REDUCING OBESITY IN CHILDREN (IROC) NUTRITION PROGRAM: THE IROC NU

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	TRITION PROGRAM IS DESIGNED TO PROVIDE A SERIES OF EIGHT 1.0 HOUR WORKSHOPS THAT WILL EMPH ASIZE PROPER NUTRITION EDUCATION FOR PARENTS AND CHILDREN INCLUDING GOAL SETTING AND MOTIV ATION RELATED TO HEALTHY BEHAVIOR ISSUES. THE WORKSHOPS ALSO PROVIDE FAMILIES WITH INFORMA TION AND RESOURCES RELEVANT TO THE TOPICS COVERED. PARENTS ATTEND AN EDUCATION WORKSHOP PR ESENTED BY A REGISTERED DIETITIAN AS CHILDREN CONCURRENTLY PARTICIPATE IN A COOKING DEMONS TRATION ACTIVITY LED BY A REGISTERED NURSE. CHILDREN CREATE AND EAT HEALTHY SNACKS IN THE CLASS THAT INTRODUCES LITTLE COOKS TO THE KITCHEN WITH EASY RECIPES, SIMPLE MEASUREMENTS A ND KITCHEN SAFETY. A1C ACHIEVER DIABETES MANAGEMENT PROGRAM: "LIFE WITH DIABETES" IS A 2-3 MONTH PROGRAM THAT COMBINES DIABETES SELF-MANAGEMENT EDUCATION AND MEDICAL NUTRITION THER APY CONCURRENTLY. PATIENTS WHO ARE REFERRED MEET WITH A DIABETES EDUCATOR FOR AN INDIVIDUA L INITIAL ASSESSMENT TO DETERMINE THE PLAN OF CARE. PATIENTS ATTEND SIX 1.5 HOUR SESSIONS AND TWO INDIVIDUAL MEDICAL NUTRITION THERAPY SESSIONS. PATIENTS SELECT HEALTHY BEHAVIOR GO ALS. ALL PATIENTS THAT ACHIEVE AN A1C OF LESS THAN 7% BECOME PART OF THE "A 1C ACHIEVER" P ROGRAM WHICH IS A PATIENT RECOGNITION PROGRAM THAT REWARDS PATIENTS FOR ACHIEVING GLYCEMIC CONTROL. DIABETES PREVENTION PROGRAM: THE NATIONAL DIABETES PREVENTION PROGRAM (NATIONAL DPP) IS AN EVIDENCE-BASED LIFESTYLE CHANGE PROGRAM. PEOPLE AT RISK FOR TYPE 2 DIABETES PAR TICIPATE IN THE PROGRAM AND WORK TO REDUCE THEIR RISK OF TYPE 2 DIABETES.HEALTHY BEHAVIOR GOALS ARE SELECTED BY PARTICIPANTS AND A DIABETES EDUCATOR AT THE BEGINNING OF THE PROGRAM AND THEN TO BE RE-EVALUATED MIDWAY THROUGH THE PROGRAM AND UPON PROGRAM COMPLETION OR AS NEEDED. COMMUNITY WELLNESS PROGRAM: THE COMMUNITY WELLNESS PROGRAM PROVIDES COMMUNITY EDUC ATION AND SCREENING PROGRAMS ON A VARIETY OF HEALTH AND WELLNESS TOPICS BOTH IN THE COMMUN ITY AND MAIN HOSPITAL LOCATION. COMPONENTS OF THE PROGRAM INCLUDE: BLOOD PRESSURE, BLOOD G LUCOSE, BLOOD LIPID, BODY FAT AND BODY MASS INDEX (BMI) SCREENINGS. HEALTH EDUCATION TOPIC S ON CHRONIC DISEASE INCLUDE HYPERTENSION, STROKE, DIABETES, OBESITY AND HEART DISEASE.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 2	Facility , 2 - AMITA HEALTH SAINT JOSEPH HOSPITAL-PART 2. LIVE WELL, BE WELL (LWBW) CHRONI C DISEASE SELF-MANAGEMENT PROGRAM: THE LWBW CHRONIC DISEASE SELF-MANAGEMENT PROGRAM IS A 6 -WEEK PROGRAM WITH EDUCATION WORKSHOPS. IT IS AN EVIDENCE BASE PROGRAM DEVELOPED BY STANFO RD SCHOOL OF MEDICINE PATIENT EDUCATION RESEARCH CENTER. THE PROGRAM PROVIDES INFORMATION AND TEACHES PRACTICAL SKILLS ON MANAGING CHRONIC HEALTH PROBLEMS. LIVE WELL, BE WELL PROGR AM GIVES PEOPLE THE CONFIDENCE AND MOTIVATION THEY NEED TO MANAGE THE CHALLENGES OF LIVING WITH CHRONIC DISEASE INCLUDING COMMUNICATION WITH PHYSICIANS, SYMPTOM MANAGEMENT, ACTION PLANNING & STRATEGIES FOR DISEASE PREVENTION. CAREGIVERS ARE ENCOURAGED TO ATTEND. INCOME AND EDUCATION LOCAL SCHOOL PARTNERSHIPS: WORK WITH AREA SCHOOLS TO DEVELOP TRAINING AND IN TERNSHIP PROGRAMS FOR STUDENTS, IMPROVE HEALTH EDUCATION, AND STRENGTHEN THE ECONOMIC VIBR ANCY OF OUR NEIGHBORHOOD. PROVIDE ADVOCACY AND SUPPORT FOR LOCAL PARTNERSHIPS WITH SCHOOLS AND SCHOOL DISTRICTS. Summary of Progress FY20: In FY20, the following indicates the prog ress made on programming conducted to address the identified health needs of the hospital, based on the most recent CHNA findings. In addition to the strategic initiatives below, e ach hospital provided many additional health education initiatives, health focused events, in-kind services and cash donations to support and respond to the needs of the community. Prioritized Health Need: Income & Education Through a commitment throughout AMITA Health, SJH associates utilized the social determinant of health software, Aunt Bertha, to connec t and refer patients to local resources such as food pantry, health clinics, utilities sup port and more. This systemic software is utilized at the patient's bedside as social needs arise that affect their health. Additionally, AMITA Health hosts Aunt Bertha on our exter nal consumer website for community members to search for their own resources. In FY20, add itional community partners were added to the resource portal and additional associates wer e trained on the platform. SJH continued to partner with the Alignment for Collaborative E ducation Partnership to increase workforce development opportunities for low-income youth from the U-46 Elgin School District. Prioritized Health Need: Mental Health AMITA Health h as committed to providing free mental health first aid training and workshops in all our h ospital communities. In FY20, SJH provided trainings to 37 community members. Due to the C OVID-19 pandemic, additional in-person trainings were put on hold. SJH continued to serve on the FUSE (Frequent Users Systems Engagement) coalition to provide wrap around services to high utilizers of health, social and law enforcement services. Prioritized Health Need: Chronic Diseases In FY20, SJH began to provide free diabetes prevention program to the co mmunity. Twelve persons participated with programming having to cease in the spring of 202 0 due to COVID-19 restrictions

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 2	. SJH continued in early FY20 to provide the Whole Body Approach to Chronic Disease Prevention, a ten week non-diet curriculum to evaluate and improve participant's relationship with food, movement and body image to lower the risk of chronic disease. Seven participants attend weekly sessions and were provided with fresh produce. This program is a partnership with Northern Illinois Food Bank and Northern Illinois University. In FY20 SJH partnered with Greater Elgin Family Care Center to provide free mini diabetes classes. The served a total of 12 participants and had to cease the program due to COVID-19 restrictions. SJH continued to provide a community garden on its campus with the annual produce yield donated low-income patients of the Diabetes Center. Seven raised bed yields were donated to these patients in need of additional fruit and vegetables.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	To better target community resources on the service area's most pressing health needs, the hospital participated in a group discussion with organizational decision makers and community leaders to prioritize the significant community health needs while considering several criteria: alignment with Ascension Health strategies of healthcare that leaves no one behind; care for the poor and vulnerable; opportunities for partnership; availability of existing programs and resources; opportunities for partnership; addressing disparities of subgroups; availability of evidence-based practices; and community input. The significant health needs are a prioritized description of the significant health needs of the community as identified through the CHNA. See Schedule H, Part V, Line 7 for the link to the CHNA and Schedule H, Part V, Line 11 for how those needs are being addressed.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - AMITA HEALTH SAINT MARY'S HOSPITAL. IN EARLY 2017, THE PARTNERSHIP FOR A HEALTHY COMMUNITY CONVENED TO CONDUCT THE THIRD ITERATION OF THE MAPP PROCESS. MAPP IS A COMMUNITY-DRIVEN, STRATEGIC PLANNING FRAMEWORK THAT ASSISTS COMMUNITIES IN DEVELOPING AND IMPLEMENTING EFFORTS AROUND THE PRIORITIZATION OF PUBLIC HEALTH ISSUES AND THE IDENTIFICATION OF RESOURCES TO ADDRESS THEM, AS DEFINED BY THE 10 ESSENTIAL PUBLIC HEALTH SERVICES. THE MAPP PROCESS HAS SIX PHASES WHICH INCLUDE FOUR ASSESSMENTS. ENGAGEMENT OF PUBLIC HEALTH EXPERTISE THE KANKAKEE COUNTY HEALTH DEPARTMENT AND PSMH CO-FACILITATED THE CHNA PROCESS BY USING THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) TOOL. THE PARTNERSHIP FOR A HEALTHY COMMUNITY FORMALLY ENGAGED THE ILLINOIS PUBLIC HEALTH INSTITUTE (IPHI) FOR ASSISTANCE IN PLANNING AND EXECUTING THE CHNA PROCESS. IPHI SERVED AS AN EXPERT PUBLIC HEALTH CONSULTANT THROUGHOUT THE CHNA TIMELINE. CHNA STEERING COMMITTEE THE STEERING COMMITTEE OF THE KANKAKEE PARTNERSHIP MEETS REGULARLY TO PROVIDE OVERSIGHT TO THE ONGOING MAPP PROCESS AND MAKE RECOMMENDATIONS. ACTION TEAMS WERE ESTABLISHED AROUND THE IDENTIFIED PRIORITIES AND HAVE BEEN IMPLEMENTING ACTION PLANS AND STRATEGIES TO ADDRESS THOSE NEEDS. THE ACTION TEAMS ARE LED BY CHAIRS AND CO-CHAIRS FROM PARTNER ORGANIZATIONS. MOST OF THE TEAMS MEET MONTHLY OR BI-MONTHLY AS NEEDED. ORGANIZATIONS ON THE KANKAKEE PARTNERSHIP FOR A HEALTHY COMMUNITY STEERING COMMITTEE ARE LISTED BELOW: - HELEN WHEELER CENTER FOR COMMUNITY MENTAL HEALTH - KANKAKEE COUNTY HEALTH DEPARTMENT - KANKAKEE COUNTY HISPANIC PARTNERSHIP - IROQUOIS & KANKAKEE COUNTY REGIONAL OFFICE OF EDUCATION - PRESENCE ST. MARY'S HOSPITAL - RIVERSIDE MEDICAL CENTER - UNITED WAY OF KANKAKEE & IROQUOIS COUNTIES THE GENERAL MEMBERSHIP CONSISTS OF PARTNERS WHO ARE NOT INVOLVED DIRECTLY WITH AN ACTION TEAM, BUT PARTICIPATE AS APPROPRIATE FOR THEIR ORGANIZATION. THEY CONTRIBUTE TO THE OVERALL ASSESSMENT PROCESS AND SOME IMPLEMENTATION STRATEGIES. PROCESS USED TO IDENTIFY COMMUNITY NEEDS EVERY FIVE YEARS, LOCAL HEALTH DEPARTMENTS IN ILLINOIS MUST COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND HEALTH PLAN AS A REQUIREMENT FOR RECERTIFICATION WITH THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH). THIS PROCESS IS KNOWN AS ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEED, (IPLAN). HOSPITALS ARE REQUIRED BY THE IRS TO COMPLETE A CHNA EVERY THREE YEARS. FOR THE 2018 ASSESSMENT AND PLANNING PROCESS, THE PARTNERSHIP FOR A HEALTHY COMMUNITY USED THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) PROCESS AS AN EQUIVALENT FOR IPLAN. THE KANKAKEE COUNTY HEALTH DEPARTMENT AND AMITA HEALTH SAINT MARY'S HOSPITAL PARTNERED TO FACILITATE THE MAPP PROCESS IN 2012 AND AGAIN IN 2015 AND 2018. FROM FEBRUARY 2017 THROUGH MARCH 2018 FOUR SEPARATE ASSESSMENTS WERE CONDUCTED. MAPP IS A PROCESS THAT PROVIDES A COMPREHENSIVE FRAMEWORK FOR ASSESSING COMMUNITY NEEDS, AND DEVELOPING AND ADDRESSING STRATEGIC ISSUES. THE PU

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	RPOSE OF THE KANKAKEE COUNTY MAPP PROCESS IS TO PROVIDE A COMMUNITY PLAN THAT IS DEVELOPED BY AND FOR THE COMMUNITY. THE BENEFITS OF KANKAKEE COUNTY ENGAGING IN THIS PROCESS INCLUD E: -A HEALTHIER COMMUNITY THAT IMPROVES THE QUALITY OF LIFE FOR THE PEOPLE WHO LIVE AND WO RK IN IT. -INCREASED VISIBILITY OF PUBLIC HEALTH IN THE COMMUNITY. -INCREASED AWARENESS AN D KNOWLEDGE ABOUT PUBLIC HEALTH ISSUES. -PREPARATION OF OUR LOCAL PUBLIC HEALTH SYSTEM TO BETTER ANTICIPATE, MANAGE AND RESPOND TO CHANGES IN THE COUNTY. -GREATER COLLABORATION AND SHARING OF RESOURCES AMONG PARTNERS. -REFLECTION OF PRIORITIES IN HOSPITAL IMPLEMENTATION STRATEGIES. MAPP HAS SIX PHASES. THE FIRST FIVE PHASES WERE COMPLETED OVER TWENTY-TWO MON THS. PHASE SIX, THE ACTION CYCLE, IS AN ONGOING PROCESS OF PLANNING, IMPLEMENTING AND EVAL UATING. KANKAKEE COUNTY IS CURRENTLY IN PHASE SIX OF THE PROCESS.

