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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 10-01-2019 , and ending 09-30-2020

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

C Name of organization
DEACONESS HOSPITAL INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
600 MARY STREET

City or town, state or province, country, and ZIP or foreign postal code
EVANSVILLE, IN 47747

D Employer identification number
35-0593390

E Telephone number
(812) 450-3296

G Gross receipts $ 1,647,192,329

F Name and address of principal officer:
SHAWN W MCCOY CEO
600 MARY STREET
EVANSVILLE, IN 47747

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.DEACONESS.COM

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

L Year of formation: 1895

M State of legal domicile: IN

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
PROVIDE QUALITY HEALTH CARE SERVICES WITH A COMPASSIONATE AND CARING SPIRIT CONTINUE TO SCH O TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE.

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	20
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	14
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	6,707
6	Total number of volunteers (estimate if necessary)	**6**	109
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	16,801,911
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	109,821

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,646,761	18,259,180
9	Program service revenue (Part VIII, line 2g)	942,375,847	967,249,119
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	20,915,857	29,721,186
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	82,689,151	86,915,133
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,047,627,616	1,102,144,618
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	850,589	1,157,407
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)	371,491,921	394,333,935
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶467,806		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	515,947,339	553,580,136
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	888,289,849	949,071,478
19	Revenue less expenses. Subtract line 18 from line 12	159,337,767	153,073,140

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,654,034,103	1,921,220,397
21	Total liabilities (Part X, line 26)	550,747,717	703,989,911
22	Net assets or fund balances. Subtract line 21 from line 20	1,103,286,386	1,217,230,486

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

****** 2021-08-16
Signature of officer Date

SHAWN W MCCOY CEO OF DEACONESS HEALTH SYSTEM
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P00832283

Firm's name ▶ BLUE & CO LLC — Firm's EIN ▶ 35-1178661

Firm's address ▶ 500 N MERIDIAN ST SUITE 200
INDIANAPOLIS, IN 46204 — Phone no. (317) 633-4705

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

SEE SCHEDULE O.

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: See Additional Data) (Expenses $ 172,711,143 including grants of $) (Revenue $ 521,323,246)

4b (Code: See Additional Data) (Expenses $ 644,632,582 including grants of $) (Revenue $ 439,698,325)

4c (Code: See Additional Data) (Expenses $ 19,502,364 including grants of $) (Revenue $ 6,227,548)

(Code:) (Expenses $ 1,157,407 including grants of $ 1,157,407) (Revenue $ 46,361,896)

ALL OTHER ACCOMPLISHMENTS:OTHER PROGRAM SERVICE REVENUE CONSISTS OF DEACONESS HOSPITAL'S INCOME FROM THE INVESTMENT IN JOINT VENTURES. OTHER PROGRAM SERVICE EXPENSES CONSISTED OF COMMUNITY BENEFIT GRANTS/ASSISTANCE.

4d Other program services (Describe in Schedule O.)
(Expenses $ 1,157,407 including grants of $ 1,157,407) (Revenue $ 46,361,896)

4e Total program service expenses ▶ 838,003,496

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI.	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
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	Yes	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		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	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	Yes	
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L,* Part I	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L,* Part I	25b		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? *If "Yes," complete Schedule L,* Part III	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a	Yes	
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b	Yes	
c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? *If "Yes," complete Schedule L, Part IV*	28c	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		No
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 Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	293		
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)*

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	6,707		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	Yes
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	Yes
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	No

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	20		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	14		
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			No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		Yes	
b	Each committee with authority to act on behalf of the governing body?	8b		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			No

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

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

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:
▶CHERYL A WATHEN 600 MARY STREET EVANSVILLE, IN 47747 (812) 450-3296

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

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

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

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								9,833,431	2,199,588	1,546,522

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 ▶ 359

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
EVANSVILLE SURGERY CENTER PO BOX 2185 EVANSVILLE, IN 47728	SURGICAL SERVICES	29,915,061
PROGRESSIVE HEALTH INDIANA LLC 150 N ROSENBERGER AVE EVANSVILLE, IN 47712	PHYSICAL THERAPY	16,516,316
TRI STATE RADIATION ONCOLOGY 700 N BURKHARDT RD EVANSVILLE, IN 47715	RADIATION & ONCOLOGY SERVICES	15,615,460
ORTHOALIGN LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630	MEDICAL SERVICES	14,347,979
EVOLENT HEALTH LLC 800 GLEBE RD SUITE 500 ARLINGTON, VA 22203	CONSULTING SERVICES	9,061,891

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 ▶ 124

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	158,681			
	d Related organizations	1d				
	e Government grants (contributions)	1e	17,264,437			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	836,062			
	g Noncash contributions included in lines 1a - 1f: $	1g	52,895			
	h **Total.** Add lines 1a-1f		18,259,180			
Program Service Revenue		Business Code				
	2a NET PATIENT REVENUE	900099	967,249,119	967,249,119		
	b					
	c					
	d					
	e					
	f All other program service revenue.					
	g **Total.** Add lines 2a–2f.		967,249,119			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		17,049,558			17,049,558
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross rents	6a 10,485,645				
	b Less: rental expenses	6b 5,637,357				
	c Rental income or (loss)	6c 4,848,288				
	d Net rental income or (loss)			4,848,288		4,848,288
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	7a 552,002,824				
	b Less: cost or other basis and sales expenses	7b 539,079,571	251,625			
	c Gain or (loss)	7c 12,923,253	-251,625			
	d Net gain or (loss)			12,671,628		12,671,628
	8a Gross income from fundraising events (not including $ 158,681 of contributions reported on line 1c). See Part IV, line 18	8a 120,450				
	b Less: direct expenses	8b 79,158				
	c Net income or (loss) from fundraising events			41,292		41,292
	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				
	b Less: cost of goods sold	10b				
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	Business Code				
	11a INVESTMENT IN JOINT VENTURES	900099	36,286,116	36,286,116		
	b OTHER HOSPITAL SERVICES	900099	28,937,526	10,075,780		18,861,746
	c LABORATORY SALES	621500	13,347,968		13,347,968	
	d All other revenue		3,453,943		3,453,943	
	e **Total.** Add lines 11a–11d		82,025,553			
	12 **Total revenue.** See instructions		1,102,144,618	1,013,611,015	16,801,911	53,472,512

