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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

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
ASCENSION NE WISCONSIN INC

Doing business as

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:
MONICA HILT
C/O TAX DEPARTMENT PO BOX 45998
ST LOUIS, MO 631455998

D Employer identification number
39-0816818

E Telephone number
(314) 733-8000

G Gross receipts \$ 331,543,390

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: 1999

M State of legal domicile: WI

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) | 14 |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 10 |
| 5 | Total number of individuals employed in calendar year 2019 (Part V, line 2a) | 1,808 |
| 6 | Total number of volunteers (estimate if necessary) | 606 |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 423,931 |
| 7b | Net unrelated business taxable income from Form 990-T, line 39 | 0 |

Revenue

| | Prior Year | Current Year |
|---|-------------|--------------|
| 8 Contributions and grants (Part VIII, line 1h) | 747,010 | 6,939,473 |
| 9 Program service revenue (Part VIII, line 2g) | 320,273,116 | 322,027,299 |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | -14,396 | -952,868 |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 2,493,411 | 2,034,029 |
| 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 323,499,141 | 330,047,933 |

Expenses

| | | |
|--|-------------|-------------|
| 13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) | 26,071 | 10,000 |
| 14 Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 101,145,068 | 103,687,068 |
| 16a Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| b Total fundraising expenses (Part IX, column (D), line 25) ▶0 | | |
| 17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 189,446,377 | 195,417,530 |
| 18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) | 290,617,516 | 299,114,598 |
| 19 Revenue less expenses. Subtract line 18 from line 12 | 32,881,625 | 30,933,335 |

Net Assets or Fund Balances

| | Beginning of Current Year | End of Year |
|---|---------------------------|-------------|
| 20 Total assets (Part X, line 16) | 318,142,541 | 302,729,796 |
| 21 Total liabilities (Part X, line 26) | 52,378,664 | 77,771,809 |
| 22 Net assets or fund balances. Subtract line 21 from line 20 | 265,763,877 | 224,957,987 |

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

2021-05-12
Date

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

Paid Preparer Use Only

| | | | | |
|----------------------------|----------------------|------|---|------|
| Print/Type preparer's name | Preparer's signature | Date | Check <input type="checkbox"/> 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 AccomplishmentsCheck 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 \$ 204,355,968 including grants of \$ 10,000) (Revenue \$ 322,057,299)
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 ► 204,355,968

Part IV Checklist of Required Schedules

| | Yes | No |
|---|----------------|----|
| 1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A  | 1 Yes | |
| 2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?  | 2 Yes | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I | 3 | No |
| 4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II  | 4 Yes | |
| 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III | 5 | |
| 6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I | 6 | No |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II | 7 | No |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III | 8 | No |
| 9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV | 9 | No |
| 10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? If "Yes," complete Schedule D, Part V  | 10 Yes | |
| 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | | |
| a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI.  | 11a Yes | |
| b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII | 11b | No |
| c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII | 11c | No |
| d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX  | 11d Yes | |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X  | 11e Yes | |
| f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X  | 11f Yes | |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII | 12a | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional  | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 | No |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 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 | No |
| 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 | 167 |
| 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 | 14 | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 10 | |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | No |
| 6 | Did the organization have members or stockholders? | 6 | Yes |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | Yes |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | |
| a | The governing body? | 8a | Yes |
| b | Each committee with authority to act on behalf of the governing body? | 8b | Yes |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | No |

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

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

Section C. Disclosure

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

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) BRIAN WALLACE TREASURER | 1.0 2.0 | X | | X | | | | 0 | 0 | 0 |
| (2) MARY SULLIVAN VICE CHAIR | 1.0 2.0 | X | | X | | | | 0 | 0 | 0 |
| (3) MONICA A HILT EX-OFFICIO/PRESIDENT | 50.0 0.0 | X | | X | | | | 444,280 | 0 | 44,387 |
| (4) TOM MCDERMOTT JR CHAIR | 1.0 2.0 | X | | X | | | | 0 | 0 | 0 |
| (5) WAYNE WIETING SECRETARY | 1.0 2.0 | X | | X | | | | 0 | 0 | 0 |
| (6) DEIDRE A FLANAGAN MD DIRECTOR | 0.0 50.0 | X | | | | | | 0 | 502,681 | 45,832 |
| (7) DIANA BUECHEL DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (8) JOHN ROWE DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (9) JOHN RUSSO DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (10) LARRY MROCZKOWSKI DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (11) MARK KEHRBERG MD DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (12) MARY HARP-JIRSCHLE DIRECTOR | 1.0 2.0 | X | | | | | | 0 | 0 | 0 |
| (13) SUDEEP S SODHI MD DIRECTOR | 0.0 50.0 | X | | | | | | 0 | 1,434,914 | 56,196 |
| (14) WENDY L SCHROEDER DO DIRECTOR | 0.0 50.0 | X | | | | | | 0 | 466,559 | 43,960 |
| (15) JONATHAN SOHN CFO, MINISTRY MARKET | 0.0 50.0 | | | X | | | | 0 | 748,838 | 40,198 |
| (16) CRYSTAL J KIRSCHLING VP, NURSING (START 9/2019) | 50.0 50.0 | | | | X | | | 53,559 | 162,067 | 39,948 |
| (17) AHPA PLYPOO PHYSICIST | 50.0 0 | | | | | X | | 191,494 | 0 | 19,514 |

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (18) ERIC C LOBB PHYSICIST | 50.00.... | | | | | X | | 181,627 | 0 | 18,987 |
| (19) MICHAEL A HOFMANN RN DIRECTOR, NURSING | 50.00.... | | | | | X | | 164,622 | 0 | 37,650 |
| (20) MICHAEL C BECKETT MD PHYSICIAN | 50.00.... | | | | | X | | 289,808 | 0 | 46,376 |
| (21) NANETTE W KRIZENESKY RN REGISTERED NURSE | 50.00.... | | | | | X | | 194,335 | 0 | 38,760 |
| (22) JAMES D ROOT FORMER KEY EMPLOYEE (END 12/2017) | 0.050.0 | | | | | | X | 0 | 139,833 | 12,391 |
| (23) JOHN M LESCHKE MD FORMER KEY EMPLOYEE (END 12/2018) | 50.050.0 | | | | | | X | 6,252 | 222,494 | 14,300 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

| | | | | |
|--|---|-----------|-----------|---------|
| 1b Sub-Total | ▶ | | | |
| c Total from continuation sheets to Part VII, Section A | ▶ | | | |
| d Total (add lines 1b and 1c) | ▶ | 1,525,977 | 3,677,386 | 458,499 |

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 ▶ 57

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

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|--|--------------------------------|---------------------|
| KENNEDY CENTER FOR THE HIP AND KNEE SC 2700 W 9TH AVE SUITE 125 OSHKOSH, WI 549047864 | MEDICAL SERVICES | 4,279,115 |
| GREEN BAY ONCOLOGY LTD 1726 SHAWANO AVE GREEN BAY, WI 543033216 | ONCOLOGY SERVICES | 3,106,683 |
| CHILDRENS HOSPITAL OF WI PO BOX 1997 MILWAUKEE, WI 53201 | PHYSICIAN SERVICES | 2,460,567 |
| SPECIALTYCARE CARDIOVASCULAR RESOURCES 3 MARYLAND FARMS SUITE 200 BRENTWOOD, TN 37027 | CARDIOVASCULAR SERVICES | 1,243,603 |
| CATALPA HEALTH 444 N WESTHILL BLVD APPLETON, WI 549145715 | MENTAL HEALTH SERVICES | 913,000 |