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

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

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

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - AMITA HEALTH SAINT MARY'S HOSPITAL. HELEN WHEELER CENTER FOR COMMUNITY MENTAL HEALTH; KANKAKEE COUNTY HEALTH DEPARTMENT; KANKAKEE COUNTY HISPANIC PARTNERSHIP; IROQUOIS & KANKAKEE COUNTY REGIONAL OFFICE OF EDUCATION; UNITED WAY OF KANKAKEE & IROQUOIS COUNTIES

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 7 Facility , 1	Facility , 1 - AMITA HEALTH SAINT MARY'S HOSPITAL. COPIES OF THE CHNA REPORT WERE MAILED AND/OR E-MAILED TO COMMUNITY PARTNERS WHO PARTICIPATED IN THE CHNA PROCESS. PARTNERS WERE ALSO PROVIDED LINKS TO THE WEBSITE FOR DISSEMINATION TO INDIVIDUALS ON THEIR MAILING LISTS AND RESPECTIVE CONSTITUENTS.

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - AMITA HEALTH SAINT MARY'S HOSPITAL-Part 1. AMITA HEALTH SAINT MARY'S HOSPITAL HAS IDENTIFIED THE FOLLOWING THREE FOCUS AREAS AS SIGNIFICANT HEALTH NEEDS FOR THE TAX YEAR 2017 CHNA. THESE ARE THE FOCUS AREAS IDENTIFIED BY THE PARTNERSHIP FOR A HEALTHY COMMUNITY (PHC) THROUGH A COLLECTIVE PRIORITIZATION PROCESS. ACCESS TO HEALTH -FOCUS AREAS: PREVENTION AND PRIMARY CARE, SOCIAL DETERMINANTS OF HEALTH & CHRONIC DISEASE BEHAVIORAL HEALTH -FOCUS AREAS: SUBSTANCE USE, MENTAL HEALTH, & TRAUMA AWARENESS AND PREVENTION EDUCATION AND EMPLOYMENT -FOCUS AREAS: JOB SKILLS, EMPLOYABILITY, & CAREER LADDER THE PRIORITIZED FOCUS AREAS WERE AGREED UPON BASED ON THE NEEDS THROUGHOUT KANKAKEE COUNTY. THESE NEEDS WERE ALSO GUIDED BY INFORMAL FEEDBACK FROM COMMUNITY AND HOSPITAL STAKEHOLDERS. NO WRITTEN FEEDBACK WAS RECEIVED ON AMITA HEALTH SAINT MARY'S HOSPITAL'S PREVIOUS CHNA OR IMPLEMENTATION STRATEGY. AMITA HEALTH SAINT MARY'S HOSPITAL HAS SEVERAL EXISTING PROGRAMS THAT ARE ALREADY ADDRESSING THESE NEEDS, AND OUR 2018 IMPLEMENTATION STRATEGY FURTHER REFINED THESE PROGRAMS AND IDENTIFIED NEW ONES TO ENSURE THAT ALL PRIORITIZED HEALTH NEEDS ARE ADDRESSED. ACCESS TO HEALTH SOCIAL DETERMINANTS OF HEALTH SCREENINGS CONDUCT ROUTINE SCREENINGS ON PATIENTS REGARDING THEIR ACCESS TO SERVICES AND RESOURCES. PROVIDE RESOURCE AND ASSISTANCE TO THOSE PATIENTS TO ENSURE ACCESS TO HEALTH. AMITA HEALTH SAINT MARY'S HOSPITAL PARTICIPATES IN THE AHC STUDY AND OUR CASE MANAGEMENT TEAM IS ACTIVELY SCREENING PATIENTS FOR SOCIAL DETERMINANTS OF HEALTH PER THE GRANT GUIDELINES AND REFERRING AS NEEDED USING THE AMITA HEALTH COMMUNITY RESOURCE PLATFORM (AUNT BERTHA). THIS COMMUNITY RESOURCE PLATFORM IS FREE FOR THE COMMUNITY AND PATIENTS TO USE TO LOOK FOR SERVICES IN THEIR AREA RELATED TO SOCIAL DETERMINANTS OF HEALTH. MOBILE FOOD PANTRY & MICRO PANTRY: DEVELOPMENT HOST MOBILE FOOD PANTRY TRUCKS AND PLACE MICRO PANTRIES IN DESIGNATED FOOD DESERTS. AMITA HEALTH SAINT MARY'S HOSPITAL ADDED A MICRO FOOD PANTRY TO OUR CAMPUS IN 2019. THIS EMERGENCY PANTRY IS STOCKED BY DONATIONS FROM OUR ASSOCIATES AND STOCKING IS COORDINATED BY OUR PATIENT CARE COUNSEL PRESIDENT. ADDITIONALLY, DUE TO FOOD INSECURITY IN KANKAKEE COUNTY, AMITA HEALTH SAINT MARY'S HOSPITAL HAS BEEN PLANNING IN CONJUNCTION WITH NORTHERN ILLINOIS FOOD BANK TO DEVELOP THE SCREEN AND INTERVENE PROGRAM. THIS PROGRAM WILL PROVIDE FREE NUTRITIOUS FOODS TO PATIENTS WHO TEST POSITIVE FOR FOOD INSECURITY AND HAVE AN UNDERLYING CHRONIC DISEASE ISSUE. READ IN A LIBRARY: PLACE AN AMITA HEALTH SAINT MARY'S HOSPITAL COMMUNITY HEALTH NURSE AT THE PUBLIC LIBRARY TO ANSWER HEALTH QUESTIONS, LINK INDIVIDUALS TO HEALTH AND OTHER SOCIAL SERVICES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH. THIS PROGRAM WAS ESTABLISHED IN JUNE 2019 AND BEGAN WITH ONSITE AMITA HEALTH SAINT MARY'S HOSPITAL NURSE TO ASSIST WITH ANSWERING GENERAL HEALTH QUESTIONS, PROVIDING GENERAL HEALTH AND WELLNESS SCREENINGS, LINK INDIVIDUALS TO HEALTH AND OTHER SOCIAL SERVICES

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>RVICE NEED TO THOSE IN THE LIBRARY. WE PROVIDE THE NURSE 4 DAYS PER MONTH (16 HOURS PER MO NTH) AND CONTINUE TO WORK WITH LIBRARY ADMINISTRATION TO TWEAK HOURS AND LOCATION OF SERVI CE. AMITA HEALTH SAINT MARY'S HOSPITAL HAS EXTENDED THE NURSE IN A LIBRARY CONCEPT TO A LO CAL CLINIC THAT SERVES PRIMARILY A HISPANIC POPULATION THAT DO NOT HAVE ACCESS TO HEALTH C ARE. THE COMMUNITY HEALTH CARE NURSE PROVIDES THESE SAME SERVICES AT THE CLINIC 2 DAYS PER WEEK AND SEES ON AVERAGE 10 PEOPLE PER SHIFT. WE FIT! & FIT N HEALTHY: PROVIDE EXERCISE A ND HEALTH PROGRAMS IN LOW-INCOME AREAS FOR YOUTH AND ADULTS. AMITA HEALTH SAINT MARY'S HOS PITAL OFFERS THE FIT-N-HEALTHY PROGRAM IN 5-10 WEEK SESSIONS IN LOW-INCOME AREAS OF KANKAK EE COUNTY FOCUSING ON THOSE AREAS IDENTIFIED AS HAVING A HIGHER RISK OF CHRONIC DISEASE AN D DECREASED ACCESS TO HEALTH. BY BRINGING THIS PROGRAM TO THE COMMUNITY, WE ARE REDUCING T HE NEED FOR TRANSPORTATION TO ACCESS FREE EXERCISE AND HEALTHY LIFESTYLE CLASSES. IN THE S UMMER, CHILDREN ARE ADDED TO THE PROGRAM WITH THE NAME WE FIT! THIS PROGRAM ENCOURAGES PAR ENTS AND THEIR CHILDREN TO EXERCISE TOGETHER TO INCREASE PHYSICAL ACTIVITY WITHIN AT RISK, LOW-INCOME COMMUNITIES. PADS PROGRAM/FORTITUDE: AMITA HEALTH SAINT MARY'S HOSPITAL PROVID ES SUPPORT AND IN-KIND SERVICES THE FAITH-BASED, ROTATING HOMELESS SHELTER MODEL IN KANKAK EE COUNTY. AMITA HEALTH SAINT MARY'S HOSPITAL ALSO ASSISTS IN COORDINATING ASSOCIATE VOLUN TEERS FOR TRAINING AND OPPORTUNITIES WITHIN THE PADS PROGRAM. BEHAVIORAL HEALTH MENTAL HEA LTH FIRST AID (MHFA): CERTIFICATE-BASED PROGRAM USING NATIONAL, EVIDENCE-BASED CURRICULUM THAT TEACHES THE SKILLS TO RESPOND TO THE SIGNS OF MENTAL ILLNESS AND SUBSTANCE USE DISORD ERS AMITA HEALTH SAINT MARY'S HOSPITAL CONDUCTS 2 MENTAL HEALTH FIRST AID TRAINING SESSION S EACH SUMMER PER YEAR IN COORDINATION WITH HELEN WHEELER COMMUNITY MENTAL HEALTH CENTER I N KANKAKEE. IN AUGUST 2018, A YOUTH TRAINING WAS PROVIDED TO THE COMMUNITY. TWO ADDITIONAL TRAINING WERE OFFERED IN JUL AND AUGUST 2019. OPIOID EDUCATION: PROVIDERS & COMMUNITY CON DUCT TRAINING FOR NURSING, PHYSICIANS AND OTHER PROVIDERS ON PAIN ASSESSMENT, MONITORING A ND SAFE OPIOID PRESCRIBING. COMMUNITY CONDUCT EDUCATION CAMPAIGN ON OPIOID ADDICTION AWARE NESS AS WELL AS SAFE USE, STORAGE, AND DISPOSAL OF OPIOIDS WHEN PRESCRIBED. MULTIPLE LEADE RS FROM AMITA HEALTH SAINT MARY'S HOSPITAL PARTICIPATE IN THE KANKAKEE COUNTY OPIOID TASK FORCE LED BY THE KANKAKEE COUNTY HEALTH DEPARTMENT. FOCUS OF THE GROUP IS TO PROVIDE COMMU NITY EDUCATION, TRAINING AND NARCAN KIT DISBURSEMENT. AMITA HEALTH SAINT MARY'S HOSPITAL I S WORKING ON DEVELOPING A TRAINING PROGRAM TO EXTEND EDUCATION FOR MEDICAL STAFF AND AMITA HEALTH MEDICAL GROUP PROVIDERS AND STAFF. CHILDREN'S MENTAL HEALTH 2.0 INITIATIVE (PROJEC T SUN): PARTNER IN COMMUNITY COLLABORATIVE TO REMEDY SYSTEM FOR CHILDREN'S MENTAL HEALTH S ERVICES. MULTIPLE LEADERS OF AMITA HEALTH SAINT MARY'S HOSPITAL PARTICIPATE IN THE PROJECT SUN COLLABORATION. FOCUS OF G</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	ROUP IS TO PROVIDE COMMUNITY AWARENESS, EDUCATION AND SUPPORT SERVICES IN RELATION TO PEDI ATRIC MENTAL HEALTH SERVICES, OF WHICH THERE IS A GAP IN SERVICES IN KANKAKEE COUNTY. EDUC ATION & EMPLOYMENT ANCHOR MISSION: ALIGNMENT OF HIRING AND PROCUREMENT PRACTICES LOCALLY T O ENSURE VITALITY IN THE COMMUNITIES WE SERVE. AMITA HEALTH SAINT MARY'S HOSPITAL LEADERS PARTICIPATES WITH KANKAKEE COUNTY WORKFORCE DEVELOPMENT AND ECONOMIC DEVELOPMENT TEAMS TO IDENTIFY NEEDS WITHIN THE COUNTY TO ADDRESS UNEMPLOYMENT, JOB FORCE TRAINING, OUT-COMMUTIN G, ETC. HEALTH CLINIC AT SCHOOL: IMPLEMENT HEALTH CLINIC ON SCHOOL CAMPUS TO INCREASE HEAL THCARE TRAINING OPPORTUNITIES AS WELL AS ACCESS TO CARE. SMH IN 2019 PARTNERED WITH KANKAK EE DISTRICT 111 TO CREATE A FIRST EVER HIGH SCHOOL CNA PROGRAM. DISTRICT 111 PROVIDES SEVE RAL COLLEGE CREDITS PROGRAMS AS PART OF THEIR CURRICULUM TO INCREASE GRADUATION AND EMPLOY MENT RATES AMONG THEIR STUDENTS. THE CNA PROGRAM AT AMITA HEALTH SAINT MARY'S HOSPITAL ALL OWS HIGH SCHOOL SENIORS STUDYING TO BE A CNA TO RECEIVE THEIR CLINICALS IN A HOSPITAL SETT ING ON THE UNITES WORKING HAND IN HAND WITH OUR NURSES. AMITA HEALTH SAINT MARY'S HOSPITAL MENTORING PROGRAM & SPEAKER BUREAU: PARTNER WITH LOCAL HIGH SCHOOLS TO DEVELOP MENTORING OPPORTUNITIES AND SPEAKING ENGAGEMENTS FOR YOUTH TO LEARN ABOUT VARIOUS HEALTH CAREERS. IN THE LAST 2 YEARS, AMITA HEALTH SAINT MARY'S HOSPITAL HAS INCREASED THEIR COLLABORATION WI TH LOCAL HIGH SCHOOLS AND EMPLOYMENT GROUPS TO PROVIDE JOB SHADOWING, HIGH SCHOOL VOLUNTEE R PROGRAM AND HAVE EVEN PARTICIPATED IN A GRADUATE TO GET PAID PROGRAM WHERE LOCAL HIGH SC HOOL COUNSELORS AND ADMINISTRATORS TOURED 4 LOCAL EMPLOYERS TO LEARN ABOUT LOCAL JOB OPPOR TUNITIES FOR THEIR STUDENTS THAT MAY NOT REQUIRE A 4-YEAR COLLEGE DEGREE. Summary of Progr ess FY20: In FY20, the following indicates the progress made on programming conducted to a ddress the identified health needs of the hospital, based on the most recent CHNA findings . In addition to the strategic initiatives below, each hospital provided many additional h ealth education initiatives, health focused events, in-kind services and cash donations to support and respond to the needs of the community. Prioritized Health Need: Education & E mployment Beginning in the fall of 2019, SMH began hosting high school students to complet e their CNA certificates to increase workforce skills. This was in participation with Kank akee District 111 Training Program. In FY20, twenty-seven students completed their trainin g program at SMH.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 2	<p>Facility , 2 - AMITA HEALTH SAINT MARY'S HOSPITAL-Part 2. Prioritized Health Need: Access to Health Through a commitment throughout AMITA Health, SMH associates utilized the social determinant of health software, Aunt Bertha, to connect and refer patients to local resources such as food pantry, health clinics, utilities support and more. This systemic software is utilized at the patient's bedside as social needs arise that affect their health. Additionally, AMITA Health hosts Aunt Bertha on our external consumer website for community members to search for their own resources. In FY20, additional community partners were added to the resource portal and additional associates were trained on the platform. SMH continued to provide free exercise and fitness program in low-income settings to reduce transportation and access to physical activity. The Fit N Healthy and We Fit program served over 900 persons in FY20. SMH provided a Nurse in the Library program in partnership with the Kankakee Public Library to identify patrons in need of assistance to health services or social services. This SMH RN provided consultations to over 45 persons in FY20. In FY20 a 24/7 emergency food pantry, a micro pantry, was added to the SMH campus. Associate time was spent organizing, coordinating donations and restocking the micro pantry that provides approximately 90 meals per day. During FY20, planning between SMH and Northern Illinois Food Bank took place to begin the Rx Mobile Pantry program in early FY21. The Rx Mobile Pantries provide free fruits, vegetables, meats and dairy to those that are in need. Prioritized Health Need: Behavioral Health AMITA Health has committed to providing free mental health first aid training and workshops in all our hospital communities. In FY20, SMH provided trainings to 23 community members. Due to the COVID-19 pandemic, additional in-person trainings were put on hold. SMH participates on the executive planning committee of Project SUN, a county-wide effort to increase linkages to behavioral health services for youth.</p>