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	1,157,407	1,157,407		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	6,768,183		6,768,183	
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	300,805,174	275,245,099	25,294,462	265,613
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	12,087,318	10,986,988	1,088,027	12,303
9 Other employee benefits	54,177,643	44,170,683	10,006,960	
10 Payroll taxes	20,495,617	18,272,790	2,208,654	14,173
11 Fees for services (non-employees):				
a Management				
b Legal	2,186,723	2,254	2,184,469	
c Accounting	107,335		107,335	
d Lobbying	30,228		30,228	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	1,593,900		1,593,900	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	139,439,670	137,001,322	2,417,823	20,525
12 Advertising and promotion	1,093,446	33,786	1,059,660	
13 Office expenses	10,351,043	8,954,185	1,373,956	22,902
14 Information technology	23,626,150	13,997,168	9,628,982	
15 Royalties				
16 Occupancy	14,809,643	9,117,777	5,691,866	
17 Travel	135,421	48,285	84,893	2,243
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	996,774	572,728	420,438	3,608
20 Interest	11,394,873	6,717,551	4,677,322	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	52,004,349	33,375,165	18,629,135	49
23 Insurance	4,874,468	3,911,173	963,295	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL/SURGICAL SUPPLI	194,440,103	194,398,278	41,825	
b MEDICAID ASSESSMENT FEE	35,385,201	35,385,201	0	
c EQUIP RENTAL/MAINTENANC	14,866,820	11,951,083	2,915,737	
d DUES & SUBSCRIPTIONS	779,511	476,339	293,307	9,865
e All other expenses	45,464,478	32,228,234	13,119,719	116,525
25 **Total functional expenses.** Add lines 1 through 24e	949,071,478	838,003,496	110,600,176	467,806
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing			1	
	2	Savings and temporary cash investments		83,582,828	2	222,180,059
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		133,412,369	4	144,630,180
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net		1,549,060	7	1,785,214
	8	Inventories for sale or use		7,388,324	8	8,511,488
	9	Prepaid expenses and deferred charges		12,822,146	9	14,069,480
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1,048,737,818			
	b	Less: accumulated depreciation	10b 554,877,255	504,830,977	10c	493,860,563
	11	Investments—publicly traded securities		770,685,857	11	844,580,684
	12	Investments—other securities. See Part IV, line 11		51,664,486	12	55,478,236
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets		48,206,614	14	48,206,614
	15	Other assets. See Part IV, line 11		39,891,442	15	87,917,879
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,654,034,103	16	1,921,220,397
Liabilities	17	Accounts payable and accrued expenses		89,449,202	17	100,455,955
	18	Grants payable			18	
	19	Deferred revenue		1,643,957	19	1,600,383
	20	Tax-exempt bond liabilities		295,600,927	20	288,892,997
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		164,053,631	25	313,040,576
	26	**Total liabilities.** Add lines 17 through 25		550,747,717	26	703,989,911
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		1,097,044,932	27	1,211,096,598
	28	Net assets with donor restrictions		6,241,454	28	6,133,888
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		1,103,286,386	32	1,217,230,486
	33	Total liabilities and net assets/fund balances		1,654,034,103	33	1,921,220,397

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,102,144,618
2	Total expenses (must equal Part IX, column (A), line 25)	2	949,071,478
3	Revenue less expenses. Subtract line 2 from line 1	3	153,073,140
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,103,286,386
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	-39,129,040
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,217,230,486

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 35-0593390

Name: DEACONESS HOSPITAL INC

Form 990 (2019)

Form 990, Part III, Line 4a:

PATIENT SERVICE REVENUE. SEE SCHEDULE O.

Form 990, Part III, Line 4b:

CHARITY CARE/SUBSIDIZED CARE. SEE SCHEDULE O.

Form 990, Part III, Line 4c:

GRADUATE MEDICAL EDUCATION, MEDICAL EDUCATION AND COMMUNITY BENEFIT. SEE SCHEDULE O.

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SHAWN MCCOY CEO OF DEACONESS HEALTH SYSTEM, INC.	33.00 22.00	X		X				776,739	417,300	246,070
DANIEL HERMANN CHAIRMAN	3.00 2.00	X						0	0	0
SHARON REED WALKER TREASURER	3.00 2.00	X						0	0	0
DAVE PAPARIELLA SECRETARY	3.00 2.00	X						0	0	0
BRUCE ADYE MD DIRECTOR	3.00 2.00	X						0	0	0
MAQBOOL AHMED MD DIRECTOR	3.00 53.00	X						720	871,388	19,030
CURTIS BEGLE DIRECTOR	3.00 2.00	X						0	0	0
JEROME BENKERT JR DIRECTOR	3.00 2.00	X						0	0	0
DR LINDA BENNETT DIRECTOR	3.00 2.00	X						0	0	0
SCOTT CORDTS MD DIRECTOR	53.00 2.00	X						310,586	3,800	45,300

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TERI HOLLANDER ALBIN DIRECTOR	3.00 2.00	X						0	0	0
ANTHONY KAISER MD DIRECTOR	3.00 2.00	X						0	0	0
KEVIN KOCH DIRECTOR	3.00 2.00	X						0	0	0
BARRY PHILLIPS MD DIRECTOR	3.00 53.00	X						7,650	424,255	46,847
RONALD ROCHON MD DIRECTOR	3.00 2.00	X						0	0	0
JAMES RYAN III DIRECTOR	3.00 2.00	X						0	0	0
DAVID RYON MD DIRECTOR	53.00 2.00	X						447,067	10,450	45,022
ERIC SCHACH DIRECTOR	3.00 2.00	X						0	0	0
STEPHEN TITZER CPA DIRECTOR	3.00 3.00	X						0	0	0
JONATHAN WEINZAPFEL DIRECTOR	3.00 2.00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CHERYL WATHEN CHIEF FINANCIAL OFFICER	30.00 25.00			X				452,916	270,172	177,530
JAMES PORTER MD PRESIDENT OF DEACONESS HEALTH SYSTEM, INC.	50.00 3.00			X				1,106,860	2,400	186,751
CHERONA HAJEWSKI CHIEF NURSING OFFICER	50.00 0.00			X				442,666	0	118,675
LYNN LINGAFELTER CHIEF OPERATION OFFICER	50.00 4.00			X				532,705	48,052	129,573
HERMAN BLANTON MD CHIEF MEDICAL OFFICER	50.00 3.00			X				609,938	81,762	105,713
MARC FLORENCE VICE PRESIDENT	50.00 7.00			X				357,722	65,209	104,873
CAROLYN MORTON PHARMACY AND LAB DIRECTOR	50.00 0.00				X			225,004	0	43,737
SUSAN BRUMLEY IMAGING AND CARDIOVASCULAR SERVICES	50.00 0.00				X			192,438	0	38,934
RAGHAV GUPTA MD ANESTHESIOLOGIST	50.00 0.00					X		980,846	0	40,231
VENKATESH MADADI MD ANESTHESIOLOGIST	50.00 0.00					X		871,492	0	52,316