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 ▶ 16

| | | | | | | |
|--|--|--|---|----------------------------------|---|-----------|
| 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 | 534,011 | | | |
| | e Government grants (contributions) | 1e | 6,405,462 | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | |
| | g Noncash contributions included in lines 1a - 1f:\$ | 1g | | | | |
| | h Total. Add lines 1a-1f ▶ | | 6,939,473 | | | |
| Program Service Revenue | Business Code | | | | | |
| | 2a NET PATIENT SERVICE REVENUE | 621990 | 323,074,911 | 322,650,980 | 423,931 | |
| | b SERVICES TO AFFILIATES | 900099 | 508,905 | 508,905 | | |
| | c PHARMACY REVENUE | 446110 | 243,760 | 243,760 | | |
| | d Contracted Services Revenue | 900099 | 83,695 | 83,695 | | |
| | e INCOME FROM JOINT VENTURES | 900099 | -1,883,972 | -1,883,972 | | |
| | f All other program service revenue. | | 0 | 0 | 0 | |
| | g Total. Add lines 2a-2f. ▶ | | 322,027,299 | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | 10,950 | | 10,950 | |
| | 4 Income from investment of tax-exempt bond proceeds ▶ | | | | | |
| | 5 Royalties ▶ | | 0 | | 0 | |
| | 6a Gross rents | (i) Real | (ii) Personal | | | |
| | | 6a | 513,362 | | | |
| | | b Less: rental expenses | 6b | 0 | | |
| | | c Rental income or (loss) | 6c | 513,362 | 0 | |
| | d Net rental income or (loss) ▶ | | 513,362 | | 513,362 | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | |
| | | 7a | | 456,846 | | |
| | | b Less: cost or other basis and sales expenses | 7b | | 1,420,664 | |
| | | c Gain or (loss) | 7c | 0 | -963,818 | |
| | d Net gain or (loss) ▶ | | -963,818 | | -963,818 | |
| | 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 ▶ | | | | | |
| | 10a Gross sales of inventory, less returns and allowances | | 10a | 80,168 | | |
| b Less: cost of goods sold | | 10b | 74,793 | | | |
| c Net income or (loss) from sales of inventory ▶ | | | 5,376 | 5,376 | | |
| Miscellaneous Revenue | | Business Code | | | | |
| 11a CAFETERIA/VENDING REVENUE | | 722514 | 1,419,293 | 1,419,293 | | |
| b EDUCATION REVENUE | | 611430 | 30,000 | 30,000 | | |
| c POST CARE FITNESS PROGRAMS | | 900099 | 17,292 | 17,292 | | |
| d All other revenue | | | 48,706 | 0 | | |
| e Total. Add lines 11a-11d ▶ | | | 1,515,291 | | | |
| 12 Total revenue. See instructions ▶ | | | 330,047,933 | 321,633,368 | 423,931 | 1,051,161 |

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 | 10,000 | 10,000 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 557,439 | | 557,439 | |
| 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 | 80,069,803 | 74,575,020 | 5,494,783 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 1,715,664 | 1,597,927 | 117,737 | |
| 9 Other employee benefits | 15,533,161 | 14,467,199 | 1,065,962 | |
| 10 Payroll taxes | 5,811,001 | 5,378,779 | 432,222 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 143,140 | 133,808 | 9,332 | |
| b Legal | 243 | | 243 | |
| c Accounting | 10,566 | | 10,566 | |
| d Lobbying | 20,482 | | 20,482 | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 11,864,695 | 10,974,491 | 890,204 | 0 |
| 12 Advertising and promotion | 466,054 | 84,532 | 381,522 | |
| 13 Office expenses | 497,776 | 480,096 | 17,680 | |
| 14 Information technology | 71,129 | 57,629 | 13,500 | |
| 15 Royalties | | | | |
| 16 Occupancy | 5,103,241 | 4,723,874 | 379,367 | |
| 17 Travel | 75,858 | 65,004 | 10,854 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 153,286 | 153,152 | 134 | |
| 20 Interest | 10,411 | | 10,411 | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 17,140,366 | 15,865,207 | 1,275,159 | |
| 23 Insurance | | | | |
| 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 MANAGEMENT FEE TO AFFILIATE | 65,363,385 | | 65,363,385 | |
| b MEDICAL SUPPLIES | 58,366,880 | 58,135,435 | 231,445 | |
| c PURCHASED SERVICES | 20,882,686 | 8,886,267 | 11,996,419 | |
| d PROVIDER TAX | 6,076,756 | 6,076,756 | | |
| e All other expenses | 9,170,576 | 2,690,792 | 6,479,784 | 0 |
| 25 Total functional expenses. Add lines 1 through 24e | 299,114,598 | 204,355,968 | 94,758,630 | 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 | | 9,229 | 1 | 7,970 | |
| | 2 | Savings and temporary cash investments | | 14,462 | 2 | 161,285 | |
| | 3 | Pledges and grants receivable, net | | 0 | 3 | 0 | |
| | 4 | Accounts receivable, net | | 52,732,334 | 4 | 43,170,752 | |
| | 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 | | 0 | 7 | 0 | |
| | 8 | Inventories for sale or use | | 6,944,913 | 8 | 7,845,390 | |
| | 9 | Prepaid expenses and deferred charges | | 533,418 | 9 | 403,639 | |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 343,728,126 | | | |
| | b | Less: accumulated depreciation | 10b | 114,585,594 | 239,155,101 | 10c | 229,142,532 |
| | 11 | Investments—publicly traded securities | | 0 | 11 | 0 | |
| | 12 | Investments—other securities. See Part IV, line 11 | | 0 | 12 | | |
| | 13 | Investments—program-related. See Part IV, line 11 | | 5,082,728 | 13 | 5,713,504 | |
| | 14 | Intangible assets | | 338,372 | 14 | 199,539 | |
| | 15 | Other assets. See Part IV, line 11 | | 13,331,984 | 15 | 16,085,185 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 318,142,541 | 16 | 302,729,796 | | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 15,343,433 | 17 | 16,724,918 | |
| | 18 | Grants payable | | 0 | 18 | 0 | |
| | 19 | Deferred revenue | | 0 | 19 | 0 | |
| | 20 | Tax-exempt bond liabilities | | 0 | 20 | 0 | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | 0 | 21 | 0 | |
| | 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 | | 0 | 23 | 0 | |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 0 | 24 | 0 | |
| | 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 | | 37,035,231 | 25 | 61,046,891 | |
| | 26 | Total liabilities. Add lines 17 through 25 | | 52,378,664 | 26 | 77,771,809 | |
| 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 | | 264,160,360 | 27 | 223,151,731 | |
| | 28 | Net assets with donor restrictions | | 1,603,517 | 28 | 1,806,256 | |
| | 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 | | 0 | 29 | 0 | |
| | 30 | Paid-in or capital surplus, or land, building or equipment fund | | 0 | 30 | 0 | |
| | 31 | Retained earnings, endowment, accumulated income, or other funds | | 0 | 31 | 0 | |
| | 32 | Total net assets or fund balances | | 265,763,877 | 32 | 224,957,987 | |
| 33 | Total liabilities and net assets/fund balances | | 318,142,541 | 33 | 302,729,796 | | |

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 | 330,047,933 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 299,114,598 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 30,933,335 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 265,763,877 |
| 5 | Net unrealized gains (losses) on investments | 5 | |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -71,739,225 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 224,957,987 |

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

- 1** Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.

| | Yes | No |
|-----------|-----|----|
| 2a | | No |
| 2b | Yes | |
| 2c | Yes | |
| 3a | | No |
| 3b | | |

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 39-0816818
Name: ASCENSION NE WISCONSIN INC

Form 990 (2019)

Form 990, Part III, Line 4a:

ASCENSION NE WISCONSIN, INC. HAS TWO HOSPITAL CAMPUSES: ST. ELIZABETH HOSPITAL, A 169-BED CAMPUS AND MERCY MEDICAL CENTER, A 115-BED CAMPUS. THESE LOCATIONS PROVIDE SERVICES WITHOUT REGARD TO PATIENT RACE, CREED, NATIONAL ORIGIN, ECONOMIC STATUS, OR ABILITY TO PAY. DURING FISCAL YEAR 2020, ASCENSION NE WISCONSIN, INC. TREATED 11,294 ADULTS AND CHILDREN FOR A TOTAL OF 47,201 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES FOR 398,675 OUTPATIENT VISITS, WHICH INCLUDED 14,645 OUTPATIENT SURGERIES AND 43,123 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
ASCENSION NE WISCONSIN INC

Employer identification number
39-0816818

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> | | |

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> | | |

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> | | |

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> | | |

Section E. Type III Functionally-Integrated Supporting Organizations

| | | |
|---|--|--|
| 1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions): | | |
| a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below. | | |
| b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below. | | |
| c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions) | | |
| 2 Activities Test. Answer (a) and (b) below. | | |
| a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <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> | | |

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: 39-0816818
Name: ASCENSION NE WISCONSIN INC

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

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

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

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

| | |
|--|--|
| Name of the organization ASCENSION NE WISCONSIN INC | Employer identification number 39-0816818 |
|--|--|

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

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

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

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

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|---|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (e) Total |
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

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

| | | (a) | | (b) |
|-----------|---|-----|----|--------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of: | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 20,482 |
| j | Total. Add lines 1c through 1i | | | 20,482 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

Part IV Supplemental Information

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

| Return Reference | Explanation |
|---|--|
| Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY | LOBBYING EXPENSES REPRESENT THE PORTION OF DUES PAID TO STATE HOSPITAL ASSOCIATIONS THAT IS SPECIFICALLY ALLOCABLE TO LOBBYING. ASCENSION NE WISCONSIN, INC. DOES NOT PARTICIPATE IN OR INTERVENE IN (INCLUDING THE PUBLISHING OR DISTRIBUTING OF STATEMENTS) ANY POLITICAL CAMPAIGN ON BEHALF OF (OR IN OPPOSITION TO) ANY CANDIDATE FOR PUBLIC OFFICE. |

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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
ASCENSION NE WISCONSIN INC

Employer identification number
39-0816818

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:

| | Amount |
|--|--------|
| 1c Beginning balance | |
| 1d Additions during the year | |
| 1e Distributions during the year | |
| 1f Ending balance | |

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds.