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

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

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

Name and address	Type of Facility (describe)
1 PRESENCE PHYSICAL THERAPY 3000 W JEFFERSON ST JOLIET, IL 60435	PHYSICAL THERAPY
1 PRESENCE PHYSICAL THERAPY SERVICES 600 SOUTH WEBER ROAD ROMEOVILLE, IL 60446	PHYSICAL THERAPY
2 PRESENCE CENTER FOR WOUND CARE 301 NORTH MADISON ST JOLIET, IL 60435	WOUND CARE CENTER
3 PRESENCE PHYSICAL THERAPYINDUSTRIAL REHAB 852 SHARP AVENUE SHOREWOOD, IL 60404	PHYSICAL THERAPY
4 MERCY PROFESSION BUILDING PHARMACY 1315 N HIGHLAND AURORA, IL 60506	OUTPATIENT PHARMACY
5 PRESENCE PHYSICAL REHAB & SPORT INJURY 2132 JEFFERSON STREET JOLIET, IL 60435	PHYSICAL THERAPY
6 PRESENCE PHYSICAL THERAPY SERVICES 1812 LINCOLN HIGHWAY NEW LENOX, IL 60451	PHYSICAL THERAPY
7 PRESENCE PHYSICAL THERAPY SERVICES 15120 WALLIN DRIVE PLAINFIELD, IL 60544	PHYSICAL THERAPY
8 PRESENCE SLEEP DISORDER CENTER 2132 JEFFERSON STREET JOLIET, IL 60435	SLEEP DISORDER CENTER
9 PRESENCE MANTENO MEDCENTRE 501 LOCUST STREET MANTENO, IL 60950	MEDICAL OFFICE BUILDING
10 PRESENCE MEDCENTRE EAST 455 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
11 PRESENCE MEDCENTRE WEST 555 WEST COURT STREET KANKAKEE, IL 60901	MEDICAL OFFICE BUILDING
12 PRESENCE MOMENCE MEDCENTRE 739 NORTH DIXIE HIGHWAY MOMENCE, IL 60954	MEDICAL OFFICE BUILDING
13 PRESENCE PEOTONE MEDCENTRE 117 SOUTH HARLEM AVENUE PEOTONE, IL 60468	MEDICAL OFFICE BUILDING
14 PRESENCE ST MARY'S REGIONAL CANCER CTR 100 PROVENA WAY BOURONNAIS, IL 60914	REGIONAL ONCOLOGY CENTER

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)
16 PRESENCE ST MARY'S IMAGING CENTER 100 PROVENA WAY BOURONNAIS, IL 60914	IMAGING CENTER
1 PRESENCE SLEEP DISORDER 656 N CONVENT STREET BOURONNAIS, IL 60914	SLEEP DISORDER CENTER
2 PRESENCE ADVANCED IMAGING 410 EAST LINCOLN HIGHWAY NEW LENOX, IL 60451	IMAGING CENTER
3 PRESENCE HEALING ARTS PAVILION 410 EAST LINCOLN HIGHWAY NEW LENOX, IL 60451	MEDICAL OFFICE BUILDING
4 PRESENCE ADVANCED IMAGING 2000 GLENWOOD AVENUE JOLIET, IL 60435	IMAGING CENTER
5 PRESENCE HEALING ARTS PAVILION 16615 SOUTH ROUTE 59 PLAINFIELD, IL 60586	MEDICAL OFFICE BUILDING

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

Schedule I
(Form 990)

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

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

Department of the
Treasury
Internal Revenue Service

Name of the organization
Presence Central and Suburban Hospitals Network

Employer identification number

36-4195126

Part I General Information on Grants and Assistance

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

☒ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of 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 4

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

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

Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) Scholarships	1	6,000			
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
Schedule I, Part I, Line 2 Procedures for monitoring use of grant funds.	ALL ORGANIZATIONS WHICH ARE RECIPIENTS OF GRANT FUNDS ARE TAX-EXEMPT ORGANIZATIONS DESCRIBED IN 501(C)(3) OR GOVERNMENTAL ENTITIES AND THEREFORE THE CORPORATION DOES NOT MONITOR THE USE OF THOSE FUNDS.

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WILL GRUNDY MEDICAL CLINIC 213 East Cass Street Joliet, IL 60432	36-3492306	501(C)(3)	50,000				GENERAL SUPPORT
UNITED WAY OF WILL COUNTY 54 N Ottawa Stree Suite 300 Joliet, IL 60432	36-2515625	501(C)(3)	25,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YOUNG MENS CHRISTIAN ASSOCIATION JOLIET 749 Houbolt Road Joliet, IL 60431	36-2169197	501(c)(3)	24,999				GENERAL SUPPORT
CENTER OF INFORMATION OF ELGIN 28 N GROVE AVE suite 200 elgin, IL 60120	36-2776988	501(c)(3)	129,924				rent assistance

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2019
Department of the Treasury Internal Revenue Service	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.	
Name of the organization Presence Central and Suburban Hospitals Network		Employer identification number 36-4195126

Part I Questions Regarding Compensation		Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use		
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence		
<input type="checkbox"/> Tax idemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees		
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
b If any of the boxes 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	
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	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract		
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study		
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a Receive a severance payment or change-of-control payment?		4a	Yes
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?		4b	Yes
c Participate in, or receive payment from, an equity-based compensation arrangement?		4c	No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a The organization?		5a	No
b Any related organization?		5b	No
If "Yes," on line 5a or 5b, describe in Part III.			
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a The organization?		6a	No
b Any related organization?		6b	No
If "Yes," on line 6a or 6b, describe in Part III.			
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.		7	No
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.		8	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	

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.

[illegible]

Part III Supplemental Information

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

Return Reference	Explanation
Schedule J, Part I, Line 3 Arrangement used to establish the top management official's compensation	A RELATED ORGANIZATION OF THE FILING ORGANIZATION, USES ONE OR MORE OF THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S TOP MANAGEMENT OFFICIAL: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - COMPENSATION SURVEY OR STUDY, AND - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE PLEASE REFER TO THE FORM 990, PART VI, LINE 15A DISCLOSURE IN SCHEDULE O FOR ADDITIONAL DETAILS ON HOW COMPENSATION OF THE ORGANIZATION'S TOP MANAGEMENT OFFICIAL IS ESTABLISHED.
Schedule J, Part I, Line 4a Severance or change-of-control payment	THE FOLLOWING INDIVIDUAL RECEIVED SEVERANCE PAYMENTS FROM THE ORGANIZATION OR A RELATED ORGANIZATION DURING CALENDAR YEAR 2019: PAUL E BELTER - \$166,098
Schedule J, Part I, Line 4b Supplemental nonqualified retirement plan	ELIGIBLE EXECUTIVES PARTICIPATE IN A PROGRAM THAT PROVIDES FOR SUPPLEMENTAL RETIREMENT BENEFITS. THE PAYMENT OF BENEFITS UNDER THE PROGRAM, IF ANY, IS ENTIRELY DEPENDENT UPON THE FACTS AND CIRCUMSTANCES UNDER WHICH THE EXECUTIVE TERMINATES EMPLOYMENT WITH THE ORGANIZATION. BENEFITS UNDER THE PROGRAM ARE UNFUNDED AND NON-VESTED. DUE TO THE SUBSTANTIAL RISK OF FORFEITURE PROVISION, THERE IS NO GUARANTEE THAT THESE EXECUTIVES WILL EVER RECEIVE ANY BENEFIT UNDER THE PROGRAM. ANY AMOUNT ULTIMATELY PAID UNDER THE PROGRAM TO THE EXECUTIVE IS REPORTED AS COMPENSATION ON FORM 990, SCHEDULE J, PART II, COLUMN B IN THE YEAR PAID. NO INDIVIDUALS RECEIVED PAYMENT FROM THE SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN DURING CALENDAR YEAR 2019.