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
NIRMAL JOSHI MD ANESTHESIOLOGIST	50.00 0.00					X		799,351	0	50,018
DAVID FISH MD ANESTHESIOLOGIST	50.00 0.00					X		765,327	0	41,076
RYAN NEAL MD ANESTHESIOLOGIST	50.00 0.00					X		757,339	0	40,753
LINDA WHITE FORMER CEO EMERITA, FOUNDATION EXEC. DIRECTOR	50.00 1.00						X	196,065	4,800	14,073

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)

9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:

10 ☐ An organization that normally receives: (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . _____

g Provide the following information about the supported organization(s).

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

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

Section A. Public Support

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

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

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

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

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a **33 1/3% support tests—2019.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 35-0593390

Name: DEACONESS HOSPITAL 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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493228014461

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	Employer identification number
DEACONESS HOSPITAL INC	35-0593390

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
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? ☐ **Yes** ☐ **No**

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
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) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		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		30,228
j	Total. Add lines 1c through 1i			30,228
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
PART II-B, LINE 1:	LOBBYING EXPENDITURES CONSISTED OF A PORTION OF MEMBERSHIP DUES TO PROFESSIONAL ORGANIZATIONS IN WHICH DEACONESS HOSPITAL AND ITS EMPLOYEES ARE MEMBERS. THE LOBBYING PORTION OF THE DUES IS NOTED ON THE MEMBERSHIP APPLICATION OR BILLING STATEMENT.

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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
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

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

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

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

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

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

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

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

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

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

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

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

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

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

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition

b ☐ Scholarly research

c ☐ Preservation for future generations

d ☐ Loan or exchange programs

e ☐ Other .....

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?. . . ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? . . . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

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

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	8,037,280	7,914,040	7,389,906	6,877,438	6,660,917
b Contributions	1,075	1,075	120	1,200	50
c Net investment earnings, gains, and losses	867,885	195,423	606,614	705,719	445,045
d Grants or scholarships					
e Other expenditures for facilities and programs	160,715	73,258	82,600	194,451	228,574
f Administrative expenses					
g End of year balance	8,745,525	8,037,280	7,914,040	7,389,906	6,877,438

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

a Board designated or quasi-endowment ▶ 12.000 %

b Permanent endowment ▶ 88.000 %

c Temporarily restricted endowment ▶ .....

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

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

	Yes	No
(i) unrelated organizations . . . . . 3a(i)		No
(ii) related organizations . . . . . 3a(ii)		No
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? 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	6,556,217	16,004,889		22,561,106
b Buildings	54,284,953	670,093,533	359,913,436	364,465,050
c Leasehold improvements				
d Equipment		270,996,137	194,963,819	76,032,318
e Other		30,802,089		30,802,089
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				493,860,563

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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ACCRUED RETIREMENT BENEFITS	121,236,240
(3) RELATED ORGANIZATION PAYABLES	3,546,242
(4) TAXABLE BOND- SERIES 2016	50,400,000
(5) DEBT ISSUE COSTS	-56,104
(6) RIGHT OF USE ASSETS	32,914,198
(7) MEDICARE ADVANCED FUNDING	103,000,000
(8) CARES ACT LIABILITY	2,000,000
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	313,040,576

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL INC

Supplemental Information

Return Reference	Explanation
PART V, LINE 4:	THE DEACONESS HOSPITAL FOUNDATION UTILIZES ENDOWMENT FUNDS TO SUPPORT AND BENEFIT THE MISSION OF DEACONESS HOSPITAL. SPECIFICALLY, ENDOWMENT FUNDS ARE USED TO HELP SUPPORT ACTIVITIES OR PROJECTS THAT HELP TO PROVIDE QUALITY HEALTH CARE SERVICES WITH A COMPASSIONATE AND CARING SPIRIT TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE.

Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	ACCOUNTING PRINCIPLES GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA REQUIRE MANAGEMENT TO EVALUATE TAX POSITIONS TAKEN BY THE COMPANY AND RECOGNIZE A TAX LIABILITY IF THE COMPANY HAS TAKEN AN UNCERTAIN POSITION THAT MORE LIKELY THAN NOT WOULD NOT BE SUSTAINED UPON EXAMINATION BY VARIOUS FEDERAL AND STATE TAXING AUTHORITIES. MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN BY THE COMPANY AND HAS CONCLUDED THAT AS OF SEPTEMBER 30, 2020 AND 2019, THERE ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY OR DISCLOSURE IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS. THE COMPANY IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS; HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS.

Supplemental Information

Return Reference	Explanation
PART VII AND IX:	SECTIONS ARE NOT REQUIRED AS THE TOTALS FOR EACH LINE ARE LESS THAN 5% OF THE TOTAL ASSETS LISTED ON FORM 990, PART X, LINE 16.

Supplemental Information

Return Reference	Explanation
PART XI AND XII:	SECTIONS ARE NOT REQUIRED AS THE ORGANIZATION IS PART OF A CONSOLIDATED FINANCIAL STATEMENT. THE CONSOLIDATED FINANCIAL STATEMENT IS AUDITED BY AN INDEPENDENT ACCOUNTING FIRM AND IS PREPARED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

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

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

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

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

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

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? **Yes**	**No**	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total . . . . . ▶						

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

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

		(a) Event #1 DH PARTY OF YR (event type)	(b) Event #2 DH CLASSIC (event type)	(c) Other events (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	163,033	116,098		279,131
	2 Less: Contributions	64,633	94,048		158,681
	3 Gross income (line 1 minus line 2)	98,400	22,050		120,450
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		5,251		5,251
	6 Rent/facility costs	500	22,359		22,859
	7 Food and beverages		160		160
	8 Entertainment	36,345	3,012		39,357
	9 Other direct expenses	3,374	8,157		11,531
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				79,158
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				41,292