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | 939,091 | 957,981 | 0 | 0 | 0 |
| b Contributions | 1,590 | 449 | 957,981 | | |
| c Net investment earnings, gains, and losses | -7,924 | 6,715 | | | |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | 136,362 | 26,054 | | | |
| f Administrative expenses | | | | | |
| g End of year balance | 796,395 | 939,091 | 957,981 | 0 | 0 |

2

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

a Board designated or quasi-endowment ▶ 0 %

b Permanent endowment ▶ 84 %

c Temporarily restricted endowment ▶ 16 %

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) | | No |
| 3a(ii) | | No |
| 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 | 14,035,030 | | 14,035,030 |
| b Buildings | 0 | 244,732,708 | 55,174,380 | 189,558,328 |
| c Leasehold improvements | 0 | 892,016 | 333,728 | 558,288 |
| d Equipment | 0 | 78,280,127 | 57,830,922 | 20,449,205 |
| e Other | 0 | 5,788,245 | 1,246,564 | 4,541,681 |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶ | | | | 229,142,532 |

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) MISCELLANEOUS CURRENT ASSETS | 1,754,580 |
| (2) DUE FROM AFFILIATES | 9,587,246 |
| (3) OTHER RECEIVABLES | 48,975 |
| (4) SECURITY DEPOSIT | 2,910 |
| (5) ESTIMATED 3RD PARTY PAYOR SETTLEMENTS | 996,901 |
| (6) RIGHT OF USE OPERATING LEASE ASSET | 3,694,573 |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) ▶ | 16,085,185 |

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 | 0 |
| 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.) ▶ | 61,046,891 |

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: 39-0816818
Name: ASCENSION NE WISCONSIN INC

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

| 1. (a) Description of Liability | (b) Book Value |
|---|----------------|
| DUE TO AFFILIATES | 33,865,962 |
| ESTIMATED 3RD PARTY PAYOR SETTLEMENT | 1,277,946 |
| RECOVERY TAIL LIABILITY | 1,205,036 |
| ACCRUED PERSONAL PROPERTY & REAL ESTATE TAX LIABILITY | 340,863 |
| OTHER MISCELLANEOUS LIABILITIES | 114,565 |
| LEASE LIABILITY | 3,700,925 |
| ASSET RETIREMENT OBLIGATION | 326,774 |
| CARES RELIEF FUNDS | 52,160 |
| MEDICARE ADVANCE PAYMENTS | 20,162,660 |

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

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
ASCENSION NE WISCONSIN INC

Employer identification number
39-0816818

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 type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 25000 % 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 checked="" type="checkbox"/> 400% <input type="checkbox"/> Other % 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) | | | 3,601,787 | 0 | 3,601,787 | 1.20 % |
| b Medicaid (from Worksheet 3, column a) | | | 39,895,535 | 33,015,266 | 6,880,269 | 2.30 % |
| 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 | 43,497,322 | 33,015,266 | 10,482,056 | 3.50 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4). | 26 | 3,092 | 223,255 | 21,787 | 201,468 | 0.07 % |
| f Health professions education (from Worksheet 5) | 8 | 175 | 1,239,756 | 137,329 | 1,102,427 | 0.37 % |
| g Subsidized health services (from Worksheet 6) | 1 | 0 | 1,755,452 | 0 | 1,755,452 | 0.59 % |
| h Research (from Worksheet 7) | 2 | 0 | 92,826 | 0 | 92,826 | 0.03 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 8 | 0 | 141,651 | 0 | 141,651 | 0.05 % |
| j Total. Other Benefits | 45 | 3,267 | 3,452,940 | 159,116 | 3,293,824 | 1.10 % |
| k Total. Add lines 7d and 7j | 45 | 3,267 | 46,950,262 | 33,174,382 | 13,775,880 | 4.61 % |

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | 0 | 0 % |
| 2 Economic development | | | | | 0 | 0 % |
| 3 Community support | | | | | 0 | 0 % |
| 4 Environmental improvements | | | | | 0 | 0 % |
| 5 Leadership development and training for community members | | | | | 0 | 0 % |
| 6 Coalition building | | | | | 0 | 0 % |
| 7 Community health improvement advocacy | | | | | 0 | 0 % |
| 8 Workforce development | 2 | 128 | 504 | 0 | 504 | 0 % |
| 9 Other | | | | | 0 | 0 % |
| 10 Total | 2 | 128 | 504 | 0 | 504 | 0 % |

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | | Yes | No |
|--|-----------|-----|----|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 | | No |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | | |
| | 3,249,864 | | |
| 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 | 112,860,224 |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 144,510,682 |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | -31,650,458 |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: | | |
| <input type="checkbox"/> Cost accounting system | <input checked="" type="checkbox"/> Cost to charge ratio | <input type="checkbox"/> Other |

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

| (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 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

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

(list in order of size from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year?

2

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 |
|---------------------------|------------------|----------|-------------|-------------------|--------------------------|-------------------|---------------------|----------------------------|-------------------|
| 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)

A

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):** _____

| | Yes | No |
|---|------------|-----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. 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>18</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://healthcare.ascension.org/CHNA</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 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>18</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>https://healthcare.ascension.org/CHNA</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)**

A

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: | Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>250.0</u> % and FPG family income limit for eligibility for discounted care of <u>400.0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input 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? | 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): | 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 checked="" 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): | Yes | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>https://healthcare.ascension.org/Financial-Assistance/wisconsin</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>https://healthcare.ascension.org/Financial-Assistance/wisconsin</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>https://healthcare.ascension.org/Financial-Assistance/wisconsin</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**

A

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)**

A

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? 0

| Name and address | Type of Facility (describe) |
|------------------|-----------------------------|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|---|
| Schedule H, Part I, Line 3c FACTORS OTHER THAN FPG | SUBJECT TO THE OTHER PROVISIONS OF THIS FINANCIAL ASSISTANCE POLICY, A PATIENT WITH INCOME GREATER THAN 400% OF THE FPL MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER A "MEANS TEST" FOR SOME DISCOUNT OF PATIENT'S CHARGES FOR SERVICES FROM THE ORGANIZATION BASED ON A PATIENT'S TOTAL MEDICAL DEBT. A PATIENT ELIGIBLE FOR THIS CATEGORY OF FINANCIAL ASSISTANCE WILL NOT BE CHARGED MORE THAN THE CALCULATED AGB CHARGES. |
| Schedule H, Part I, Line 7g Subsidized Health Services | ASCENSION NE WISCONSIN, INC. HAS A SEPARATELY ORGANIZED ENTITY, WHERE ALL PHYSICIAN CLINIC COSTS ARE GROUPED. THE HOSPITAL HAS THEREFORE NOT INCLUDED ANY PHYSICIAN CLINIC COSTS IN SUBSIDIZED HEALTH SERVICES. |

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. |
| Schedule H, Part II Community Building Activities | ASCENSION NE WISCONSIN -- ST. ELIZABETH CAMPUS PROVIDED HEALTH CAREER PRESENTATIONS AND JOB SHADOWING EXPERIENCES TO STUDENTS. ASSURING THAT COMMUNITIES HAVE A VIBRANT HEALTH CARE WORKFORCE IN THE FUTURE WILL HELP INCREASE ACCESS TO QUALITY CARE IN THE FUTURE. |