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 36-4195126
Name: Presence Central and Suburban Hospitals Network

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1DAVID J BORDO MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	370,909	0	36,214	0	25,453	432,576	0
1PATRICIA EDDY FORMER OFFICER (END 12/2018)	(i)	0	0	0	0	0	0	0
	(ii)	263,583	4,932	19,964	0	28,586	317,065	0
2BETTINA A JOHNSON FORMER OFFICER (END 12/2018)	(i)	0	0	0	0	0	0	0
	(ii)	252,122	50,000	14,241	0	17,045	333,408	0
3JULIE P ROKNICH SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	225,904	0	17,507	0	18,059	261,470	0
4EARL J BARNES II TREASURER (START 11/2019)	(i)	0	0	0	0	0	0	0
	(ii)	383,654	110,000	21,000	0	1,716	516,370	0
5DANA L GILBERT PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	461,080	0	55,567	0	26,829	543,476	0
6PAUL E BELTER TREASURER (END 11/2019)	(i)	0	0	0	0	0	0	0
	(ii)	474,053	360,954	263,162	8,400	17,668	1,124,237	0
7CONNIE J NOLTEMEYER FORMER KEY EMPLOYEE (END 12/2014)	(i)	0	0	0	0	0	0	0
	(ii)	146,200	0	1,779	0	10,628	158,607	0
8ROBERT J ERICKSON FORMER KEY EMPLOYEE (END 12/2018)	(i)	0	0	0	0	0	0	0
	(ii)	308,310	54,614	52,613	0	21,469	437,006	0
9MICHAEL L BROWN FORMER KEY EMPLOYEE (END 12/2018)	(i)	0	0	0	0	0	0	0
	(ii)	359,519	56,037	46,340	0	13,430	475,326	0
10CHRISTOPHER S SHRIDE FORMER KEY EMPLOYEE (END 12/2018)	(i)	0	0	0	0	0	0	0
	(ii)	326,671	19,180	31,773	0	28,881	406,505	0

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 Presence Central and Suburban Hospitals Network		Employer identification number 36-4195126

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IV, Line 20b AUDITED FINANCIAL STATEMENT	The activity of PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK is reported in the consolidated financial statements of Ascension Health Alliance. No individual audit of PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK is completed. Therefore, the audited financial statements are of Ascension Health Alliance and Affiliates, which include the activity of PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Process for Determining Compensation of Top Management Official	THE PROCESS FOR DETERMINING COMPENSATION OF THE ORGANIZATION'S CEO, EXECUTIVE DIRECTOR, OR TOP MANAGEMENT OFFICIAL, AS WELL AS THAT OF ANY OTHER OFFICERS OR SENIOR EXECUTIVES (IF A NY), IS DIRECTED BY A RELATED ORGANIZATION. THE RELATED ORGANIZATION'S BOARD COMMITTEE RESPONSIBLE FOR COMPENSATION OVERSEES THE PROCESS, UTILIZING INDEPENDENT DELEGATES WITHIN THE ORGANIZATION AS APPROPRIATE, DEPENDING ON THE ROLE. IN SOME CASES, THE PROCESS MAY UTILIZE COMPARABILITY DATA AND ANALYSIS FROM A NATIONAL THIRD-PARTY COMPENSATION FIRM; OR, IF MORE APPROPRIATE FOR THE ROLE, IT MAY INSTEAD UTILIZE OTHER APPLICABLE SOURCES OF MARKET COMPARABILITY DATA AS NEEDED TO VERIFY REASONABLENESS. THE PROCESS ALSO INCLUDES CONTEMPORANEOUS SUBSTANTIATION OF THE ANALYSIS AND DECISION REGARDING THE COMPENSATION ARRANGEMENT. COMPENSATION IS REVIEWED AT LEAST ANNUALLY AND THE PROCESS IS ADMINISTERED TO ASSURE INDEPENDENCE, AVOID CONFLICTS OF INTEREST, ENSURE REASONABLENESS AND MARKET COMPARABILITY OF TOTAL COMPENSATION, AND TO OTHERWISE ABIDE BY PERTINENT LAWS AND REGULATIONS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b PROCESS FOR DETERMINING COMPENSATION OF OTHER OFFICERS OR KEY EMPLOYEES	THE PROCESS FOR DETERMINING COMPENSATION OF THE ORGANIZATION'S CEO, EXECUTIVE DIRECTOR, OR TOP MANAGEMENT OFFICIAL, AS WELL AS THAT OF ANY OTHER OFFICERS OR SENIOR EXECUTIVES (IF ANY), IS DIRECTED BY A RELATED ORGANIZATION. THE RELATED ORGANIZATION'S BOARD COMMITTEE RESPONSIBLE FOR COMPENSATION OVERSEES THE PROCESS, UTILIZING INDEPENDENT DELEGATES WITHIN THE ORGANIZATION AS APPROPRIATE, DEPENDING ON THE ROLE. IN SOME CASES, THE PROCESS MAY UTILIZE COMPARABILITY DATA AND ANALYSIS FROM A NATIONAL THIRD-PARTY COMPENSATION FIRM; OR, IF MORE APPROPRIATE FOR THE ROLE, IT MAY INSTEAD UTILIZE OTHER APPLICABLE SOURCES OF MARKET COMPARABILITY DATA AS NEEDED TO VERIFY REASONABLENESS. THE PROCESS ALSO INCLUDES CONTEMPORANEOUS SUBSTANTIATION OF THE ANALYSIS AND DECISION REGARDING THE COMPENSATION ARRANGEMENT. COMPENSATION IS REVIEWED AT LEAST ANNUALLY AND THE PROCESS IS ADMINISTERED TO ASSURE INDEPENDENCE, AVOID CONFLICTS OF INTEREST, ENSURE REASONABLENESS AND MARKET COMPARABILITY OF TOTAL COMPENSATION, AND TO OTHERWISE ABIDE BY PERTINENT LAWS AND REGULATIONS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 6 Classes of members or stockholders	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK HAS ONE MEMBER, PRESENCE CARE TRANSFORMATION CORPORATION.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7a Members or stockholders electing members of governing body	Subject to the AMITA Affiliation Agreement and the decision making authority of Ascension and Ascension Health, the Ascension Class directors of the Corporate member shall decide the appointment and removal of members of the Board of Corporation of PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders	Subject to the AMITA affiliation agreement and the decision making authority of Ascension and Ascension Health, the Ascension Class Directors of the Corporate member shall decide all decisions that have a material impact on PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 11b Review of form 990 by governing body	DURING THE RETURN PREPARATION PROCESS, THE TAX DEPARTMENT WORKS WITH OTHER FUNCTIONAL AREAS WHICH MAY INCLUDE, AS NEEDED, FINANCE, ACCOUNTING, TREASURY, LEGAL, HUMAN RESOURCES, AND CORPORATE COMPLIANCE FOR ADVICE, INFORMATION AND ASSISTANCE IN ORDER TO PREPARE A COMPLETE AND ACCURATE RETURN. A COMPLETE FINAL COPY OF THE RETURN IS PROVIDED TO DESIGNATED MANAGEMENT TEAM MEMBERS WITH EXPERIENCE IN TAX IN LIEU OF THE FULL BOARD.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 12c Conflict of interest policy	THE ORGANIZATION REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY IN THAT ANY DIRECTOR, PRINCIPAL OFFICER, OR MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS, WHO HAS A DIRECT OR INDIRECT FINANCIAL INTEREST, MUST DISCLOSE THE EXISTENCE OF THE FINANCIAL INTEREST AND BE GIVEN THE OPPORTUNITY TO DISCLOSE ALL MATERIAL FACTS TO THE DIRECTORS AND MEMBERS OF THE COMMITTEES WITH GOVERNING BOARD DELEGATED POWERS CONSIDERING THE PROPOSED TRANSACTION OR ARRANGEMENT. THE REMAINING INDIVIDUALS ON THE GOVERNING BOARD OR COMMITTEE WILL DECIDE IF CONFLICTS OF INTEREST EXIST. EACH DIRECTOR, PRINCIPAL OFFICER AND MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS ANNUALLY SIGNS A STATEMENT WHICH AFFIRMS SUCH PERSON HAS RECEIVED A COPY OF THE CONFLICTS OF INTEREST POLICY, HAS READ AND UNDERSTANDS THE POLICY, HAS AGREED TO COMPLY WITH THE POLICY, AND UNDERSTANDS THAT THE ORGANIZATION IS CHARITABLE AND IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION IT MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ITS TAX-EXEMPT PURPOSE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 19 Required documents available to the public	THE ORGANIZATION WILL PROVIDE ANY DOCUMENTS OPEN TO PUBLIC INSPECTION UPON REQUEST.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VII, Section A RELATED ENTITIES	THE ORGANIZATION UTILIZES AN AFFILIATE AS THE COMMON PAY AGENT. EMPLOYEES REPORTED IN PART VII MAY HAVE DUTIES THAT IMPACT MULTIPLE RELATED ENTITIES. TOTAL AVERAGE HOURS WORKED AND COMPENSATION AND BENEFITS PAID ARE REPORTED. IN DOING SO, IF AVAILABLE, A COMMON LAW EMPLOYER ANALYSIS IS USED TO DETERMINE WHETHER THE HOURS AND COMPENSATION/BENEFITS ARE REPORTABLE AS ATTRIBUTABLE DIRECTLY TO THE FILING ORGANIZATION OR ANOTHER ENTITY; OTHERWISE, THE BEST AVAILABLE INFORMATION HAS BEEN USED AS THE BASIS FOR ALLOCATIONS UTILIZED IN THE REPORTING.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VIII, Line 11d Other Miscellaneous Revenue	Miscellaneous Revenue - Total Revenue: 381661, Related or Exempt Function Revenue: 199899, Unrelated Business Revenue: 34192, Revenue Excluded from Tax Under Sections 512, 513, or 514: 147570; late penalty fees - Total Revenue: 1235, Related or Exempt Function Revenue: , Unrelated Business Revenue: , Revenue Excluded from Tax Under Sections 512, 513, or 514: 1235;

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IX, Line 11g Other Expenses	<p>Other Miscellaneous Operating Expense - Total Expense: 25537, Program Service Expense: 25537, Management and General Expenses: , Fundraising Expenses: ; Physician Fees to Affiliate - Total Expense: 3367636, Program Service Expense: 3367636, Management and General Expenses: , Fundraising Expenses: ; Minor Equipment - Total Expense: 1798293, Program Service Expense: 1674455, Management and General Expenses: 123838, Fundraising Expenses: ; Equipment Lease - Total Expense: 5671133, Program Service Expense: 4972198, Management and General Expenses: 698935, Fundraising Expenses: ; Provider Tax - Total Expense: 44930580, Program Service Expense: 44930580, Management and General Expenses: , Fundraising Expenses: ; Other Non Medical Supplies - Total Expense: 5076200, Program Service Expense: 1727106, Management and General Expenses: 3349094, Fundraising Expenses: ; Dues - Total Expense: 193561, Program Service Expense: 112114, Management and General Expenses: 81447, Fundraising Expenses: ; Maintenance & Repairs - Total Expense: 2358346, Program Service Expense: 1522456, Management and General Expenses: 835890, Fundraising Expenses: ; Licenses & Permits - Total Expense: 354956, Program Service Expense: 112753, Management and General Expenses: 242203, Fundraising Expenses: ; Books & Subscriptions - Total Expense: 96216, Program Service Expense: 65219, Management and General Expenses: 30997, Fundraising Expenses: ; Charitable Expense - Total Expense: 482160, Program Service Expense: 482160, Management and General Expenses: , Fundraising Expenses: ; Purchased Services - Total Expense: 105229196, Program Service Expense: 74964955, Management and General Expenses: 30264241, Fundraising Expenses: ; ambulance transport expenses - Total Expense: 230106, Program Service Expense: 74601, Management and General Expenses: 155505, Fundraising Expenses: ; record retention expenses - Total Expense: 129571, Program Service Expense: 103371, Management and General Expenses: 26200, Fundraising Expenses: ;</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9 Other changes in net assets or fund balances	TRANSFERS WITH AFFILIATES - -171109891;

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XII, Line 2c oversight of audit or selection of independent accountant	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK is included in the consolidated financial statements of Ascension Health Alliance. The Finance and Audit committee of Ascension Health Alliance's Board assumes responsibility for the consolidated organization as a whole.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Page 1, Box C d/b/a names	PRESENCE CENTRAL AND SUBURBAN HOSPITALS NETWORK ALSO OPERATES UNDER THE FOLLOWING ASSUMED NAMES: - Mercy Professional Building Pharmacy - Covenant Outpatient Pharmacy - Highland Answering Service - Presence Covenant Medical Center - Presence Mercy Medical Center - Presence Saint Joseph Hospital - Elgin - Presence Saint Joseph Medical Center - Presence United Samaritans Medical Center - Presence St. Mary's Hospital - Presence Surgery Center - Joliet - The Apothecary - Danville - Presence Immediate Care - Plainfield - Presence Imaging - Plainfield - Presence United Samaritans Medical Center Foundation - Presence St. Mary's Hospital Foundation - Presence Saint Joseph Medical Center Foundation - Presence Mercy Medical Center Foundation - Presence Covenant Medical Center Foundation - Presence Saint Joseph Hospital - Elgin Foundation - Pro Ambulance - Presence N.E.W. You Center - AMITA Health Mercy Medical Center Aurora - AMITA Health Saint Joseph Hospital Elgin - AMITA Health Saint Joseph Medical Center Joliet - AMITA Health St. Mary's Hospital Kankakee

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Page 1 Box J Website	<p>Presence Central and Suburban Hospitals Network does not have its own direct website; however, Presence Central and Suburban Hospitals Network operates the following hospitals which have their own websites as follows: AMITA St. Joseph Medical Center- https://www.amitahealth.org/our-locations/hospitals/amita-health-saint-joseph-medical-center-joliet/ AMITA Mercy Medical Center- https://www.amitahealth.org/our-locations/hospitals/amita-health-mercy-medical-center-aurora/ AMITA St. Joseph Hospital- https://www.amitahealth.org/our-locations/hospitals/amita-health-saint-joseph-hospital-elgin/ AMITA St. Mary's Hospital- https://www.amitahealth.org/our-locations/hospitals/amita-health-st-mary-s-hospital-kankakee/</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 1 PHYSICAL ADDRESS	THE PHYSICAL ADDRESS FOR THIS ENTITY IS 200 South Wacker Drive, Suite 1200, Chicago, Illinois 60606. THE ADDRESS ON PAGE 1 IS FOR MAILING PURPOSES ONLY.