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

13 Indicate the percentage of gaming activity conducted in:

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

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶ ----------

16 Gaming manager information:

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

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

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

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

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	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 eligibile 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)			18,403,743		18,403,743	1.940 %
b Medicaid (from Worksheet 3, column a)			169,530,610	124,740,549	44,790,061	4.720 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			187,934,353	124,740,549	63,193,804	6.660 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			911,125		911,125	0.100 %
f Health professions education (from Worksheet 5)			7,930,670	2,586,556	5,344,114	0.560 %
g Subsidized health services (from Worksheet 6)			237,904		237,904	0.030 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			2,075,850	40,196	2,035,654	0.210 %
j **Total.** Other Benefits			11,155,549	2,626,752	8,528,797	0.900 %
k **Total.** Add lines 7d and 7j			199,089,902	127,367,301	71,722,601	7.560 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing			1,500		1,500	0 %
2 Economic development			1,500		1,500	0 %
3 Community support			20,059		20,059	0 %
4 Environmental improvements						
5 Leadership development and training for community members			5,000		5,000	0 %
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			19,215		19,215	0 %
9 Other						
10 Total			47,274		47,274	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	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2 21,982,543			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	224,512,832
6	Enter Medicare allowable costs of care relating to payments on line 5	6	212,667,648
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	11,845,184

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

☐ Cost accounting system ☐ Cost to charge ratio ☑ Other

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures**

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? **4**

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

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group DEACONESS HOSPITAL INC

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): HTTP://WWW.DEACONESS.COM/CHNA			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTP://WWW.DEACONESS.COM/CHNA			
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)

DEACONESS HOSPITAL INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☑ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART V			
b	☑ The FAP application form was widely available on a website (list url): SEE PART V			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

DEACONESS HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

DEACONESS HOSPITAL INC

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group DEACONESS GATEWAY HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): HTTP://WWW.DEACONESS.COM/CHNA			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTP://WWW.DEACONESS.COM/CHNA			
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)

DEACONESS GATEWAY HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☑ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART V			
b	☑ The FAP application form was widely available on a website (list url): SEE PART V			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

DEACONESS GATEWAY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

DEACONESS GATEWAY HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group DEACONESS CROSS POINTE

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a ☑ Hospital facility's website (list url): HTTP://WWW.DEACONESS.COM/CHNA			
b ☐ Other website (list url):			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url): HTTP://WWW.DEACONESS.COM/CHNA **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)

DEACONESS CROSS POINTE

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b ☐ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☐ Insurance status			
f ☐ Underinsurance discount			
g ☐ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☑ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a ☑ The FAP was widely available on a website (list url): SEE PART V			
b ☑ The FAP application form was widely available on a website (list url): SEE PART V			
c ☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

DEACONESS CROSS POINTE

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

DEACONESS CROSS POINTE

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group THE HEART HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): HTTP://WWW.DEACONESS.COM/CHNA			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): HTTP://WWW.DEACONESS.COM/CHNA			
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)

THE HEART HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☑ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART V			
b	☑ The FAP application form was widely available on a website (list url): SEE PART V			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

THE HEART HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THE HEART HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **34**