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 IN FISCAL YEAR 2020 WAS \$9,259,379 AT CHARGES, (\$3,249,864 AT COST). |
| Schedule H, Part III, Line 3 Bad Debt Expense Methodology | THE ORGANIZATION HAS A VERY ROBUST FINANCIAL ASSISTANCE PROGRAM; THEREFORE, NO ESTIMATE IS MADE FOR BAD DEBT ATTRIBUTED 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. |
| 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 | THE ORGANIZATION 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. |
| Schedule H, Part V, Section B, Line 16a FAP website | A - ASCENSION NE WISCONSIN, INC. - ST. ELIZABETH CAMPUS: Line 16a URL: https://healthcare.ascension.org/Financial-Assistance/wisconsin; |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|--|
| Schedule H, Part V, Section B, Line 16b FAP Application website | A - ASCENSION NE WISCONSIN, INC. - ST. ELIZABETH CAMPUS: Line 16b URL: https://healthcare.ascension.org/Financial-Assistance/wisconsin; |
| Schedule H, Part V, Section B, Line 16c FAP plain language summary website | A - ASCENSION NE WISCONSIN, INC. - ST. ELIZABETH CAMPUS: Line 16c URL: https://healthcare.ascension.org/Financial-Assistance/wisconsin; |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| Schedule H, Part VI, Line 2 Needs assessment | IN ADDITION TO THE CHNA REPORTED IN PART V, SECTION B, ASCENSION NE WISCONSIN, INC. USE BOTH HOSPITAL DATA AND RELIABLE, THIRD PARTY REPORTS, INCLUDING DATA FROM GOVERNMENT SOURCES, TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY IT SERVES. THESE REPORTS PROVIDE INFORMATION ABOUT KEY HEALTH, SOCIOECONOMIC, AND DEMOGRAPHIC INDICATORS THAT POINT TO AREAS OF NEED. ASCENSION NE WISCONSIN (F/K/A ST. ELIZABETH HOSPITAL, INC.) UTILIZES THIS INFORMATION TO DETERMINE DEVELOP PROGRAMS AND SERVICES TO BE PROVIDED FOR THE COMMUNITY. THESE NEEDS AND INITIATIVES ARE PRESENTED TO SENIOR LEADERSHIP AND BOARD MEMBERS TO ENSURE THE FINDINGS ARE CONSIDERED IN DEVELOPING THE ORGANIZATION'S STRATEGY, POLICY DEVELOPMENT, AND INTERNAL FINANCIAL AND OPERATIONAL DECISIONS. |
| Schedule H, Part VI, Line 3 Patient education of eligibility for assistance | ASCENSION NE WISCONSIN GOES TO GREAT LENGTHS IN ORDER TO INFORM AND EDUCATE PATIENTS/PERSONS WHO MAY BE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE OR LOCAL GOVERNMENT PROGRAMS AND UNDER THE ORGANIZATIONS AFFINITY CARE POLICY. THE AFFINITY CARE POLICY AND APPLICATION IS POSTED ON THE ORGANIZATION'S WEBSITE. ADMISSIONS AND OTHER KEY AREAS CONTAIN SUMMARY INFORMATION OF THE AFFINITY CARE POLICY. AS PART OF THE INTAKE/DISCHARGE PROCESS, PATIENTS ARE PROVIDED WITH A COPY OF THE POLICY AND OTHER INFORMATION FOR FINANCIAL ASSISTANCE. IF DURING THE COURSE OF THE PATIENT REGISTRATION PROCESS, CARE ENCOUNTER, TREATMENT, OR UPON DISCHARGE IT BECOMES EVIDENT THAT A PATIENT MAY NEED FINANCIAL ASSISTANCE, THE PATIENT SHALL BE REFERRED TO THE ORGANIZATIONS AFFINITY CARE PROGRAM. PATIENTS MAY BE IDENTIFIED AS NEEDING FINANCIAL ASSISTANCE AT ANY TIME DURING THE COURSE OF AN ENCOUNTER. A REFERRAL FOR CONSIDERATION OF AFFINITY CARE FINANCIAL ASSISTANCE CAN BE INITIATED BY ANY MEMBER OF THE HOSPITAL'S WORKFORCE, INCLUDING MEDICAL STAFF MEMBERS, WHO BECOME AWARE OF THE PATIENTS POTENTIAL NEED FOR AFFINITY CARE FINANCIAL ASSISTANCE. THE AFFINITY CARE BROCHURE WAS ALSO TRANSLATED INTO DIALECTS PREVALENT IN THE COMMUNITY IN ORDER TO REACH OUT TO THOSE THAT MAY SPEAK ANOTHER LANGUAGE (SPANISH AND HMONG). PATIENT REGISTRATION STAFF AND FINANCIAL COUNSELORS ARE PROVIDED WITH GUIDELINES TO FOLLOW WHEN INTERACTING WITH PATIENTS. AS PART OF THE AFFINITY CARE PROCESS, PATIENTS MUST REGISTER WITH THE COUNTY PUBLIC ASSISTANCE TO SEE IF THEY MAY QUALIFY UNDER ANY OTHER FEDERAL OR STATE PROGRAMS. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|--|
| Schedule H, Part VI, Line 4 Community information | <p>ASCENSION NE WISCONSIN -- MERCY CAMPUS AND ASCENSION NE WISCONSIN -- ST. ELIZABETH CAMPUS PRIMARILY SERVE THE RESIDENTS OF WINNEBAGO AND OUTAGAMIE COUNTIES AND THE SURROUNDING COUNTIES IN AN URBAN AREA OF EAST CENTRAL WISCONSIN. THE POPULATION OF WINNEBAGO COUNTY IS APPROXIMATELY 169,000, WITH 11% OF RESIDENTS LIVING AT OR BELOW THE FEDERAL POVERTY THRESHOLD. THE MEDIAN HOUSEHOLD INCOME IS OVER \$55,000. APPROXIMATELY 5% OF THE INDIVIDUALS LIVING IN THE COUNTY ARE UNINSURED AND 18% RECEIVE MEDICAID. WINNEBAGO COUNTY INCLUDES DESIGNATED MENTAL HEALTH CARE AND DENTAL HEALTH CARE SHORTAGE AREAS. THERE ARE 4 HOSPITALS IN WINNEBAGO COUNTY (ASCENSION NE WISCONSIN -- MERCY CAMPUS, AURORA MEDICAL CENTER IN OSHKOSH, CHILDREN'S HOSPITAL OF WISCONSIN -- FOX VALLEY AND AN INPATIENT MENTAL HEALTH CENTER). THE POPULATION OF OUTAGAMIE COUNTY IS APPROXIMATELY 181,000, WITH 7% OF RESIDENTS LIVING AT OR BELOW THE FEDERAL POVERTY THRESHOLD. THE MEDIAN HOUSEHOLD INCOME IS OVER \$61,000. APPROXIMATELY 4% OF THE INDIVIDUALS LIVING IN THE COUNTY ARE UNINSURED AND 15% RECEIVE MEDICAID. OUTAGAMIE COUNTY INCLUDES DESIGNATED PRIMARY CARE, MENTAL HEALTH CARE AND DENTAL HEALTH CARE SHORTAGE AREAS. THERE ARE 3 HOSPITALS IN OUTAGAMIE COUNTY (ASCENSION NE WISCONSIN -- ST. ELIZABETH CAMPUS, THEDACARE REGIONAL MEDICAL CENTER -- APPLETON, THEDACARE MEDICAL CENTER -- NEW LONDON). BOTH CAMPUSES ARE DISPROPORTIONATE SHARE HOSPITALS. (DISPROPORTIONATE SHARE HOSPITALS SERVE A SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS AND RECEIVE PAYMENTS FROM THE CENTERS FOR MEDICAID AND MEDICARE SERVICES TO COVER THE COSTS OF PROVIDING CARE TO UNINSURED PATIENTS.)</p> |
| Schedule H, Part VI, Line 5 Promotion of community health | <p>THE ORGANIZATION STRIVES TO FURTHER ITS EXEMPT PURPOSES BY THE FOLLOWING: (1) THE ORGANIZATION'S GOVERNING BOARD CONSISTS PRIMARILY OF PERSONS WHO RESIDE WITHIN THE PRIMARY SERVICE AREA WHO ARE NOT EMPLOYEES OF THE ORGANIZATION. (2) AS MENTIONED, THE ORGANIZATION PROVIDES SEVERAL SERVICES WHICH ARE NOT OTHERWISE AVAILABLE BEING IN A RURAL SETTING. (3) BASED ON THE ORGANIZATION'S MISSION, EMERGENCY ROOMS ARE MADE AVAILABLE TO ALL PATIENTS REGARDLESS OF THE ABILITY TO PAY. (4) THE ORGANIZATION ALSO PARTICIPATES IN THE EDUCATION AND TRAINING OF HEALTHCARE PROFESSIONALS THROUGH INTERNSHIP PROGRAMS. CERTAIN SPECIALIZED SERVICES AVAILABLE INCLUDE: DENTAL SERVICES TO PRIMARILY THE INDIGENT, FERTILITY CLINIC SERVICES AND WIC HOME VISITS TO NEW MOTHERS AND INFANTS.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| Schedule H, Part VI, Line 6 Affiliated health care system | <p>ASCENSION NE WISCONSIN, IS AN AFFILIATE OF MINISTRY HEALTH CARE, INC. AND ASCENSION HEALTH. ASCENSION NE WISCONSIN, AFFILIATES ARE LARGE MULTI-FACETED, INTEGRATED, NOT-FOR-PROFIT MINISTRIES INCLUDING HOSPITAL AND NON-HOSPITAL MINISTRIES (PHYSICIAN GROUP PRACTICES, HOSPITAL ORGANIZATIONS, RESEARCH, HOME HEALTH, DURABLE MEDICAL EQUIPMENT AND SENIOR FACILITIES). 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, 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 STATES AND THE DISTRICT OF COLUMBIA. ASCENSION IS SPONSORED BY ASCENSION SPONSOR, A PUBLIC JURIDIC PERSON. THE PARTICIPATING 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. THE SYSTEM DIRECTS ITS GOVERNANCE AND MANAGEMENT ACTIVITIES TOWARD STRONG, VIBRANT, CATHOLIC HEALTH MINISTRIES UNITED IN SERVICE AND HEALING AND DEDICATES ITS RESOURCES TO SPIRITUALLY CENTERED CARE THAT SUSTAINS AND IMPROVES THE HEALTH OF THE INDIVIDUALS AND COMMUNITIES IT SERVES. IN ACCORDANCE WITH THE SYSTEM'S MISSION OF SERVICE TO THOSE PERSONS LIVING IN POVERTY AND TO OTHER VULNERABLE PERSONS, EACH HEALTH MINISTRY ACCEPTS PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. THE SYSTEM USES FOUR CATEGORIES TO IDENTIFY THE RESOURCES UTILIZED FOR THE CARE OF PERSONS LIVING IN POVERTY AND FOR COMMUNITY BENEFIT PROGRAMS: TRADITIONAL CHARITY CARE INCLUDES THE COST OF SERVICES PROVIDED TO PERSONS WHO CANNOT AFFORD HEALTH CARE BECAUSE OF INADEQUATE RESOURCES AND/OR WHO ARE UNINSURED OR UNDERINSURED. UNPAID COST OF PUBLIC PROGRAMS, EXCLUDING MEDICARE, REPRESENTS THE UNPAID COST OF SERVICES PROVIDED TO PERSONS COVERED BY PUBLIC PROGRAMS FOR PERSONS LIVING IN POVERTY AND FOR OTHER VULNERABLE PERSONS. COST OF OTHER PROGRAMS FOR PERSONS LIVING IN POVERTY AND FOR OTHER VULNERABLE PERSONS INCLUDES UNREIMBURSED COSTS OF PROGRAMS INTENTIONALLY DESIGNED TO SERVE THE PERSONS LIVING IN POVERTY AND THE OTHER VULNERABLE PERSONS OF THE COMMUNITY, INCLUDING SUBSTANCE ABUSERS, THE HOMELESS, VICTIMS OF CHILD ABUSE, AND PERSONS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME. COMMUNITY BENEFIT CONSISTS OF THE UNREIMBURSED COSTS OF COMMUNITY BENEFIT PROGRAMS AND SERVICES FOR THE GENERAL COMMUNITY, NOT SOLELY FOR THE PERSONS LIVING IN POVERTY, INCLUDING HEALTH PROMOTION AND EDUCATION, HEALTH CLINICS AND SCREENINGS, AND MEDICAL RESEARCH. DISCOUNTS ARE PROVIDED TO ALL UNINSURED PATIENTS, INCLUDING THOSE WITH THE MEANS TO PAY. DISCOUNTS PROVIDED TO THOSE PATIENTS WHO DID NOT QUALIFY FOR ASSISTANCE UNDER CHARITY CARE GUIDELINES ARE NOT INCLUDED IN THE COST OF PROVIDING CARE TO PERSONS LIVING IN POVERTY OR IN THE COST OF OTHER COMMUNITY BENEFIT PROGRAMS. THE COST OF PROVIDING CARE TO PERSONS LIVING IN POVERTY AND OF OTHER COMMUNITY BENEFIT PROGRAMS IS ESTIMATED USING INTERNAL COST DATA AND IS ESTIMATED BY REDUCING CHARGES FORGONE BY A FACTOR DERIVED FROM THE RATIO OF TOTAL OPERATING EXPENSES TO BILLED CHARGES FOR PATIENT CARE.</p> |