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
Presence Central and Suburban Hospitals Network

Employer identification number
36-4195126

Part I

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II

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

See Additional Data Table

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

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

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) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

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

See Additional Data Table

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

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity

1a

No

b Gift, grant, or capital contribution to related organization(s)

1b

No

c Gift, grant, or capital contribution from related organization(s)

1c

Yes

d Loans or loan guarantees to or for related organization(s)

1d

No

e Loans or loan guarantees by related organization(s)

1e

No

f Dividends from related organization(s)

1f

No

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

Yes

k Lease of facilities, equipment, or other assets from related organization(s)

1k

Yes

l Performance of services or membership or fundraising solicitations for related organization(s)

1l

No

m Performance of services or membership or fundraising solicitations by related organization(s)

1m

No

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

Yes

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

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

[illegible]

Part VII

Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID: 19010655

Software Version: 2019v5.0

EIN: 36-4195126

Name: Presence Central and Suburban Hospitals Network

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1568866	HEALTH SYSTEM	IL	501(c)(3)	Type II	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-2847744	SUPPORT PROVIDENCE HOSPITAL	AL	501(c)(3)	10	GULF COAST HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 47-2360513	JOINT OPERATING COMPANY	IL	501(c)(3)	Type II	NA		No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4336931	Physician services	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4251848	Behavioral health hospital	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3527899	Housing and supportive care services for persons with HIV/AIDS	IL	501(c)(3)	10	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3045007	Outpatient community mental health services	IL	501(c)(3)	10	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4344423	PACE- Comprehensive & Coordinated Community Based Services	IL	501(c)(3)	10	Ascension Health Senior Care	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3260495	Supports the provision of healthcare services for related corporations for which it is a member	IL	501(c)(3)	Type III-FI	Ascension Health	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3276552	Supports the provision of healthcare services for related corporations	IL	501(c)(3)	Type III-FI	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1470362	SKILLED NURSING FACILITY	MO	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 47-1930457	Physician services	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-2596381	Acute care hospital	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 81-1110738	SPECIALTY PHYSICIAN PRACTICE GROUP	IL	501(c)(3)	3	ALEXIAN BROTHERS HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 94-1530037	Acute care hospital (sold in 1998)	TX	501(c)(3)	Type I	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4484290	Supports the provision of healthcare for related corporations	IL	501(c)(3)	Type II	Alexian Brothers Health System	Yes	
3040 W Salt Creek Ln Arlington Heights, IL 60005 43-1295333	HUD housing	MO	501(c)(3)	10	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1592502	SKILLED NURSING FACILITY	MO	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 80-0710751	Specialty physician practice group	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1351584	CONTINUING CARE RETIREMENT COMMUNITY	WI	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1136742	CONTINUING CARE RETIREMENT COMMUNITY	TN	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
2434 Interstate Plaza Drive Hammond, IN 46234 20-3238867	HEALTH CARE	IN	501(c)(3)	3	Presence Central & Suburban Hospitals Network AND PRESENCE CHICAGO HOSPITAL S NETWORK	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0952490	SPORTS MEDICINE	AL	501(c)(3)	7	ST VINCENT'S BIRMINGHAM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-2841358	RETIREMENT COMMUNITY	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1570877	FOUNDATION	WI	501(c)(3)	7	ASCENSION ALL SAINTS HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1264986	HOSPITAL	WI	501(c)(3)	3	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2802463	FUNDRAISING	MI	501(c)(3)	Type I	ASCENSION ALLEGAN HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1359180	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-5800012	HEALTH CARE	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 86-0455920	HOSPITAL	AZ	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7222558	FUNDRAISING	MI	501(c)(3)	Type I	ASCENSION BORGESS HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1360526	HEALTHCARE SERVICES	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2860459	FUNDRAISING	MI	501(c)(3)	Type III-FI	ASCENSION BORGESS-LEE HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1490190	HEALTHCARE SERVICES	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1576680	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0905385	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-1121862	Health care	MO	501(c)(3)	Type I	Ascension Care Management LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2734755	SUPPORTING ORGANIZATION	MO	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0985690	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1958763	HEALTH CARE	MI	501(c)(3)	10	ST JOHN PROVIDENCE	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3591148	FOUNDATION	MI	501(c)(3)	Type II	GENESYS HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2377821	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1627755	FOUNDATION	WI	501(c)(3)	Type II	ASCENSION GOOD SAMARITAN HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0808503	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 31-1662309	NATIONAL HEALTH SYSTEM	MO	501(c)(3)	Type I	ASCENSION HEALTH ALLIANCE		No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 65-1257719	SUPPORTING ORGANIZATION	MO	501(c)(3)	Type I	ASCENSION HEALTH ALLIANCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-3358926	NATIONAL HEALTH SYSTEM	MO	501(c)(3)	Type I	NA		No
RUST C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-7046706	SUPPORTING ORGANIZATION	MO	501(c)(3)	Type I	ASCENSION HEALTH ALLIANCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 65-1205990	SUPPORTING ORGANIZATION	MO	501(c)(3)	Type I	ASCENSION HEALTH ALLIANCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1227406	PARENT COMPANY	MO	501(c)(3)	Type II	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 82-4710412	RETIREMENT COMMUNITY	WI	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3322109	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 83-1617112	HEALTH CARE	MI	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3494637	HEALTH CARE	MI	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3193801	HEALTHCARE SERVICES	MI	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1127163	CLINICAL HEALTHCARE SERVICES	WI	501(c)(3)	3	AFFINITY HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1965593	MEDICAL GROUP	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1791586	MEDICAL GROUP	WI	501(c)(3)	3	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2631907	HEALTH CARE	MI	501(c)(3)	10	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2601348	HEALTH CARE	MI	501(c)(3)	10	ST JOHN PROVIDENCE	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-3174701	SUPPORTING ORGANIZATION	MO	501(c)(3)	Type I	ASCENSION HEALTH ALLIANCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0816818	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0807065	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-1109636	HEALTHCARE SERVICES	TX	501(c)(3)	3	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3526629	FUNDRAISING	MI	501(c)(3)	7	ST JOHN PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1358212	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2627336	SUPPORTING	MI	501(c)(3)	Type I	ASCENSION PROVIDENCE ROCHESTER HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1359247	GENERAL HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3160564	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1390638	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0816857	HOSPITAL	WI	501(c)(3)	3	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-1109643	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	3	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2262856	HEALTH CARE	MI	501(c)(3)	3	ST JOHN PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 72-1531917	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1256677	FOUNDATION	WI	501(c)(3)	7	AFFINITY HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0907740	HOSPITAL	WI	501(c)(3)	3	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-2961579	FUNDRAISING	MI	501(c)(3)	7	ST JOHN PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1359063	HEALTH CARE	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 01-0790428	FUNDRAISING	MI	501(c)(3)	Type I	ASCENSION ST JOSEPH'S HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1443395	HEALTH CARE	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2246366	FUNDRAISING	MI	501(c)(3)	Type III-FI	ASCENSION ST MARY'S HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-0997730	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1657410	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION ST MICHAEL'S HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0808443	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-1671120	HOSPITAL	MI	501(c)(3)	3	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-4364243	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-0958974	MANAGEMENT COMPANY	KS	501(c)(3)	10	ASCENSION VIA CHRISTI HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1172107	HEALTH SYSTEM PARENT	KS	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1186704	HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-0543778	HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-1965272	HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1172106	HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-0948571	PROPERTY MANAGEMENT	KS	501(c)(4)		ASCENSION VIA CHRISTI HOSPITALS WICHITA INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1158274	REHABILITATION HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HOSPITALS WICHITA INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1601369	VEBA	MO	501(c)(9)		ASCENSION HEALTH ALLIANCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1494981	FOUNDATION	WI	501(c)(3)	7	COLUMBIA ST MARY'S INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1701402	LABORATORY	WI	501(c)(3)	10	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1613624	PHARMACY	WI	501(c)(3)	10	WHEATON FRANCISCAN HEALTHCARE-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 58-1509251	COMMUNITY HEALTH PROMOTION	TN	501(c)(3)	Type I	SAINT THOMAS NETWORK	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 58-1861378	INACTIVE	TN	501(c)(3)	Type I	SAINT THOMAS MIDTOWN HOSPITAL	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2971975	OWN OIL AND MINERAL RIGHTS, REAL ESTATE	TX	501(c)(3)	Type III-FI	SETON FUND OF THE DAUGHTERS OF CHARITY OF ST VINCENT DE PAUL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2468823	HOLDING COMPANY	MI	501(c)(3)	3	BORGESS HEALTH ALLIANCE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2335286	HEALTH SYSTEM PARENT	MI	501(c)(3)	Type III-FI	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2555589	SKILLED NURSING FACILITY	MI	501(c)(3)	3	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 86-0749574	FOUNDATION	AZ	501(c)(3)	Type I	ASCENSION ARIZONA	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1276738	HEALTH SYSTEM PARENT	MO	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2505427	SKILLED NURSING FACILITY	MO	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 81-4769136	MEDICAL GROUP	NY	501(c)(3)	3	ST MARY'S HEALTHCARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 83-2068871	SKILLED NURSING FACILITY	DC	501(c)(3)	10	Ascension Health Senior Care	Yes	
N4642 COUNTY N APPLETON, WI 54914 45-4681563	BEHAVIORAL HEALTH SERVICES	WI	501(c)(3)	3	AFFINITY HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2514708	ADULT DAY CARE	MI	501(c)(3)	Type II	Ascension Health Senior Care	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1869951	FREESTANDING OUTPATIENT CENTER	IN	501(c)(3)	Type III-FI	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-0468031	FUNDRAISING	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1596986	COLLEGE	WI	501(c)(3)	2	COLUMBIA ST MARY'S HOSPITAL MILWAUKEE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0806315	HOSPITAL	WI	501(c)(3)	3	COLUMBIA ST MARY'S INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0807063	HOSPITAL	WI	501(c)(3)	3	COLUMBIA ST MARY'S INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1834639	HEALTH SYSTEM	WI	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1241079	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2800601	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1357365	NURSING/ASSISTED LIVING SERVICES	WI	501(c)(3)	10	HOWARD YOUNG HEALTH CARE INC	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2790703	MEDICAL RESEARCH ORGANIZATION	MI	501(c)(3)	10	ASCENSION ST MARY'S HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 75-3193633	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION ST CLARE'S HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1684957	FOUNDATION	WI	501(c)(3)	Type II	SAINT JOSEPH'S HOSPITAL OF MARSHFIELD INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2371754	HEALTH SRVCS/STAFFING/PROP MNGT	MI	501(c)(3)	Type II	GENESYS HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2317364	CONVALESCENT CENTER	MI	501(c)(3)	3	GENESYS AMBULATORY HEALTH SERVICES	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3339703	HEALTH SYSTEM PARENT	MI	501(c)(3)	Type II	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0934712	HEALTH SYSTEM	AL	501(c)(3)	Type III-FI	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-3620346	NURSING HOME	FL	501(c)(3)	10	SACRED HEART HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-3220767	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1499115	HOME OFFICE	WI	501(c)(3)	Type II	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-0606129	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-1440267	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
18927 HICKORY CREEK DRIVE SUITE 300 MOKENA, IL 60448 36-3438977	LOW INCOME HOUSING FOR ELDERLY AND HANDICAPPED INDIVIDUALS	IL	501(c)(3)	10	PRESENCE LIFE CONNECTIONS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 91-1528577	FUNDRAISING	WA	501(c)(3)	Type I	OUR LADY OF LOURDES HOSPITAL AT PASCO	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 22-2873637	Rental of Health Care Facilities	NY	501(c)(2)		Our Lady of Lourdes Memorial Hospital Inc	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 14-1776546	MEDICAL OFFICE BUILDING	NY	501(c)(25)		ST MARY'S HEALTHCARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3495969	HEALTH CARE	IL	501(c)(3)	10	Presence Health Partners Services	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7140261	FOUNDATION	WI	501(c)(3)	10	AFFINITY HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 94-3436893	Medical Group	WI	501(c)(3)	3	ASCENSION MEDICAL GROUP-SOUTHEAST WISCONSIN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1490371	PARENT CORPORATION	WI	501(c)(3)	Type I	ASCENSION HEALTH	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 91-0349750	HEALTHCARE	WA	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 15-0532221	HOSPITAL	NY	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 16-1608735	SKILLED NURSING FACILITY	NY	501(c)(3)	3	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-3700131	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4286236	HEALTH CARE	IL	501(c)(3)	10	Presence Care Transformation Corporation	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-2709982	HEALTH CARE	IL	501(c)(3)	10	Presence Care Transformation Corporation	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-0483587	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3366652	MGMT SUPPORT	IL	501(c)(3)	Type III-FI	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-2235165	HEALTH CARE	IL	501(c)(3)	3	Presence Care Transformation Corporation	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-2644178	HEALTH CARE	IL	501(c)(3)	Type II	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3330928	HEALTH CARE	IL	501(c)(3)	3	Presence Care Transformation Corporation	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-0483581	HEALTH CARE	IL	501(c)(3)	10	PRESENCE CARE TRANSFORMATION CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 37-1127787	RETIREMENT COMMUNITY	IL	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7061646	RETIREMENT COMMUNITY	IL	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-8775914	DORMANT	IN	501(c)(3)	10	ST MARY'S HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0914564	SUPPORT PROVIDENCE HOSPITAL	AL	501(c)(2)		GULF COAST HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0915493	SUPPORT PROVIDENCE HOSPITAL	AL	501(c)(3)	7	GULF COAST HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2683112	SUPPORT CHARITABLE PURPOSE OF ASCENSION PROVIDENCE	TX	501(c)(3)	Type I	ASCENSION PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2696970	PHYSICIAN PRACTICES	TX	501(c)(3)	3	ASCENSION PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-1275583	FUNDRAISING ORGANIZATION	DC	501(c)(3)	Type I	PROVIDENCE HOSPITAL	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-1275587	PHYSICIAN PRACTICES	DC	501(c)(3)	Type I	PROVIDENCE HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0288861	HOSPITAL	AL	501(c)(3)	3	GULF COAST HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 53-0196636	HOSPITAL	DC	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 61-1759304	SKILLED NURSING FACILITY	TX	501(c)(3)	3	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3296367	HEALTH CARE	IL	501(c)(3)	10	Presence Care Transformation Corporation	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-2436597	FOUNDATION	FL	501(c)(3)	7	SACRED HEART HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-0634434	HOSPITAL	FL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 57-1183283	INVESTMENT	FL	501(c)(3)	Type I	SACRED HEART HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0902199	REHAB SERVICES	WI	501(c)(3)	3	COLUMBIA ST MARY'S INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 41-0693877	HOSPITAL	MN	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0847631	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 58-1716804	SYSTEM PARENT	TN	501(c)(3)	Type II	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 58-1663055	OPERATES FOUNDATION	TN	501(c)(3)	7	SAINT THOMAS NETWORK	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 58-1737573	HOSPITAL	TN	501(c)(3)	3	BAPTIST HEALTH CARE AFFILIATES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1836937	HOME HEALTH CARE	TN	501(c)(3)	10	SAINT THOMAS HICKMAN HOSPITAL	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1529858	HEALTHCARE PROVIDER	TN	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1869474	ACUTE CARE HOSPITAL	TN	501(c)(3)	3	SAINT THOMAS HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1284994	HEALTH INVESTMENT ENTITY	TN	501(c)(3)	10	SAINT THOMAS HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 47-4063046	HOSPITALS	TN	501(c)(3)	3	SAINT THOMAS HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-1167917	FOUNDATION	TN	501(c)(3)	Type I	SAINT THOMAS RUTHERFORD HOSPITAL	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-0475842	HOSPITAL	TN	501(c)(3)	3	SAINT THOMAS HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-0347580	HOSPITAL	TN	501(c)(3)	3	SAINT THOMAS HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1948057	MEDICAL EQUIPMENT	KS	501(c)(3)	10	ASCENSION VIA CHRISTI HEALTH PARTNERS INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-3308965	Owns or leases properties where healthcare services are delivered	IL	501(c)(2)		Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-4364681	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	Type I	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 26-4562522	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-1311790	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2212968	FUNDRAISING	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 26-2842608	FUNDRAISING	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2820107	HEALTH CARE	MI	501(c)(3)	10	ST JOHN PROVIDENCE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-2498998	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	ASCENSION SETON	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-4364813	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-2960726	SKILLED NURSING FACILITY	PA	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-2064992	PROVIDE HEALTH CARE SERVICES TO THE COMMUNITY	MD	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0937704	SUPPORT PROVIDENCE HOSPITAL	AL	501(c)(3)	Type II	GULF COAST HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 42-1670843	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7326976	REAL ESTATE	AL	501(c)(2)		ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-5330986	FUNDRAISING	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2869762	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 82-0204264	HOSPITAL	ID	501(c)(3)	3	ASCENSION HEALTH	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 82-1103087	HEALTHCARE	NY	501(c)(3)	3	OUR LADY OF LOURDES MEMORIAL HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-1415083	FUNDRAISING	MD	501(c)(3)	Type I	ST AGNES HEALTHCARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-0591657	HOSPITAL	MD	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4251846	Acute care hospital	IL	501(c)(3)	3	Alexian Brothers Health System	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-1878316	SKILLED NURSING FACILITY	FL	501(c)(3)	3	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-0999759	HEALTH CARE	OK	501(c)(3)	10	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3833117	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 61-1659782	REAL ESTATE	OK	501(c)(2)		ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-1133139	FUNDRAISING	OK	501(c)(3)	7	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-1215174	SYSTEM PARENT	OK	501(c)(3)	Type I	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-0579286	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2244034	PARENT	MI	501(c)(3)	Type II	ASCENSION MICHIGAN	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-0662663	HEALTH CARE	OK	501(c)(3)	3	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-1077367	NURSING HOME	OK	501(c)(3)	10	ST JOHN HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7313206	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST JOSEPH HOSPITAL & HEALTH CENTER INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-0992717	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1388461	FUNDRAISING	MO	501(c)(3)	Type I	CARONDELET HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 51-0168321	FUNDRAISING	ID	501(c)(3)	Type I	SJRCM Inc	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-1835288	SKILLED NURSING FACILITY	MD	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 26-0479484	HOSPITAL	FL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM INC	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1899560	DME/HOME CARE	IN	501(c)(3)	Type I	ST MARY'S HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7248362	REAL ESTATE HOLDING COMPANY	IN	501(c)(2)		ST MARY'S HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 23-7045370	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST MARY'S HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1679526	INVESTMENT SERVICES	IN	501(c)(3)	Type I	ST MARY'S HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-0869065	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 14-1347719	HOSPITAL	NY	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 43-1918107	FUNDRAISING	MO	501(c)(3)	Type I	CARONDELET HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 26-1356310	PHYSICIAN PROFESSIONAL SERVICES	IN	501(c)(3)	10	ST VINCENT MEDICAL GROUP INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-3474697	DORMANT	IN	501(c)(3)	Type I	ST MARY'S MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-5342518	AMBULANCE SERVICES	IN	501(c)(4)		ST MARY'S HEALTH SERVICES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1343019	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2053693	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT ANDERSON REGIONAL HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-0877261	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-3107055	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2112529	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-2192831	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 45-4243702	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1531734	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT FRANKFORT HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2099320	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2052591	PARENT COMPANY	IN	501(c)(3)	Type III-FI	ASCENSION HEALTH	Yes	