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A:	DEACONESS HOSPITAL PREPARES AN ANNUAL COMMUNITY BENEFIT REPORT. THE REPORT IS MADE AVAILABLE ON THE DEACONESS WEBSITE AT HTTP://WWW.DEACONESS.COM/CHNA
PART I, LINE 7:	A COST TO CHARGE RATIO WAS USED FOR MOST OF THE CALCULATIONS FOR THE TABLE. IRS INSTRUCTION'S WORKSHEET 2 WAS USED FOR THIS CALCULATION. WE DID NOT USE THE COST TO CHARGE RATIO FOR LINE 7G AS IT WAS NOT RELEVANT TO THESE SERVICES. THE ACTUAL COST FROM OUR COSTING SYSTEM WAS USED WHEN AVAILABLE. THE COST TO CHARGE RATIO FOR EACH SERVICE TYPE WAS USED TO ESTIMATE COST WHEN NOT AVAILABLE FROM OUR INTERNAL COSTING SYSTEM.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G:	SUBSIDIZED HEALTH SERVICES ATTRIBUTED TO PHYSICIAN CLINICS HAVE A COST OF $11,047.
PART I, LN 7 COL(F):	BAD DEBT EXPENSE IS NOT INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A) DUE TO ADOPTION OF (ASU) 2014-09 TOPIC 606.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	DEACONESS PROVIDES SUPPORT TO NUMEROUS ORGANIZATIONS THAT FOCUS ON EDUCATION, COMMUNITY IMPROVEMENTS, AND LEADERSHIP DEVELOPMENT. DEACONESS BELIEVES THAT IN SUPPORTING THESE LOCAL SCHOOLS AND ORGANIZATIONS WE ARE PROVIDING ASSISTANCE IN BETTERING OUR COMMUNITY AND OUR PATIENTS.NORMAL ACTIVITIES SUCH AS OUR HEALTH SCIENCE INSTITUTE IN WHICH LOCAL HIGH SCHOOL STUDENTS LIVE ON CAMPUS AND LEARN ABOUT HEALTHCARE CAREERS HAD TO BE CANCELLED THIS YEAR DUE TO COVID-19. DEACONESS STILL INCURRED COSTS OF $8,715 FOR THE PROGRAM AND PLANS TO HOST THE INSTITUTE IN 2021.DEACONESS DID PROVIDE SUPPORT TO OUR LOCAL CHAMBER OF COMMERCE TO HOST NUMEROUS LUNCHEONS AND AWARD CEREMONIES THAT PROMOTES LEADERSHIP DEVELOPMENT AND THE IMPORTANCE OF COMMUNITY AND GOVERNMENT INVOLVEMENT. DEACONESS ALSO PROVIDED SUPPORT TO IMPORTANT COMMUNITY ORGANIZATIONS SUCH AS LOCAL SCHOOLS AND OUR ZOO TO SHOW OUR SUPPORT OF THEIR MISSIONS.
PART III, LINE 2:	THE SYSTEM ESTIMATES THE TRANSACTION PRICE FOR PATIENTS WITH DEDUCTIBLES AND COINSURANCE AND FROM THOSE WHO ARE UNINSURED BASED ON HISTORICAL EXPERIENCE AND CURRENT MARKET CONDITIONS. THE INITIAL ESTIMATE OF THE TRANSACTION PRICE IS DETERMINED BY REDUCING THE STANDARD CHARGE BY ANY CONTRACTUAL ADJUSTMENTS, DISCOUNTS, AND IMPLICIT PRICE CONCESSIONS. SUBSEQUENT CHANGES TO THE ESTIMATE OF THE TRANSACTION PRICE ARE GENERALLY RECORDED AS ADJUSTMENTS TO NET PATIENT SERVICE REVENUE IN THE PERIOD OF THE CHANGE. SUBSEQUENT CHANGES THAT ARE SIGNIFICANT AND DETERMINED TO BE THE RESULT OF AN ADVERSE CHANGE IN THE PATIENT'S ABILITY TO PAY, DETERMINED ON A PORTFOLIO BASIS, ARE RECORDED AS BAD DEBT EXPENSE. CONSISTENT WITH THE SYSTEM'S MISSION, CARE IS PROVIDED TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. THEREFORE, THE SYSTEM HAS DETERMINED IT HAS PROVIDED IMPLICIT PRICE CONCESSIONS TO UNINSURED PATIENTS AND PATIENTS WITH OTHER UNINSURED BALANCES. THE IMPLICIT PRICE CONCESSIONS INCLUDED IN ESTIMATING THE TRANSACTION PRICE REPRESENT THE DIFFERENCE BETWEEN AMOUNTS BILLED TO PATIENTS AND THE AMOUNTS THE SYSTEM EXPECTS TO COLLECT BASED ON ITS COLLECTION HISTORY WITH THOSE PATIENTS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3:	DEACONESS HOSPITAL DOES NOT ATTRIBUTE ANY BAD DEBT EXPENSE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY (FAP), THEREFORE NO PORTION OF BAD DEBT ATTRIBUTABLE TO FAP-ELIGIBLE INDIVIDUALS IS CONSIDERED A COMMUNITY BENEFIT.
PART III, LINE 4:	THE FOOTNOTE DESCRIBING BAD DEBT EXPENSES IS INCLUDED IN THE ATTACHED AUDITED FINANCIAL STATEMENTS UNDER FOOTNOTE "CHARITY CARE, COMMUNITY BENEFIT AND ASSISTANCE TO THE UNINSURED" STARTING ON PAGE 12 AND "PATIENT ACCOUNTS RECEIVABLE AND NET PATIENT SERVICE REVENUE" STARTING ON PAGE 11.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8:	THE SOURCE USED TO DETERMINE THE AMOUNT OF MEDICARE REVENUE AND ALLOWABLE COSTS REPORTED FOR PART III, SECTION B, LINE 8: THE MEDICARE TOTAL REVENUE AND ALLOWABLE COSTS WERE ACTUAL BASED UPON THE 2020 MEDICARE COST REPORT.