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 39-0816818
Name: ASCENSION NE WISCONSIN INC

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

| Section A. Hospital Facilities | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER—24 hours | ER—other | Other (Describe) | Facility reporting group |
|---|---|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 2 | | | | | | | | | | | |
| Name, address, primary website address, and state license number | | | | | | | | | | | |
| 1 | ASCENSION NE WISCONSIN INC - ST ELIZABETH CAMPUS 1506 SOUTH ONEIDA STREET APPLETON, WI 54915 https://healthcare.ascension.org/Locations/Wisconsin/WIAPA/Appleton-Ascension-NE-Wisconsin-St-Elizab 88 | X | X | | X | | | X | | | A |
| 2 | MERCY MEDICAL CENTER OF OSHKOSH INC 500 SOUTH OAKWOOD ROAD OSHKOSH, WI 54904 https://healthcare.ascension.org/Locations/Wisconsin/WIAPA/Oshkosh-Ascension-NE-Wisconsin-Mercy-Camp 186 | X | X | | | | | X | | | A |

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

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

| Form and Line Reference | Explanation |
|--|--|
| Schedule H, Part V, Section B, Line 3E | THE PRIORITIZATION PROCESS INCLUDED TWO STEPS: 1. THE LOCAL COMMUNITY HEALTH IMPROVEMENT LEAD (CHIP) LEAD AND SYSTEM CHIP LEADERS REVIEWED THE DATA, DISCUSSED POTENTIAL PRIORITIES AND MADE A FORMAL RECOMMENDATION. 2. THE RECOMMENDATION WAS REVIEWED AND AFFIRMED BY THE ASCENSION NE WISCONSIN - ST. ELIZABETH CAMPUS PRESIDENT AND ASCENSION NE WISCONSIN - MERCY CAMPUS CHIEF ADMINISTRATIVE OFFICER. PRIORITIZATION CRITERIA INCLUDED: SCOPE OF PROBLEM (E.G., NUMBER OF PEOPLE IMPACTED, SEVERITY) ; HEALTH DISPARITIES (E.G., BY INCOME AND/OR RACE AND ETHNICITY); FEASIBILITY (E.G., ARE THERE KNOWN INTERVENTIONS, CAN WE HAVE AN IMPACT); MOMENTUM/COMMITMENT (E.G., POLITICAL WILL, COMMUNITY READINESS); ALIGNMENT WITH OTHERS (E.G., LOCAL HEALTH DEPARTMENT PRIORITIES). |