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						Yes	No
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-1227327	HEALTH AND WELLNESS SERVICES	IN	501(c)(3)	10	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-0869066	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-6088862	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT HOSPITAL AND HEALTH CARE CENTER INC	Yes	
301 HENRY STREET NORTH VERNON, IN 47265 84-1703732	DORMANT	IN	501(c)(3)	1	ST VINCENT JENNINGS HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1841606	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-0876389	HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-2039417	PHYSICIAN PROFESSIONAL SERVICES	IN	501(c)(3)	10	ST VINCENT CARMEL HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 31-1066871	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT MADISON COUNTY HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2133006	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT RANDOLPH HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-2103153	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 47-1289091	RETAIL AMBULATORY SERVICES	IN	501(c)(3)	10	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 27-0847538	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-1712001	LONG TERM CARE HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-3130159	SUPPORTING ORGANIZATION	IN	501(c)(3)	Type I	ST VINCENT WILLIAMSPORT HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 35-0784551	CRITICAL ACCESS HOSPITAL	IN	501(c)(3)	3	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-2292041	PHYSICIAN PRACTICE	FL	501(c)(3)	10	ASCENSION MEDICAL GROUP LLC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0288864	HOSPITAL	AL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0909073	HOSPITAL	AL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 06-1331677	INACTIVE	CT	501(c)(3)	10	STVINCENT'S MEDICAL CENTER	Yes	
95 MERRITT BOULEVARD TRUMBULL, CT 06611 22-2554128	REAL ESTATE HOLDINGS	CT	501(c)(25)		ST VINCENT'S HEALTH SERVICES CORP	Yes	

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
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0578923	HOSPITAL	AL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0868066	FUNDRAISING	AL	501(c)(3)	7	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-2219923	FUND RAISING	FL	501(c)(3)	7	ST VINCENT'S HEALTH SYSTEM INC	Yes	
2800 MAIN STREET BRIDGEPORT, CT 06606 22-2558134	HOLDING COMPANY	CT	501(c)(3)	Type I	ST VINCENT'S MEDICAL CENTER	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0931008	HEALTH SYSTEM	AL	501(c)(3)	Type III-FI	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-3650609	PARENT ENTITY	FL	501(c)(3)	Type II	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 06-0646886	HOSPITAL AND SYSTEM PARENT	CT	501(c)(3)	3	ASCENSION HEALTH	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 22-2558132	FUNDRAISING	CT	501(c)(3)	7	ST VINCENT'S MEDICAL CENTER	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 59-0624449	HOSPITAL	FL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 46-1523194	HOSPITAL	FL	501(c)(3)	3	ST VINCENT'S HEALTH SYSTEM INC	Yes	
2800 MAIN STREET BRIDGEPORT, CT 06606 80-0458769	PHYSICIAN PRACTICES	CT	501(c)(3)	Type I	ST VINCENT'S MEDICAL CENTER	Yes	
95 MERRITT BOULEVARD TRUMBULL, CT 06611 06-0702617	PROGRAMS FOR SPECIAL NEEDS INDIVIDUALS	CT	501(c)(3)	10	ST VINCENT'S HEALTH SERVICES CORP	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-5002285	REAL ESTATE HOLDING COMPANY	IN	501(c)(3)	Type III-FI	ST VINCENT HEALTH INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-2427678	PRG RELATED INVESTMENTS	MI	501(c)(3)	Type II	GENESYS HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-0873606	HOSPITAL	WI	501(c)(3)	3	MINISTRY HEALTH CARE INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2727509	SPIRITUALITY CENTER	TX	501(c)(3)	Type II	ASCENSION TEXAS	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 26-4562712	DELIVERY OF HEALTH CARE SERVICES	TX	501(c)(3)	10	SETON CLINICAL ENTERPRISE CORPORATION	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-2855201	TO HOLD TITLE TO REAL PROPERTY	TX	501(c)(25)		SETON FUND OF THE DAUGHTERS OF CHARITY OF ST VINCENT DE PAUL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 63-0932323	PHYSICIAN GROUP	AL	501(c)(3)	Type II	ST VINCENT'S HEALTH SYSTEM	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 36-4943550	FOUNDATION	KS	501(c)(3)	7	ASCENSION VIA CHRISTI HEALTH INC	Yes	