PART III, LINE 9B:	DEACONESS HOSPITAL MAKES A DISTINCTION BETWEEN CHARITY AND BAD DEBT. IN DETERMINING AN INDIVIDUAL OR FAMILY'S ABILITY TO PAY, DEACONESS HOSPITAL EVALUATES WHETHER OR NOT THE RESPONSIBLE PARTY HAS SUFFICIENT RESOURCES FOR PAYMENT. IF AN INDIVIDUAL IS DETERMINED TO NOT HAVE SUFFICIENT RESOURCES TO PAY, THEY WILL BE CONSIDERED ELIGIBLE FOR CHARITY CARE AND WILL NOT BE PROCESSED THROUGH EITHER INTERNAL OR EXTERNAL COLLECTIONS. ACCOUNTS OF CHARITY CARE PATIENTS WHO ARE UNABLE TO PAY DO NOT RESULT IN BAD DEBT AND ARE NOT COLLECTED UPON.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	NEEDS ASSESSMENT PROCESS: DEACONESS UTILIZES A VARIETY OF SOURCES TO GATHER DATA ON LOCAL HEALTH CARE NEEDS. WE USE DATA FROM THE UNITED WAY OF SOUTHWESTERN INDIANA'S COMPREHENSIVE NEEDS ASSESSMENT, WELBORN BAPTIST FOUNDATION'S GREATER EVANSVILLE HEALTH SURVEY, COUNTY HEALTH RANKINGS WEBSITE, INDIANA STATE DEPARTMENT OF HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, AND THE U.S. CENSUS BUREAU. ADDITIONAL INFORMATION COMES FROM OUR OWN ELECTRONIC MEDICAL RECORD SYSTEM AND THROUGH OUR INTERACTION WITH LOCAL SERVICE PROVIDERS AND OTHER NON-PROFIT ORGANIZATIONS. THAT INCLUDES "PROMISE ZONE" INITIATIVES THAT KEEP US AWARE OF CHANGING NEEDS IN OUR MOST DISENFRANCHISED POPULATION.
PART VI, LINE 3:	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE: DEACONESS HOSPITAL UTILIZES FINANCIAL COUNSELORS TO EDUCATE, INFORM AND ASSIST PATIENTS AND FAMILIES IN UNDERSTANDING THEIR FINANCIAL OBLIGATION, ABILITY TO QUALIFY FOR FINANCIAL ASSISTANCE THROUGH DEACONESS HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM AND PAYMENT OPTIONS. SPECIFICALLY, FINANCIAL COUNSELORS STAFF THE EMERGENCY DEPARTMENT, REGISTRATION AREAS, CASHIER AREA, AS WELL AS, FLOAT AMONG INPATIENT AREAS TO ENSURE EACH AND EVERY PATIENT REQUIRING ASSISTANCE IS REACHED. IN ADDITION TO THE PERSONAL AND INDIVIDUALIZED COUNSELING PROVIDED BY THE FINANCIAL COUNSELORS, VARIOUS FORMS OF MEDIA ARE DISTRIBUTED THROUGHOUT DEACONESS HOSPITAL EXPLAINING THE FINANCIAL ASSISTANCE PROCESS. ADDITIONALLY, POLICIES FOR FINANCIAL ASSISTANCE ARE POSTED WIDELY THROUGHOUT DEACONESS HOSPITAL AND ON THE INTERNET AT WWW.DEACONESS.COM. HTTPS://WWW.DEACONESS.COM/FOR-YOU/PATIENTS-AND-VISITORS/PATIENTS/FINANCIAL-ASSISTANCE. IN ADDITION TO THE VARIOUS PLACES THAT THE PROGRAM IS PUBLISHED, IT IS ALSO REFERENCED ON OUR PATIENT STATEMENT AND PHONE MESSAGE WHEN THE PATIENT CALL THE BILLING PHONE NUMBER.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4:	DEACONESS DEFINES ITS COMMUNITY AS ALL PEOPLE LIVING IN VANDERBURGH AND WARRICK COUNTIES AT ANY TIME DURING THE YEAR.VANDERBURGH COUNTY VANDERBURGH COUNTY IS MORE DIVERSE THAN MUCH OF INDIANA IN TERMS OF RACIAL AND ETHNIC CHARACTERISTICS, EVENLY SPLIT WITH REGARD TO GENDER, WITH THE MAJORITY OF INDIVIDUALS LIVING IN AREAS CONSIDERED URBAN. VANDERBURGH COUNTY'S POPULATION OF 180,974 PERSONS IS SIMILAR TO THE STATEWIDE POPULATION, WITH ABOUT 84% OF THE POPULATION BEING WHITE, 9.6% BLACK/AFRICAN AMERICAN, 1.3% ASIAN, AND THE REMAINDER BEING OF OTHER OR 2 OR MORE RACES. HOWEVER, VANDERBURGH COUNTY REPORTS A 2.7% HISPANIC POPULATION COMPARED TO 7% FOR THE STATE. VANDERBURGH COUNTY IS ALSO ONE OF THE MORE URBAN AREAS WITH A 9.2% RURAL RATING COMPARED TO THE INDIANA AVERAGE OF 27.6%. ACCORDING TO THE 2020 COUNTY HEALTH RANKINGS, VANDERBURGH COUNTY RANKS 82 OUT OF 92 INDIANA COUNTIES FOR HEALTH OUTCOMES AND 65 OUT OF 92 INDIANA COUNTIES FOR HEALTH FACTORS. INSTANCES OF VIOLENT CRIME, INJURY DEATHS, SEXUALLY TRANSMITTED INFECTIONS, AND CHILDREN LIVING IN POVERTY ARE HIGHER IN VANDERBURGH COUNTY THAN THE INDIANA AVERAGE. THIS INFORMATION MATCHES OUR CHNA DATA.WARRICK COUNTY - CONVERSELY, WARRICK COUNTY RANKS 13 OUT OF 92 INDIANA COUNTIES FOR HEALTH OUTCOMES AND 6 OUT OF 92 INDIANA COUNTIES FOR HEALTH FACTORS ON THE 2020 COUNTY HEALTH RANKINGS. INCIDENTS OF VIOLENT CRIME, INJURY DEATHS, SEXUALLY TRANSMITTED INFECTIONS, AND CHILDREN LIVING IN POVERTY ARE SIGNIFICANTLY LOWER THAN THE STATE AVERAGE. WARRICK COUNTY HAS LESS DIVERSITY THAN VANDERBURGH COUNTY AND THE STATE OF INDIANA. MORE THAN 92% OF PEOPLE THERE IDENTIFY AS WHITE COMPARED TO 79% FOR INDIANA. ONLY 1.6 % OF THE POPULATION IS LISTED AS BLACK/AFRICAN AMERICAN AND 1.9% AS HISPANIC. THAT'S COMPARED TO STATE AVERAGES OF 9.5% AND 7% RESPECTIVELY. WARRICK COUNTY IS ALSO MORE RURAL THAN THE AVERAGE INDIANA COUNTY (29.3% RURAL IN WARRICK COUNTY COMPARED TO 27.6% STATE AVERAGE).