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 A, 1 | Facility A, 1 - ASCENSION NE WISCONSIN, INC. AND MERCY MEDICAL CENTER OF OSHKOSH, INC.. AS CENSION NE WISCONSIN - ST. ELIZABETH CAMPUS AND MERCY CAMPUS ARE COMMITTED TO ADDRESSING C OMMUNITY HEALTH NEEDS COLLABORATIVELY WITH LOCAL PARTNERS. ASCENSION NE WISCONSIN - ST. ELIZABETH CAMPUS AND MERCY CAMPUS AND THEIR COMMUNITY PARTNERS (OTHER HOSPITALS AND HEALTH D EPARTMENTS) USED THE FOLLOWING METHODS TO LISTEN TO COMMUNITY MEMBERS' THOUGHTS ON THE STR ENGTHS AND CHALLENGES OF BEING A HEALTHY COMMUNITY. THESE METHODS PROVIDED US WITH ADDITIO NAL PERSPECTIVES ON HOW TO SELECT AND ADDRESS TOP HEALTH ISSUES FACING OUR COMMUNITIES. IN PUT FROM COMMUNITY LEADERS: INPUT WAS RECEIVED FROM COMMUNITY LEADERS THROUGH KEY INFORMAN T/STAKEHOLDER INTERVIEWS IN SUMMER 2018. ASCENSION NE WISCONSIN - ST. ELIZABETH CAMPUS AND MERCY CAMPUS AND COMMUNITY PARTNERS CONDUCTED 50 INTERVIEWS WITH LEADERS IN OUTAGAMIE, WI NNEBAGO AND CALUMET COUNTIES. THE WRITTEN NOTES FROM THOSE MEETINGS WERE SHARED WITH JKV R ESEARCH WHO COMPILED THE RESULTS INTO A REPORT. SEE THE STAKEHOLDER LIST BELOW. INPUT FROM MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS AND/OR ORGANIZATION S THAT REPRESENT THOSE POPULATIONS: ASCENSION WISCONSIN IS FUELED BY A COMMITMENT TO HUMAN DIGNITY, THE COMMON GOOD, JUSTICE AND SOLIDARITY. WE BELIEVE THE CHNA PROCESS MUST BE INF ORMED BY DIRECT INPUT FROM PERSONS WHO EXPERIENCE HEALTH DISPARITIES BASED ON INCOME AND/O R RACE AND ETHNICITY. WITH THAT IN MIND, ASCENSION NE WISCONSIN - ST. ELIZABETH CAMPUS AND MERCY CAMPUS AND COMMUNITY PARTNERS SURVEYED INDIVIDUALS AT LOCATIONS THAT WERE LARGELY S ERVING INDIVIDUALS WITH LOW INCOME, INDIVIDUALS WHO ARE MEDICALLY UNDERSERVED AND/OR INDIV IDUALS WHO ARE FROM A MINORITY COMMUNITY. THIS INCLUDED THE FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER AND A COUNTY-BASED WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM. FIFTY-THREE SU RVEYS WERE COMPLETED IN JUNE 2018. THE SURVEYS WERE SHARED WITH JKV RESEARCH WHO COMPILED THE RESULTS INTO A REPORT. KEY EXTERNAL STAKEHOLDERS INCLUDED: 2-1-1 ADRC IN OUTAGAMIE COU NTY * AFRICAN AMERICAN HERITAGE, INC. ** AUORAL MEDICAL CENTER OSHKOSH EMERGENCY DEPARTM ENT APPLETON DOWNTOWN INC. ASCENSION WISCONSIN BEHAVIORAL HEALTH AND SECURITY SERVICES ASC ENSION CALUMET HOSPITAL CAMPUS - EMERGENCY DEPARTMENT AURORA SEXUAL ASSAULT CENTER CALUMET COUNTY - PUBLIC HEALTH CALUMET COUNTY ECONOMIC DEVELOPMENT CASA HISPANA *** CATALPA * CHI LDCARE RESOURCE AND REFERRAL CHILTON POLICE DEPARTMENT CHILTON SCHOOL DISTRICT CITY OF MEN ASHA COMMUNITY DEVELOPMENT COMMUNITY FOR HOPE ESTHER ** *** FIT OSHKOSH GOODWILL INDUSTRIE S NEIGHBORHOOD PARTNERS * ** HMONG AMERICAN PARTNERSHIP *** HOMELESS CONNECTIONS * ** MENA SHA BOARD OF HEALTH MENASHA POLICE DEPARTMENT MENASHA SENIOR CENTER* NEENAH-MENASHA YMCA N EW HOLSTEIN CHAMBER OF COMMERCE NORTHEAST WISCONSIN MENTAL HEALTH CONNECTION * OSHKOSH ARE A SCHOOL DISTRICT OSHKOSH AREA UNITED WAY EARLY INTERVENTION PROGRAM OF OUTAGAMIE AND WINN EBAGO COUNTIES (BIRTH TO 3 PRO |

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 A, 1 | GRAM) OUTAGAMIE COUNTY HEALTH AND HUMAN SERVICES OUTAGAMIE COUNTY PUBLIC HEALTH OUTAGAMIE SHERIFF'S OFFICE RURAL HEALTH INITIATIVE * ** SAMARITAN COUNSELING *** UW- OSHKOSH HEAD STA RT PROGRAM UNIVERSITY OF WISCONSIN-OSHKOSH WINNEBAGO COUNTY YMCA *DENOTES ORGANIZATIONS OR PROGRAMS REPRESENTING MEDICALLY UNDERSERVED POPULATIONS. **DENOTES ORGANIZATIONS OR PROGR AMS REPRESENTING LOW-INCOME POPULATIONS. ***DENOTES ORGANIZATIONS OR PROGRAMS REPRESENTING MINORITY POPULATIONS. |

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 A, 1 | Facility A, 1 - ASCENSION NE WISCONSIN, INC. AND MERCY MEDICAL CENTER OF OSHKOSH, INC.. ASCENSION NE WISCONSIN IS PART OF THE FOX VALLEY COMMUNITY HEALTH IMPROVEMENT COALITION (FVCHIC), A REGIONAL COLLABORATIVE. THE FVCHIC WORKED TOGETHER TO CONDUCT A NUMBER OF COMPONENTS OF THE ASSESSMENT. THE MEMBERS OF THE FVCHIC INCLUDE HEALTH DEPARTMENTS AND HOSPITAL SYSTEMS IN A THREE-COUNTY AREA (OUTAGAMIE, WINNEBAGO, CALUMET). HOSPITALS OR HEALTH SYSTEMS INCLUDED: ASCENSION CALUMET HOSPITAL; THEDACARE (MULTIPLE HOSPITALS IN THE REGION); CHILDREN'S WISCONSIN -- FOX VALLEY HOSPITAL; AURORA MEDICAL CENTER IN OSHKOSH. |

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 A, 1 | Facility A, 1 - ASCENSION NE WISCONSIN, INC. AND MERCY MEDICAL CENTER OF OSHKOSH, INC.. ASCENSION NE WISCONSIN IS PART OF THE FOX VALLEY COMMUNITY HEALTH IMPROVEMENT COALITION (FVCHIC), A REGIONAL COLLABORATIVE. THE FVCHIC WORKED TOGETHER TO CONDUCT A NUMBER OF COMPONENTS OF THE ASSESSMENT. THE MEMBERS OF THE FVCHIC INCLUDE HEALTH DEPARTMENTS AND HOSPITAL SYSTEMS IN A THREE-COUNTY AREA (OUTAGAMIE, WINNEBAGO, CALUMET). THE FOLLOWING GOVERNMENTAL PUBLIC HEALTH ENTITIES ARE PARTNERS IN FVCHIC: WINNEBAGO COUNTY HEALTH DEPARTMENT; OUTAGAMIE COUNTY PUBLIC HEALTH DIVISION; CALUMET COUNTY PUBLIC HEALTH; CITY OF MENASHA HEALTH DEPARTMENT; CITY OF APPLETON HEALTH DEPARTMENT. |