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
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1236589	PACE (SNF)	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1129325	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 20-2828680	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1078862	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-1247723	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 74-3070971	RETIREMENT COMMUNITY	KS	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 73-1153337	RETIREMENT COMMUNITY	OK	501(c)(3)	10	VIA CHRISTI VILLAGES INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 48-0559086	MANAGEMENT COMPANY	KS	501(c)(3)	Type III-FI	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 93-0838390	FOUNDATION	WI	501(c)(3)	10	ASCENSION ALL SAINTS HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 72-1526400	HOSPITAL	KS	501(c)(3)	3	ASCENSION VIA CHRISTI HOSPITAL MANHATTAN INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-2028808	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION SE WISCONSIN HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1636804	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION SE WISCONSIN HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-6068950	AUXILIARY	WI	501(c)(3)	Type III-FI	ASCENSION SE WISCONSIN HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 32-0135258	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION ST FRANCIS HOSPITAL INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1486775	RETIREMENT COMMUNITY	WI	501(c)(3)	10	ASCENSION HEALTH SENIOR CARE	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 56-2426294	FOUNDATION	WI	501(c)(3)	Type I	ASCENSION WISCONSIN PHARMACY INC	Yes	
C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 39-1568865	PARENT CORPORATION	IL	501(c)(3)	Type I	ASCENSION HEALTH	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
Alexian Rehabilitation Services LLC 935 Beisner Elk Grove Village, IL 60007 30-0221481	Rehabilitation hospital	IL	NA	N/A								
ALLEGAN GENERAL HOSPITAL PAIN ADMINISTRATION SERVICES LLC 555 LINN STREET ALLEGAN, MI 49010 47-3706652	PAIN MANAGEMENT	MI	NA	N/A								
ALVERNO CLINICAL LABORATORIES LLC 2434 INTERSTATE PLAZA DRIVE HAMMOND, IN 46324 20-3240648	MEDICAL SERVICE	IN	NA	N/A								
AMBULATORY SURGERY CENTER LP 818 N Emporia Ste 108 WICHITA, KS 67214 48-1114690	SURGERY CENTER	KS	NA	N/A								
ASCENSION ALPHA FUND LLC 101 SOUTH HANLEY ROAD SUITE 200 ST LOUIS, MO 63105 90-0786464	INVESTMENTS	MO	NA	N/A								
ASCENSION ATHO CARRY LP 101 SOUTH HANLEY ROAD ST LOUIS, MO 63105 84-4224833	INVESTMENTS	DE	NA	N/A								
ASCENSION HEALTH AT HOME LLC 1A BURTON HILLS BOULEVARD NASHVILLE, TN 37215 47-1704527	INVESTMENTS	DE	NA	N/A								
ASCENSION TOWERBROOK HEALTHCARE OPPORTUNITIES LP 65 EAST 55TH STREET 19TH FLOOR NEW YORK, NY 10022 98-1500387	INVESTMENTS	NY	NA	N/A								
ASCENSION VIA CHRISTI IMAGING MANHATTAN LLC 1823 College Avenue MANHATTAN, KS 66502 48-1251984	RADIOLOGY SERVICES	KS	NA	N/A								
ASCENSION WISCONSIN EMERUS JV LLC 8040 EXCELSIOR DRIVE SUITE 400 MADISON, WI 53717 38-4118568	ACUTE CARE HOSPITALS	WI	NA	N/A								
BAPTIST WOMENS HEALTH CENTER LLC 1900 CHURCH STREET SUITE 300 NASHVILLE, TN 37203 62-1772195	OWNS AND OPERATES SPECIALTY HOSPITAL	TN	NA	N/A								
BELMONT HARLEM SURGERY CENTER LLC 3101 NORTH HARLEM CHICAGO, IL 60634 41-2237162	MEDICAL SERVICE	IL	NA	N/A								
Bonaventure Medical Foundation LLC 2601 Navistar Drive Lisle, IL 60532 36-3978153	Manages managed care contracts	DE	NA	N/A								
Borgess Health Partners LLC 28000 DeQuindre Warren, MI 48092 38-2648846	MANAGED CARE	MI	NA	N/A								
CARMEL AMBULATORY SURGERY CENTER LLC 13421 OLD MERIDIAN STREET STE 150 CARMEL, IN 46032 32-0014795	AMBULATORY SURGERY CENTER	IN	NA	N/A								

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(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) Dispropportionate 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	
CB-AH PARALLEL FUND II LP 200 CLARENDON STREET 17TH FLOOR BOSTON, MA 02116 04-3585156	INVESTMENTS	MA	NA	N/A								
CENTRAL TEXAS LAUNDRY LLC 4255 PROFIT STREET SAN ANTONIO, TX 78219 36-4778018	LAUNDRY SERVICES	TX	NA	N/A								
CHV II LP 101 SOUTH HANLEY ROAD CLAYTON, MO 63105 26-0534243	INVESTMENTS	MO	NA	N/A								
CHV III LP 101 SOUTH HANLEY ROAD ST LOUIS, MO 63105 45-4486925	INVESTMENTS	MO	NA	N/A								
CHV IV LP 101 SOUTH HANLEY ROAD ST LOUIS, MO 63105 81-3953953	INVESTMENTS	DE	NA	N/A								
COLLABORATIVE HEALTH VENTURES V LP 101 SOUTH HANLEY ROAD CLAYTON, MO 63105 84-4668723	INVESTMENTS	MO	NA	N/A								
CUMBERLAND BEHAVIORAL HEALTH LLC 6100 Tower Circle Suite 1000 Franklin, TN 37067 32-0530876	behavioral clinic operations	TN	NA	N/A								
ENDOSCOPY CENTER LLC 13421 OLD MERIDIAN STREET STE 150 CARMEL, IN 46032 32-0029881	ENDOSCOPY CENTER	IN	NA	N/A								
ENDOSCOPY GROUP LLC 4810 NORTH DAVIS HIGHWAY PENSACOLA, FL 32503 59-3519881	MEDICAL SERVICES	FL	NA	N/A								
HAYS JV PARTNERS LLC 569 Brookwood Village Suite 901 Birmingham, AL 35209 85-2037257	Holding Company for Ambulatory Surgery Center Investment	TX	NA	N/A								
Hospital Consolidated Laboratories LLC 39595 W 10 Mile Rd Novi, MI 48375 38-3318428	LAB SERVICES	MI	NA	N/A								
INTERVENTIONAL REHABILITATION CENTER LLC 1549 AIRPORT BOULEVARD STE 420 PENSACOLA, FL 32503 59-3673361	MEDICAL SERVICES	FL	NA	N/A								
KANSAS SURGERY AND RECOVERY CENTER LLC 2770 North Webb Road WICHITA, KS 67226 48-1148580	SURGERY CENTER	KS	NA	N/A								
KENOSHA DIGESTIVE HEALTH CENTER 1033 N MAYFAIR ROAD SUITE 101 WAUWATOSA, WI 53226 84-2167873	DIGESTIVE HEALTH	WI	NA	N/A								
Lourdes Health Support LLC 333 Butternut Drive Suite 100 Dewitt, NY 13214 16-1611707	Medical Equipment Provider	NY	NA	N/A								

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(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?		(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	
MIDDLE TENNESSEE IMAGING LLC 400 N HIGHLAND AVENUE MURFREESBORO, TN 37219 01-0570490	DIAGNOSTIC IMAGING CENTER	TN	NA	N/A								
MURFREESBORO DIAGNOSTIC IMAGING LLC 400 N HIGHLAND AVENUE MURFREESBORO, TN 37219 20-0291952	DIAGNOSTIC IMAGING CENTER	TN	NA	N/A								
MY HEALTH ASCENSION MANAGEMENT LLC 28000 DEQUINDRE ROAD WARREN, MI 48092 85-1304904	URGENT CARE CENTER	MI	NA	N/A								
NAAB ROAD SURGERY CENTER LLC 8260 NAAB ROAD STE 100 INDIANAPOLIS, IN 46260 35-1991390	AMBULATORY SURGERY CENTER	IN	NA	N/A								
Oklahoma Cancer Specialists Real Estate Company LLC 12697 E 51st St South TULSA, OK 74146 61-1774455	REAL ESTATE HOLDING	OK	NA	N/A								
Open MRI of Michigan 411 W 13 MILE ROAD MADISON HEIGHTS, MI 48071 38-3544539	MRI Center	MI	NA	N/A								
ORTHOPEDIC SURGERY CENTER OF THE FOX VALLEY LLC 2223 LIME KILN ROAD SUITE 101 GREEN BAY, WI 54311 84-2016212	SURGERY CENTER	WI	NA	N/A								
PCAC GI JV LLC 2601 Navistar Drive Lisle, IL 60532 85-0878312	AMBULATORY SURGERY CENTER	IL	NA	N/A								
PET LLC 5149 NORTH 9TH AVENUE SUITE 124 PENSACOLA, FL 32504 59-3788701	MEDICAL SERVICES	FL	NA	N/A								
PREMIER RADIOLOGY WISCONSIN LLC 500 W BROWN DEER ROAD SUITE 202 BAYSIDE, WI 53217 83-3180104	RADIOLOGY	WI	NA	N/A								
Presence Lakeshore Gastroenterology LLC 150 N River Road Suite 210 Des Plaines, IL 60016 81-1750563	Medical Service	IL	NA	N/A								
PROFESSIONAL CLINICAL LABORATORIES LLC 2434 INTERSTATE PLAZA DR HAMMOND, IN 46324 30-0711211	MEDICAL SERVICES	IN	NA	N/A								
RADS OF AMERICA LLC PO BOX 249 GOODLETTSVILLE, TN 370700249 20-0597581	AMBULATORY SURGERY CENTER	TN	NA	N/A								
SAINT THOMAS HOME RECOVERY CARE LLC 49 MUSIC SQUARE WEST SUITE 401 NASHVILLE, TN 37203 84-2100096	MEDICAL AND REHABILITATION SERVICES	TN	NA	N/A								
SAINT THOMAS REHABILITATION HOSPITAL LLC 680 S 4TH STREET LOUISVILLE, KY 40202 81-4303298	REHABILITATION HOSPITAL	KY	NA	N/A								

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
SOUTH COAST REAL ESTATE VENTURE LLC 5907 HIGHWAY 90 MOSS POINT, MS 39563 45-5599047	OWN REAL ESTATE FOR A PHYSICIAN OFFICE BUILDING	MS	NA	N/A								
ST VINCENT'S OUTPATIENT SURGERY SERVICES LLC 810 ST VINCENTS DRIVE BIRMINGHAM, AL 35205 20-0708162	OUTPATIENT SURGERY	AL	NA	N/A								
ST VINCENT'S SLEEP DISORDER CENTER 810 ST VINCENTS DRIVE BIRMINGHAM, AL 35205 63-1282288	SLEEP DISORDER CENTER	AL	NA	N/A								
ST VINCENT HEART CENTER OF INDIANA LLC 10580 N MERIDIAN STREET INDIANAPOLIS, IN 46290 36-4492612	HEART HOSPITAL	IN	NA	N/A								
STHS SLEEP CENTER LLC 102 WOODMONT BOULEVARD SUITE 800 NASHVILLE, TN 37205 20-3664894	OPERATES A SLEEP CENTER	TN	NA	N/A								
STONEGATE JV PARTNERS LLC 569 Brookwood Village Suite 901 Birmingham, AL 35209 85-2023852	Holding Company for Ambulatory Surgery Center Investment	TX	NA	N/A								
THP - ST VINCENT VENTURE LLC 1415 LOUISIANA STREET 27TH FLOOR HOUSTON, TX 77002 81-3184703	FREESTANDING ED'S	TX	NA	N/A								
TOWNE CENTRE SURGERY CENTER LLC 4599 TOWNE CENTRE SAGINAW, MI 48604 20-4943843	OUTPATIENT SERVICES	MI	NA	N/A								
VIA CHRISTI MERCY CLINIC LLC 1 Mt Carmel Place Pittsburg, KS 66762 81-2927645	MEDICAL SERVICES	KS	NA	N/A								
RACINE DIGESTIVE HEALTH CENTER LLC 1033 N MAYFAIR ROAD SUITE 101 WAUWATOSA, WI 53226 84-4211105	DIGESTIVE HEALTH	WI	NA	N/A								
PROVIDENCE VENTURES LLC 26750 PROVIDENCE PKWY SUITE 100 NOVI, MI 48734 16-1704029	INVESTMENT	MI	NA	N/A								