PART VI, LINE 5:	DEACONESS LED THE COVID-19 RESPONSE FOR THE SOUTHERN PART OF INDIANA AND NEIGHBORING COUNTIES IN KENTUCKY AND ILLINOIS. WE BECAME A TRUSTED RESOURCE BY CREATING SPECIFIC COVID-19 WEBPAGES FOR THE GENERAL PUBLIC AND BUSINESSES SO THEY HAD THE MOST CURRENT INFORMATION ABOUT TESTING, REGULATIONS, AND EVENTUALLY VACCINES. WE ALSO CREATED A SEPARATE COPING PAGE THAT LINKED PEOPLE TO A VARIETY OF RESOURCES ABOUT MENTAL AND EMOTIONAL HEALTH. WE RELEASED A YOUTUBE VIDEO EXPLAINING HOW TO MAKE CLOTH MASKS, COLLABORATED WITH A VARIETY OF HEALTH AND ACADEMIC INSTITUTIONS TO OPERATE A CONVALESCENT PLASMA PROGRAM AND CONDUCT A COMMUNITY PREVALENCE STUDY, AS WELL AS ADMINISTERED MONOCLONAL ANTIBODY TREATMENT.ADDITIONALLY, WE CREATED AND DISTRIBUTED WRITTEN AND VISUAL CONTENT THAT ADDRESSED SPECIFIC ISSUES AND CONCERNS OUR COMMUNITY HAD REGARDING COVID-19. 7/16/2020 - COVID TESTING - DR. GINA HUHNKE7/16/2020 - MASK MYTHS - DR. BRAD SCHEU7/16/2020 - FB LIVE WITH DR. PORTER - MAYOR WINNECKE, DR. PORTER7/20/2020 - HPV PANEL DISCUSSION - DRS. SCHUMAN, CAPRI WEYER7/21/2020 - FB LIVE WITH DR. HUHNKE - DR. GINA HUHNKE7/30/2020 - FB LIVE WITH DR. PORTER - DR. PORTER, BRIAN SPENCER PHARMDE-NEWSLETTER ARTICLES 7/15/2020:-LYME DISEASE T. GEHLHAUSEN, DO, OAKLAND CITY-KEEPING PAIN IN CHECK NP, PAIN CENTER-ABCS OF HEPATITIS MD, DC GASTRO-PREPARING TO GO BACK TO SCHOOL MD, DC PEDIATRICS-SUPER SUMMER NUTRITION RD DIETICIAN8/27/2020:-FB LIVE WITH DR. PORTER DRS. PORTER AND DAVID RYONE-NEWSLETTER ARTICLES 8/15/2020:-EXPERIENCING HEEL PAIN MD, DC PODIATRY-ADULT VACCINES MD, DC MARY STREET-KEEP MOVING FOR BETTER HEALTH DO, DC OAKLAND CITY-HELPING CHILDREN NAVIGATE DIFFICULT TIMES S. BRANAM, CAO CROSS POINTE9/2/2020: COVID TESTING PROCESS APRIL ABBOTT, PHIL GAMBLE9/10/2020: FLU SHOTS DURING PANDEMIC DR. BRAD SCHEU9/24/2020: FB LIVE DR. PORTER AND SHAWN MCCOYE-NEWSLETTER ARTICLES 9/15/2020:-GET A FLU SHOT DURING COVID PANDEMIC DR. SHEU, DC ADMIN-MAMMOGRAMS, WHO NEEDS THEM AND WHEN MD, BREAST RADIOLOGIST-TIPS ON WEARING A FACE MASK MARKETING STAFF-PREVENTING SUICIDE JANIE CHAPPELL, CROSS POINTESCREENING MAMMOGRAMS VIA MOBILE BREAST CENTER:2019 NUMBER SCREENEDOCTOBER - 347NOVEMBER - 242DECEMBER - 1702020 NUMBER SCREENEDJANUARY - 138FEBRUARY - 197MARCH - 130APRIL - 0MAY - 153JUNE - 244JULY - 286AUGUST - 214SEPTEMBER - 272PATIENT CARE:-MEDICATION ASSISTANCE AND FAMILY MEDICINE RESIDENCY CLINIC; DEACONESS PROVIDES FREE AND REDUCED CARE WITHIN OUR HOSPITAL BUILDINGS. THROUGH OUR MEDICATION ASSISTANCE PROGRAM (MAP) AND OUR FAMILY PRACTICE RESIDENCY CLINIC, PATIENTS CAN ACCESS THE HIGH QUALITY HEALTH CARE THEY NEED IN CONVENIENT LOCATIONS AND AT A PRICE THEY CAN AFFORD. IN FY19-20, OUR RESIDENTS TREATED NEARLY 16,000 PATIENTS AT A COST TO THE HOSPITAL OF $3 MILLION. SIMILARLY, ALMOST 2,000 MAP PATIENTS RECEIVED NEEDED MEDICATION AT A COST TO THE HOSPITAL OF $339,000. -BEHAVIORAL HEALTH AND SUICIDE PREVENTION; STAFF FROM DEACONESS CROSS POINTE EDUCATED 14,000 PEOPLE IN THE SURROUNDING COMMUNITY ABOUT BEHAVIORAL HEALTH, RELATED RESOURCES, AND SUICIDE PREVENTION.LOCAL SPONSORSHIPS: IN FY19-20, DEACONESS SPONSORED PROGRAMS AND ACTIVITIES FOR MORE THAN 170,000 PEOPLE, CONTRIBUTING $1.1 MILLION IN SUPPORT OF CLUBS, GROUPS, SOCIAL SERVICE ORGANIZATIONS, AND OTHERS STRIVING TO MAKE OUR COMMUNITY A BETTER PLACE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6:	AFFILIATED HEALTH CARE SYSTEM:DEACONESS HOSPITAL WORKS IN CONCERT WITH DEACONESS HEALTH SYSTEM, DEACONESS CLINIC AND DEACONESS SPECIALTY PHYSICIANS TO PROVIDE HEALTHCARE SERVICES WITH A COMPASSIONATE AND CARING SPIRIT TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE. DEACONESS HEALTH SYSTEM WORKS TO INCREASE ACCESS TO HEALTHCARE SERVICES WITHIN OUR COMMUNITY THROUGH DEACONESS HOSPITAL AND DEACONESS CLINIC. DEACONESS HOSPITAL IS A MEDICAL INSTITUTION DEDICATED TO PROVIDING QUALITY PATIENT CARE WITH UNRELENTING ATTENTION TO CLINICAL EXCELLENCE, PATIENT SAFETY AND AN UNPARALLELED PASSION AND COMMITMENT TO ASSURE THE VERY BEST HEALTHCARE FOR THE PATIENTS SERVED. DEACONESS CLINIC PROVIDES EXCELLENT PRIMARY AND MULTI-SPECIALTY HEALTHCARE IN A PERSONALIZED FASHION WITH A DEDICATED FOCUS TO SERVE THE COMMUNITY WITH EXCELLENT, TIMELY AND COMPASSIONATE PATIENT CARE.DEACONESS HEALTH SYSTEM HAS PARTNERED WITH MANY RURAL HOSPITALS TO PROVIDE RESOURCES NEEDED SO THAT RESIDENTS IN THESE COMMUNITIES HAVE ACCESS TO CARE CLOSE TO HOME. THESE HOSPITALS INCLUDE FERRELL HOSPITAL AND LAWRENCE COUNTY HOSPITAL IN ILLINOIS, GIBSON COUNTY HOPSITAL IN INDIANA, AND METHODIST HOSPITAL IN KENTUCKY.
PART VI, LINE 7, REPORTS FILED WITH STATES	IN