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 A, 1 | Facility A, 1 - MERCY MEDICAL CENTER OF OSHKOSH, INC.. USING THE CHNA COMPLETED IN JUNE 2019, THE HOSPITALS WORKED ON EXECUTING A THREE-YEAR IMPLEMENTATION STRATEGY TO ADDRESS PRIORITY COMMUNITY HEALTH NEEDS. IN FISCAL YEAR 2020 (TAX YEAR 2019), THE HOSPITALS IMPLEMENTED THE FOLLOWING PLAN TO ADDRESS THE PRIORITY NEEDS: HEALTHY WEIGHT: INCREASE THE PROPORTION OF RESIDENTS WHO HAVE A HEALTHY DIET AND REGULAR PHYSICAL ACTIVITY -- PARTICIPATED IN THE REGIONAL BE WELL FOX VALLEY COALITION (FORMERLY WEIGHT OF THE FOX VALLEY), WHICH OFFERED EVENTS, NEWSLETTERS AND SOCIAL MEDIA POSTS. THE FOX VALLEY COALITION IS WORKING ON A FOOD AS MEDICINE PROGRAM AND HOSTED AMERICORPS MEMBERS TO DELIVER EDUCATION PROGRAMS. -- IMPLEMENTED ROUTINE BODY MASS INDEX SCREENING IN PRIMARY CARE SETTINGS MENTAL HEALTH: REDUCE SUICIDES IN OUTAGAMIE AND WINNEBAGO COUNTIES -- INCREASED AWARENESS, EDUCATION AND TRAINING AROUND MENTAL HEALTH AND SUICIDE PREVENTION THROUGH PARTICIPATION IN REGIONAL COALITIONS. THOSE COALITIONS CONDUCTED THREE KINDS OF TRAININGS: QUESTION, PERSUADE, REFER (QPR) FOR INDIVIDUAL COMMUNITY MEMBERS; ZERO SUICIDE FOR ORGANIZATIONS SEEKING TO CHANGE THEIR INTERNAL SYSTEMS TO REDUCE SUICIDE; CALM (COUNSELING ON ACCESS TO LETHAL MEANS). ADDITIONALLY, WELLNESS SCREENING PARENT PACKETS WERE DISTRIBUTED THROUGH SCHOOLS. -- BEGAN IMPLEMENTING ROUTINE DEPRESSION SCREENING IN PRIMARY CARE ----- THE DESCRIPTION BELOW INCLUDES THE NEEDS NOT BEING ADDRESSED IN THE 2019-2022 CHNA AS WELL AS THE REASON WHY THE NEEDS ARE NOT BEING ADDRESSED. ALCOHOL MISUSE/SUBSTANCE ABUSE WAS NOT SELECTED IN THIS CHNA CYCLE. ADDRESSING ALCOHOL AND SUBSTANCE ABUSE AT THE COMMUNITY LEVEL IS A COLLABORATIVE UNDERTAKING. AT THIS TIME, COMMUNITY MOMENTUM AND PARTNERSHIPS ON THIS ISSUE ARE LIMITED. AS OPPORTUNITIES ARISE TO SUBSTANTIVELY AND COLLABORATIVELY ADDRESS SUBSTANCE ABUSE IN OUTAGAMIE AND WINNEBAGO COUNTIES, THE HOSPITAL CAMPUSES WILL PARTICIPATE. ADDITIONALLY, THE CAMPUSES WILL SEEK INTERNAL OPPORTUNITIES TO ADDRESS ALCOHOL MISUSE/SUBSTANCE ABUSE. |

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 A, 2 | Facility A, 2 - ASCENSION NE WISCONSIN, INC. (ST. ELIZABETH CAMPUS). USING THE CHNA COMPLETED IN JUNE 2019, THE HOSPITALS WORKED ON EXECUTING A THREE-YEAR IMPLEMENTATION STRATEGY TO ADDRESS PRIORITY COMMUNITY HEALTH NEEDS. IN FISCAL YEAR 2020 (TAX YEAR 2019), THE HOSPITALS IMPLEMENTED THE FOLLOWING PLAN TO ADDRESS THE PRIORITY NEEDS: HEALTHY WEIGHT: INCREASE THE PROPORTION OF RESIDENTS WHO HAVE A HEALTHY DIET AND REGULAR PHYSICAL ACTIVITY -- PARTICIPATED IN THE REGIONAL BE WELL FOX VALLEY COALITION (FORMERLY WEIGHT OF THE FOX VALLEY), WHICH OFFERED EVENTS, NEWSLETTERS AND SOCIAL MEDIA POSTS. THE FOX VALLEY COALITION IS WORKING ON A FOOD AS MEDICINE PROGRAM AND HOSTED AMERICORPS MEMBERS TO DELIVER EDUCATION PROGRAMS. THE HOSPITAL HELPED FUND BEWELL FOX VALLEY. -- IMPLEMENTED ROUTINE BODY MASS INDEX SCREENING IN PRIMARY CARE SETTINGS MENTAL HEALTH: REDUCE SUICIDES IN OUTAGAMIE AND WINNEBAGO COUNTIES -- INCREASED AWARENESS, EDUCATION AND TRAINING AROUND MENTAL HEALTH AND SUICIDE PREVENTION THROUGH PARTICIPATION IN REGIONAL COALITIONS. THOSE COALITIONS CONDUCTED THREE KINDS OF TRAININGS: QUESTION, PERSUADE, REFER (QPR) FOR INDIVIDUAL COMMUNITY MEMBERS; ZERO SUICIDE FOR ORGANIZATIONS SEEKING TO CHANGE THEIR INTERNAL SYSTEMS TO REDUCE SUICIDE; CALM (COUNSELING ON ACCESS TO LETHAL MEANS). ADDITIONALLY, WELLNESS SCREENING PARENT PACKETS WERE DISTRIBUTED THROUGH SCHOOLS. -- THE HOSPITAL FUNDED A NUMBER OF LOCAL MENTAL HEALTH EFFORTS. -- BEGAN IMPLEMENTING ROUTINE DEPRESSION SCREENING IN PRIMARY CARE ----- THE DESCRIPTION BELOW INCLUDES THE NEEDS NOT BEING ADDRESSED IN THE 2019-2022 CHNA AS WELL AS THE REASON WHY THE NEEDS ARE NOT BEING ADDRESSED. ALCOHOL MISUSE/SUBSTANCE ABUSE WAS NOT SELECTED IN THIS CHNA CYCLE. ADDRESSING ALCOHOL AND SUBSTANCE ABUSE AT THE COMMUNITY LEVEL IS A COLLABORATIVE UNDERTAKING. AT THIS TIME, COMMUNITY MOMENTUM AND PARTNERSHIPS ON THIS ISSUE ARE LIMITED. AS OPPORTUNITIES ARISE TO SUBSTANTIVELY AND COLLABORATIVELY ADDRESS SUBSTANCE ABUSE IN OUTAGAMIE AND WINNEBAGO COUNTIES, THE HOSPITAL CAMPUSES WILL PARTICIPATE. ADDITIONALLY, THE CAMPUSES WILL SEEK INTERNAL OPPORTUNITIES TO ADDRESS ALCOHOL MISUSE/SUBSTANCE ABUSE. |

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

ASCENSION NE WISCONSIN INC

Employer identification number

39-0816818

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) MERCY HEALTH FOUNDATION INC C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 | 23-7140261 | 501(C)(3) | 10,000 | | | | GENERAL SUPPORT |

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table▶1
- 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) | | | | | |
| (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. | THE FILING ORGANIZATION ENSURES THAT FUNDS ARE DISTRIBUTED APPROPRIATELY ACCORDING TO ASCENSION'S STRATEGIC BUSINESS PLAN AND CONSISTENT WITH CORPORATE POLICIES AND PROCEDURES. |

| | | |
|--|---|--|
| Schedule J (Form 990) | Compensation Information | OMB No. 1545-0047 |
| | | 2019 |
| | | Open to Public Inspection |
| 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 ASCENSION NE WISCONSIN INC | | Employer identification number 39-0816818 |

| 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 | No |
| 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 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 CURRENT YEAR DISTRIBUTIONS. |

Additional Data

Software ID: 19010655
Software Version: 2019v5.0
EIN: 39-0816818
Name: ASCENSION NE WISCONSIN INC

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 | | | | |
| 1MONICA A HILT EX-OFFICIO/PRESIDENT | (i) | 411,075 | 0 | 33,205 | 18,200 | 26,187 | 488,667 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1WENDY L SCHROEDER DO DIRECTOR | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 415,728 | 49,910 | 921 | 16,800 | 27,160 | 510,519 | 0 |
| 2SUDEEP S SODHI MD DIRECTOR | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 1,028,276 | 404,016 | 2,622 | 18,200 | 37,996 | 1,491,110 | 0 |
| 3DEIDRE A FLANAGAN MD DIRECTOR | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 419,779 | 80,541 | 2,361 | 18,200 | 27,632 | 548,513 | 0 |
| 4JONATHAN SOHN CFO, MINISTRY MARKET | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 504,590 | 198,227 | 46,021 | 18,200 | 21,998 | 789,036 | 0 |
| 5JOHN M LESCHKE MD FORMER KEY EMPLOYEE (END 12/2018) | (i) | 6,122 | 0 | 130 | 337 | 101 | 6,690 | 0 |
| | (ii) | 218,137 | 50 | 4,307 | 11,921 | 1,941 | 236,356 | 0 |
| 6JAMES D ROOT FORMER KEY EMPLOYEE (END 12/2017) | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 138,815 | 0 | 1,018 | 9,035 | 3,356 | 152,224 | 0 |
| 7CRYSTAL J KIRSCHLING VP, NURSING (START 9/2019) | (i) | 53,373 | 0 | 186 | 9,126 | 6,087 | 68,772 | 0 |
| | (ii) | 151,324 | 10,200 | 543 | 4,737 | 19,998 | 186,802 | 0 |
| 8MICHAEL C BECKETT MD PHYSICIAN | (i) | 289,357 | 0 | 451 | 15,970 | 30,406 | 336,184 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9MICHAEL A HOFMANN RN DIRECTOR, NURSING | (i) | 163,820 | 250 | 552 | 11,565 | 26,085 | 202,272 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10NANETTE W KRIZENESKY RN REGISTERED NURSE | (i) | 191,661 | 2,444 | 230 | 13,138 | 25,622 | 233,095 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 11ERIC C LOBB PHYSICIST | (i) | 181,510 | 0 | 117 | 9,231 | 9,756 | 200,614 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 12AHPA PLYPOO PHYSICIST | (i) | 191,363 | 0 | 131 | 9,721 | 9,793 | 211,008 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