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
ADVANTAGE HEALTHCO INC 1345 PHILOMENA STREET AUSTIN, TX 78723 74-2698151	HEALTH SERVICES	TX	NA	C Corporation				Yes	
AFFILIATED HEALTH SERVICES INC 28000 DEQUINDRE WARREN, MI 48092 38-2292922	MEDICAL SERVICES	MI	NA	C Corporation				Yes	
AFFILIATED MEDICAL SERVICES LABORATORY INC 2916 E CENTRAL WICHITA, KS 67214 48-1239522	MEDICAL LABORATORY	KS	NA	C Corporation				Yes	
AH INCUBATIONS ACCELERATOR INC 101 SOUTH HANLEY ROAD SUITE 450 ST LOUIS, MO 63105 45-5078523	MEDICAL SERVICE	MO	NA	C Corporation				Yes	
ALEXIAN BROTHERS CORPUS CHRISTI HOUSING PROJECT LLC 3900 SOUTH GRAND ST LOUIS, MO 63118 94-3465394	HOUSING	MO	NA	C Corporation				Yes	
Alexian Brothers Health Providers Association Inc 2601 Navistar Drive Lisle, IL 60532 36-3853286	Messenger model IPA	IL	NA	C Corporation				Yes	
Alexian Village of Elk Grove 3040 W Salt Creek Ln Arlington Heights, IL 60005 35-2211303	Tax credit financed housing	IL	NA	C Corporation				Yes	
AMITA HEALTH CLINICALLY INTEGRATED NETWORK LLC 2601 NAVISTAR DRIVE LISLE, IL 60532 80-0967178	MANAGED CARE	IL	NA	C Corporation				Yes	
ASCENSION CAPITAL UK LIMITED FOUNTAIN HOUSE 130 FENCHURCH STREET LONDON, ENGLAND EC3M5DJ UK	INSURANCE	UK	NA	C Corporation				Yes	
Ascension Care Management Health Partners Tennessee 102 WOODMONT BOULEVARD SUITE 700 NASHVILLE, TN 37205 45-2958482	ACCOUNTABLE CARE ORGANIZATION	TN	NA	C Corporation				Yes	
ASCENSION CARE MANAGEMENT HEALTH PARTNERS INC 101 SOUTH HANLEY ROAD SUITE 200 CLAYTON, MO 63105 45-4413419	MEDICAL SERVICE	MO	NA	C Corporation				Yes	
ASCENSION CARE MANAGEMENT HOLDINGS LTD AND SUBSIDIARIES 8220 IRVING STERLING HEIGHTS, MI 48312 38-3269272	INSURANCE AND TPA	MI	NA	C Corporation				Yes	
ASCENSION HEALTH INSURANCE LIMITED PO BOX 1159 GRAND CAYMAN, Bahamas KY1102 CJ	INSURANCE	CJ	NA	C Corporation				Yes	
ASCENSION HEALTH RISK PURCHASING GROUP 101 SOUTH HANLEY ROAD SUITE 450 ST LOUIS, MO 63105 27-4176480	SUPPORTING ORGANIZATION	MO	NA	C Corporation				Yes	
ASCENSION MEDICAL GROUP VIA CHRISTI PA 3311 EAST MURDOCK WICHITA, KS 67208 48-0993446	PROFESSIONAL ASSOCIATION	KS	NA	C Corporation				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
ASCENSION VENTURES CORPORATION 810 ST VINCENTS DRIVE BIRMINGHAM, AL 35205 63-1217059	MISC HEALTHCARE SERVICES	AL	NA	C Corporation				Yes	
BAPTIST HEALTH CARE VENTURES INC 2000 CHURCH STREET NASHVILLE, TN 37236 62-0469214	HOLDING COMPANY	TN	NA	C Corporation				Yes	
BAYLEY CONDOMINIUM ASSOCIATION 2121 HIGHLAND AVENUE SOUTH BIRMINGHAM, AL 35205 63-1209915	CONDOMINIUM ASSOCIATION	AL	NA	C Corporation				Yes	
BEECHER BALLENGER SERVICES INC AND SUBSIDIARIES ONE GENESYS PARKWAY GRAND BLANC, MI 484398065 38-2497922	HOLDING COMPANY	MI	NA	C Corporation				Yes	
CARONDELET MEDICAL GROUP INC 101 South Hanley Road ST LOUIS, MO 63105 86-0836126	MEDICAL GROUP	AZ	NA	C Corporation				Yes	
CARONDELET SPECIALIST GROUP INC 101 South Hanley Road ST LOUIS, MO 63105 26-1558773	PHYSICIAN PRACTICE	AZ	NA	C Corporation				Yes	
CLINICAL HOLDINGS CORP 101 SOUTH HANLEY ROAD SUITE 200 CLAYTON, MO 63105 45-3802297	HOLDING COMPANY	MO	NA	C Corporation				Yes	
CONSOLIDATED PHARMACY SERVICES INC AND SUBSIDIARIES 4205 BELFORT ROAD SUITE 4030 JACKSONVILLE, FL 32216 59-3398033	RETAIL PHARMACY & PATIENT TRANSPORT	FL	NA	C Corporation				Yes	
Corbett Corporation 169 Riverside Drive Binghamton, NY 13905 16-1268267	Property Management	NY	NA	C Corporation				Yes	
CRITTENTON DEVELOPMENT CORPORATION AND SUBSIDIARIES 2251 N SQUIRREL RD STE 310 AUBURN HILLS, MI 48326 38-2594115	REAL ESTATE	MI	NA	C Corporation				Yes	
DELL CHILDREN'S HEALTH ALLIANCE 1345 PHILOMENA STREET AUSTIN, TX 78723 27-1311909	HEALTH SERVICES	TX	NA	C Corporation				Yes	
FAMILY MEDICINE CENTER CONDOMINIUM ASSOCIATION INC 1 SHIRCLIFF WAY JACKSONVILLE, FL 32204 26-1983355	CONDOMINIUM ASSOCIATION	FL	NA	C Corporation				Yes	
FRANKLIN MEDICAL OFFICE BUILDING CONDOMINIUM ASSOCIATION INC 400 WEST RIVER WOODS PARKWAY GLENDALE, WI 53212 34-1983857	CONDO ASSOCIATION	WI	NA	C Corporation				Yes	
GULF COAST DIVERSIFIED INC 5154 NORTH 9TH AVENUE PENSACOLA, FL 32507 59-2432798	INVESTMENT	FL	NA	C Corporation				Yes	
INDIAN CREEK CENTER INC 101 South Hanley Road St Louis, MO 63105 48-0956627	MANAGEMENT	MO	NA	C Corporation				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
INTEGRATED HEALTHCARE SYSTEMS INC 3311 EAST MURDOCK WICHITA, KS 67208 48-0941549	CLINIC SERVICES	KS	NA	C Corporation				Yes	
L GILBRAITH INSURANCE SPC LTD C/O Strategic Risk Solutions PO BOX 1159 GRAND CAYMAN KY11102 CJ	INSURANCE	CJ	NA	C Corporation				Yes	
MADISON MEDICAL AFFILIATES INC 4425 N PORT WASHINGTON RD GLENDALE, WI 53212 39-1855720	HEALTHCARE	WI	NA	C Corporation				Yes	
MID-STATE PROPERTIES INC 2000 CHURCH STREET NASHVILLE, TN 37236 62-1232018	INACTIVE	TN	NA	C Corporation				Yes	
MISSISSIPPI PROVIDENCE HEALTHCARE SERVICES INC 6801 AIRPORT BLVD MOBILE, AL 36608 46-1130426	HEALTHCARE SERVICES	MS	NA	C Corporation				Yes	
PRESENCE SERVICE CORPORATION 2380 E DEMPSTER STREET DES PLAINES, IL 60016 36-4314354	MEDICAL	IL	NA	C Corporation				Yes	
PRESENCE VENTURES INC and SUBSIDIARY 100 NORTH RIVER ROAD DES PLAINES, IL 60016 37-1168085	MEDICAL	IL	NA	C Corporation				Yes	
PROVIDENCE PARK Inc PO BOX 850429 MOBILE, AL 36685 63-0886846	REAL ESTATE	AL	NA	C Corporation				Yes	
RESOURCE PHARMACIES INC 1150 VARNUM STREET NE WASHINGTON, DC 20017 52-1410076	RETAIL PHARMACY	DC	NA	C Corporation				Yes	
SETON INSURANCE COMPANY 1345 PHILOMENA STREET AUSTIN, TX 78723 47-5395483	HEALTH SERVICES	TX	NA	C Corporation				Yes	
SETON HEALTH ALLIANCE 1345 PHILOMENA STREET AUSTIN, TX 78723 45-3047469	HEALTH SERVICES	TX	NA	C Corporation				Yes	
SETON HEALTH PLAN INC 1345 PHILOMENA STREET AUSTIN, TX 78723 74-2725348	HMO	TX	NA	C Corporation				Yes	
SETON MSO INC 1345 PHILOMENA STREET AUSTIN, TX 78723 74-2870455	HEALTH SERVICES	TX	NA	C Corporation				Yes	
SETON PHYSICIAN HOSPITAL NETWORK AND SUBSIDIARIES 1345 PHILOMENA STREET AUSTIN, TX 78723 74-2643825	HEALTH SERVICES	TX	NA	C Corporation				Yes	
SOVA INC 102 WOODMONT BOULEVARD SUITE 700 NASHVILLE, TN 37205 26-1319638	HEALTH SERVICES	TN	NA	C Corporation				Yes	

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								Yes	No
ST AGNES HEALTH VENTURES INC 900 CATON AVENUE BALTIMORE, MD 21229 52-1733632	HOLDING COMPANY	MD	NA	C Corporation				Yes	
ST JOSEPH HEALTH ENTERPRISES 200 HEMLOCK ROAD TAWAS CITY, MI 48764 38-2686747	OTHER MEDICAL	MI	NA	C Corporation				Yes	
St Mary's Health 800 S Washington Avenue Saginaw, MI 48601 38-3477017	Dormant	MI	NA	C Corporation				Yes	
ST MARY'S MEDICAL GROUP INC 3700 WASHINGTON AVE EVANSVILLE, IN 47750 35-2076827	INVESTMENT	IN	NA	C Corporation				Yes	
SUNFLOWER ASSURANCE LTD PO BOX 1085 GRAND CAYMAN, Bahamas KY11102 CJ	INSURANCE	CJ	NA	C Corporation				Yes	
TEXTILE SYSTEMS INC 817 WALBRIDGE KALAMAZOO, MI 49007 38-2705047	LAUNDRY SERVICES	MI	NA	C Corporation				Yes	
THE PROSPECT MEDICAL COMMONS CONDOMINIUM ASSOCIATION INC 4425 N PORT WASHINGTON RD GLENDALE, WI 53212 20-8042108	CONDO ASSOCIATION	WI	NA	C Corporation				Yes	
Thelen Corporation 3040 Salt Creek Lane Arlington Heights, IL 60005 36-3266316	Owns/ leases property; joint venture partner	IL	NA	C Corporation				Yes	
TRAVEL SERVICES CORPORATION PO BOX 45998 ST LOUIS, MO 631455998 26-3764978	TRAVEL SERVICES	MO	NA	C Corporation				Yes	
UTICA SERVICES INC AND SUBSIDIARIES 1923 SOUTH UTICA AVENUE TULSA, OK 74104 73-1057650	MEDICAL SERVICES	OK	NA	C Corporation				Yes	
VCH IOWA PC 8200 E THORN DRIVE WICHITA, KS 67226 27-3983977	PROFESSIONAL ASSOCIATION	IA	NA	C Corporation				Yes	
VCH IOWA PC TRUST 8200 E THORN DRIVE WICHITA, KS 67226 27-6937322	BENEFICIARY TRUST	IA	NA	Trust				Yes	
VIA CHRISTI CLINIC SERVICES INC 8200 E THORN DRIVE WICHITA, KS 67226 27-3984287	CLINIC SERVICES	KS	NA	C Corporation				Yes	
VIA CHRISTI HEALTH ALLIANCE IN ACCOUNTABLE CARE INC 8200 E THORN DRIVE WICHITA, KS 67226 46-2872857	ACO	KS	NA	C Corporation				Yes	
VINCENTIAN VENTURES OF NORTH ALABAMA INC AND SUBSIDIARIES 810 ST VINCENTS DRIVE BIRMINGHAM, AL 35205 63-0965456	MISC HEALTHCARE SERVICES	AL	NA	C Corporation				Yes	

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

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								Yes	No
VINCENTURES INC 95 MERRITT BOULEVARD TRUMBULL, CT 06611 06-1211417	INACTIVE	CT	NA	C Corporation				Yes	
WHEATON FRANCISCAN HOLDINGS INC AND SUBSIDIARIES 400 WEST RIVER WOODS PARKWAY GLENDALE, WI 53212 39-1836357	HOLDING CO	WI	NA	C Corporation				Yes	
WHEATON FRANCISCAN PROVIDER NETWORK INC 400 WEST RIVER WOODS PARKWAY GLENDALE, WI 53212 39-1952140	PROVIDER CONTRACT	WI	NA	C Corporation				Yes	
WHEATON WAY CONDOMINIUM OWNERS ASSOCIATION INC 10101 SOUTH 27TH STREET FRANKLIN, WI 53212 30-0659830	CONDO ASSOCIATION	WI	NA	C Corporation				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
Alexian Brothers Ambulatory Group	P	54,421	FAIR MARKET VALUE
Alexian Brothers Health System	C	772,873	FAIR MARKET VALUE
Alexian Brothers Health System	P	83,671,394	FAIR MARKET VALUE
Alexian Brothers Health System	Q	20,721,135	FAIR MARKET VALUE
Alexian Brothers Medical Center	Q	102,071	FAIR MARKET VALUE
AMITA Health Clinically Integrated Network LLC	Q	94,620	FAIR MARKET VALUE
Ascension Health Alliance Professional and General Liability Self Insurance Trust	P	11,167,203	FAIR MARKET VALUE
Ascension Health-IS Inc	P	247,441	FAIR MARKET VALUE
Presence Care Transformation	J	247,725	FAIR MARKET VALUE
Presence Care Transformation	P	288,568,669	FAIR MARKET VALUE
Presence Care Transformation	Q	12,643,386	FAIR MARKET VALUE
Presence Care Transformation	S	646,745,581	FAIR MARKET VALUE
Presence Healthcare Services	J	1,182,343	FAIR MARKET VALUE
Presence Healthcare Services	O	179,585	FAIR MARKET VALUE
Presence Healthcare Services	P	3,729,367	FAIR MARKET VALUE
Presence Healthcare Services	Q	123,290	FAIR MARKET VALUE
Presence Properties	P	187,219	FAIR MARKET VALUE
Rainbow Hospice and Palliative	P	1,200,071	FAIR MARKET VALUE
St Alexius Medical Center	Q	73,409	FAIR MARKET VALUE
Medicare Value Partners	S	511,357	FAIR MARKET VALUE