SCHEDULE O
(Form 990 or 990-EZ)Department of the Treasury
Internal Revenue Service
Name of the organization
ASCENSION NE WISCONSIN INC**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****Employer identification number**

39-0816818

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 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 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 | ASCENSION NE WISCONSIN, INC. HAS A SINGLE CORPORATE MEMBER, MINISTRY HEALTHCARE, INC. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| Form 990, Part VI, Line 7a Members or stockholders electing members of governing body | ASCENSION NE WISCONSIN, INC. HAS A SINGLE CORPORATE MEMBER, MINISTRY HEALTHCARE, INC., WHO HAS THE ABILITY TO ELECT MEMBERS TO THE GOVERNING BODY OF ASCENSION NE WISCONSIN, INC. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders | ASCENSION NE WISCONSIN, INC. HAS A SINGLE CORPORATE MEMBER, MINISTRY HEALTHCARE, INC., WHO HAS THE ABILITY TO ELECT MEMBERS TO THE GOVERNING BODY OF ASCENSION NE WISCONSIN, INC. ALL DECISIONS THAT HAVE A MATERIAL IMPACT TO ASCENSION NE WISCONSIN, INC. FINANCIAL INFORMATION OR CORPORATION AS A WHOLE ARE SUBJECT TO APPROVAL BY ITS SOLE CORPORATE MEMBER, MINISTRY HEALTHCARE, INC. |

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 | LATE PENALTY FEES - Total Revenue: 2298, Related or Exempt Function Revenue: , Unrelated Business Revenue: , Revenue Excluded from Tax Under Sections 512, 513, or 514: 2298; MISCELLANEOUS REVENUE - Total Revenue: 46408, Related or Exempt Function Revenue: , Unrelated Business Revenue: , Revenue Excluded from Tax Under Sections 512, 513, or 514: 46408; |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| Form 990, Part XI, Line 9 Other changes in net assets or fund balances | FASB 136 ADJUSTMENT - -46624; TRANSFERS WITH AFFILIATES - -71914314; CATALPA TEMPORARILY RESTRICTED INVESTMENT - 221713; |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| Form 990, Part XII, Line 2b AUDITED FINANCIAL STATEMENTS | THE ACTIVITY OF ASCENSION NE WISCONSIN, INC. IS REPORTED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF ASCENSION HEALTH ALLIANCE. NO INDIVIDUAL AUDIT OF ASCENSION NE WISCONSIN, INC. IS COMPLETED. THEREFORE, THE ATTACHED AUDITED FINANCIAL STATEMENTS ARE OF ASCENSION HEALTH ALLIANCE AND AFFILIATES, WHICH INCLUDE THE ACTIVITY OF ASCENSION NE WISCONSIN, INC. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| Form 990, Part XII, Line 2c AUDIT COMMITTEE | ASCENSION NE WISCONSIN, INC. 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, ITEM J ENTITY WEBSITE | ST. ELIZABETH CAMPUS https://healthcare.ascension.org/Locations/Wisconsin/WIAPA/Appleton-Ascension-NE-Wisconsin-St-Elizabeth-Campus MERCY CAMPUS https://healthcare.ascension.org/Locations/Wisconsin/WIAPA/Oshkosh-Ascension-NE-Wisconsin-Mercy-Campus |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PAGE 1 PHYSICAL ADDRESS | THE PHYSICAL ADDRESS FOR THIS ENTITY IS 1506 SOUTH ONEIDA STREET, APPLETON, WI 54915-1397. THE ADDRESS ON PAGE 1 IS FOR MAILING PURPOSES ONLY. |

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493132040841

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
ASCENSION NE WISCONSIN INC

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

Employer identification number

39-0816818

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

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

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

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

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

j Lease of facilities, equipment, or other assets to related organization(s)

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

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

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

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

r Other transfer of cash or property to related organization(s)

s Other transfer of cash or property from related organization(s)

Yes

No

1a

1b

1c

1d

1e

1f

1g

1h

1i

1j

1k

1l

1m

1n

1o

1p

1q

1r

1s

No

No

No

No

No

No

No

No

No

No

No

No

Yes

Yes

Yes

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 |
|-------------------------------------|----------------------------------|------------------------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Schedule R (Form 990) 2019

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: 39-0816818

Name: ASCENSION NE WISCONSIN INC

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 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 | |
| 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 | |

| 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 |
| 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 | |
| C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 38-3591148 | FOUNDATION | MI | 501(c)(3) | Type II | GENESYS HEALTH SYSTEM | Yes | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

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

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|--|--|---|-------------------------------|---|---|--|----|
| | | | | | | Yes | No |
| 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 | |
| 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 | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

| 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 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 36-4195126 | HEALTH CARE | IL | 501(c)(3) | 3 | Presence Care Transformation Corporation | 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 | |
| C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 52-1275587 | PHYSICIAN PRACTICES | 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 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 | |
| C/O TAX DEPARTMENT PO BOX 45998 ST LOUIS, MO 631455998 62-0475842 | HOSPITAL | TN | 501(c)(3) | 3 | SAINT THOMAS HEALTH | Yes | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
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| | | | | | | Yes | No |
| 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 | SJPMC 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 | |
| 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 | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

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| | | | | | | Yes | No |
| 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 | |
| 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 | |

| 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 63-0868066 | 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 | |
| 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 | |

| 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 48-1129325 | 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) Disproporionate 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) Disproporportionate 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) 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 | |
| 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 48374 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 KY11102 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 | |

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|---|--|---|-------------------------------------|--|---------------------------------|---|--------------------------------|--|----|
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| | | | | | | | | 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 | |

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| | | | | | | | | 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 | |

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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 |
|--|---------------------------------|------------------------|--|
| ASCENSION HEALTH IS INC | P | 62,495 | FAIR MARKET VALUE |
| COLUMBIA ST MARY'S HOSPITAL MILWAUKEE INC | P | 237,277 | FAIR MARKET VALUE |
| COLUMBIA ST MARY'S INC | P | 39,128,681 | FAIR MARKET VALUE |
| ASCENSION CALUMET HOSPITAL INC | Q | 145,624 | FAIR MARKET VALUE |
| ASCENSION MEDICAL GROUP-FOX VALLEY WISCONSIN INC | P | 5,965,372 | FAIR MARKET VALUE |
| ASCENSION ST MICHAEL'S HOSPITAL INC | Q | 156,864 | FAIR MARKET VALUE |
| MERCY HEALTH FOUNDATION INC | C | 203,421 | FAIR MARKET VALUE |
| MINISTRY HEALTH CARE INC | S | 38,566,660 | FAIR MARKET VALUE |
| ASCENSION ST ELIZABETH HOSPITAL FOUNDATION INC (FKA ST ELIZABETH HOSPITAL F FOUNDATION INC) | C | 330,590 | FAIR MARKET VALUE |
| ASCENSION ST ELIZABETH HOSPITAL FOUNDATION INC (FKA ST ELIZABETH HOSPITAL F FOUNDATION INC) | P | 567,183 | FAIR MARKET VALUE |
| ASCENSION ST ELIZABETH HOSPITAL FOUNDATION INC (FKA ST ELIZABETH HOSPITAL F FOUNDATION INC) | Q | 312,251 | FAIR MARKET VALUE |
| REGIONAL MEDICAL LAB | P | 663,713 | FAIR MARKET VALUE |
| ASCENSION ALL SAINTS HOSPITAL INC | Q | 65,563 | FAIR MARKET VALUE |
| ASCENSION WISCONSIN PHARMACY INC | P | 289,372 | FAIR MARKET VALUE |
| MERCY HEALTH FOUNDATION INC | Q | 210,855 | FAIR MARKET VALUE |