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL INC

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	DEACONESS HOSPITAL INC 600 MARY STREET EVANSVILLE, IN 47747 WWW.DEACONESS.COM 20-005074-1	X	X		X			X			
2	DEACONESS GATEWAY HOSPITAL 4011 GATEWAY BLVD NEWBURGH, IN 47630 WWW.DEACONESS.COM 20-005074-1	X	X		X			X			
3	DEACONESS CROSS POINTE 7200 E INDIANA STREET EVANSVILLE, IN 47715 WWW.DEACONESS.COM 20-005074-1	X									
4	THE HEART HOSPITAL 4007 GATEWAY BLVD NEWBURGH, IN 47630 WWW.DEACONESS.COM 18-011772-1	X									

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

Form and Line Reference	Explanation
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 5: PARTNERS CONDUCTING THE CHNA COLLABORATED WITH A WIDE RANGE OF PUBLIC HEALTH AND SOCIAL SERVICE PARTNERS TO ENSURE THAT DIVERSE SCIENTIFIC AND COMMUNITY- BASED INSIGHTS WERE INCLUDED THROUGHOUT THE PROCESS. OF PARTICULAR IMPORTANCE WAS THE INCL USION OF INDIVIDUALS WHO DIRECTLY OR INDIRECTLY REPRESENTED THE NEEDS OF THREE IMPORTANT G ROUPS: 1) THOSE WITH PARTICULAR EXPERTISE IN PUBLIC HEALTH PRACTICE AND RESEARCH, 2) THOSE WHO ARE MEDICALLY UNDERSERVED, LOW-INCOME, OR CONSIDERED AMONG THE MINORITY POPULATIONS S ERVED BY THE HOSPITAL, AND 3) THE BROADER COMMUNITY AT LARGE AND THOSE WHO REPRESENT THE B ROAD INTERESTS AND NEEDS OF THE COMMUNITY SERVED.KEY PARTNER ORGANIZATIONS INCLUDED:-THE U NIVERSITY OF EVANSVILLE. FACULTY, STAFF, AND STUDENTS IN PUBLIC HEALTH AREAS COLLABORATED WITH THE HOSPITAL ON THE DATA-ORIENTED ASPECTS OF THE PROJECT.-INDIANA UNIVERSITY SCHOOL O F PUBLIC HEALTH. FACULTY AND STUDENTS COLLABORATED WITH THE HOSPITAL THROUGHOUT THE SURVEY PROCESS.-INDIANA UNIVERSITY CENTER FOR SURVEY RESEARCH. FACULTY AND STAFF PROVIDED IN-DEP TH TECHNICAL ASSISTANCE AND GUIDANCE THROUGHOUT THE SURVEY PROCESS, AND WORKED CLOSELY WIT H THE HOSPITALS AND THE UNIVERSITY OF EVANSVILLE TO FIELD THE COMMUNITY HEALTH SURVEY.SURV EY PROCESS AND METHODS - 8 KEY PARTNER ORGANIZATIONS: -MEASURES MATTER, LLC. MEASURES MATT ER IS A COMMUNITY-BASED RESEARCH CONSULTING FIRM BASED IN BLOOMINGTON, INDIANA AND PALM SP RINGS, CALIFORNIA. MEASURES MATTER CONDUCTED AN INDEPENDENT ANALYSIS OF THE SURVEY DATA AN D ALSO FACILITATED THE PRIORITIZATION PROCESS WITH THE HOSPITAL AND ITS PARTNERS.-COUNTY H EALTH DEPARTMENTS. REPRESENTATIVES OF THE VANDERBURGH COUNTY HEALTH DEPARTMENT WERE PARTNE RS IN THE LARGER NETWORK OF ORGANIZATIONS AND HOSPITALS THAT WORKED TO ENHANCE CONSISTENCY IN STATEWIDE CHNA ACTIVITIES, PARTICULARLY THE CHNA COMMUNITY SURVEY AND FOCUS GROUPS. AD DITIONALLY, GIVEN THAT THE SURVEY PROCESS WAS COORDINATED IN CONJUNCTION WITH MULTIPLE OTH ER HOSPITAL SYSTEMS AND LOCAL ORGANIZATIONS THROUGHOUT THE STATE, OTHER HEALTH DEPARTMENTS INVOLVED IN THE PROCESS INCLUDED THOSE FROM TIPPECANOE, CLAY, FOUNTAIN, WARREN, HOWARD, J ENNINGS, LAWRENCE, MADISON, RANDOLPH, WASHINGTON, WARRICK, HAMILTON, AND MARION COUNTIES.- COMMUNITY HEALTH AND SOCIAL SERVICE ORGANIZATIONS. A WIDE RANGE OF COMMUNITY-BASED HEALTH AND SOCIAL SERVICE ORGANIZATIONS COLLABORATED THROUGHOUT THE CHNA PROCESS TO CONSIDER DATA FROM THE CHNA, MAKE DECISIONS REGARDING HEALTH PRIORITIES, AND INITIATE CONSIDERATIONS OF SUBSEQUENT ACTIONS BASED ON THE CHNA.CHNA PRIORITIZATION PROCESS ATTENDEES:LISA MAISH, DE ACONESSLISA MEYER, ST. VINCENT EVVASHLEY TENBARGE, ST. VINCENT EVVLORI GRIMM, DEACONESS TH E WOMEN'S HOSPITALDR. KEN SPEAR, VANDERBURGH COUNTY HEALTH DEPARTMENTJILL BUTTRY, DEACONES SANDREA HAYS, WELBORN BAPTIST FOUNDATIONAMY CANTERBURY, UNITED WAY OF SWIDR. CHAD PERKINS, ST. VINCENT EVVSANDEE STRADER-MCMILLEN, ECHO HEALTHPAM HIGHT, DEACONESSJANET RAISOR, ST. VINCENT EVVDR. MARIA DEL RIO H

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
DEACONESS HOSPITAL, INC.	OOVER, ST. VINCENT EVVSABRINA JONES, ST. VINCENT EVVSCOTT BRANAM, DEACONESS CROSS POINTEAS HLEY JOHNSON, DEACONESSJENNA ALVIA ST. VINCENT WARRICKDR. CARRIE ANN LAWRENCE, IU SCHOOL O F PUBLIC HEALTH - FACILITATOR

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
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 5: DESCRIPTION OF COMMUNITY INPUT IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 5: DESCRIPTION OF COMMUNITY INPUT IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
THE HEART HOSPITAL	PART V, SECTION B, LINE 5: DESCRIPTION OF COMMUNITY INPUT IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 6A: OTHER HOSPITAL FACILITIES CHNA WAS CONDUCTED WITH:EIGHT HEALTH SYSTEMS WORKED TOGETHER TO ADMINISTER THE SAME CHNA SURVEY TO RESIDENTS IN 31 INDIANA COUNTIES. PARTICIPATING HEALTH SYSTEMS (IN ADDITION TO DEACONESS HEALTH SYSTEM) INCLUDED ASCENSION/ST. VINCENT, GIBSON GENERAL HOSPITAL, FRANCISCAN HEALTH, NORTH CENTRAL HEALTH SERVICES D.B.A. RIVER BEND HOSPITAL, IU HEALTH, COMMUNITY HEALTH NETWORK, AND RIVERVIEW HEALTH.

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

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

Form and Line Reference	Explanation
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 6A: OTHER HOSPITAL FACILITIES CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 6A: OTHER HOSPITAL FACILITIES CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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

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Form and Line Reference	Explanation
THE HEART HOSPITAL	PART V, SECTION B, LINE 6A: OTHER HOSPITAL FACILITIES CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 6B: KEY PARTNER ORGANIZATIONS INCLUDED THE UNIVERSITY OF EVANSVILLE, INDIANA UNIVERSITY SCHOOL OF PUBLIC HEALTH, INDIANA UNIVERSITY CENTER FOR SURVEY RESEARCH, MEASURES MATTER, LLC. OTHER LOCAL ORGANIZATIONS PARTICIPATED IN OUR FOCUS GROUPS AND PRIORITIZATION SESSIONS.

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
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 6B: OTHER ORGANIZATIONS CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 6B: OTHER ORGANIZATIONS CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
THE HEART HOSPITAL	PART V, SECTION B, LINE 6B: OTHER ORGANIZATIONS CHNA WAS CONDUCTED WITH IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 11: WE CONTINUE TO USE OUR IMPLEMENTATION PLAN TO GUIDE WORK IN THE IDENTIFIED AREAS OF NEED. CHNA PROJECTS WERE SIGNIFICANTLY DERAILED DUE TO COVID-19.VANDERBURGH COUNTY - FROM THE FIVE ENDORSED ISSUES IDENTIFIED FOR PRIORITIZATION, THE GROUP SELECTED MENTAL HEALTH, SUBSTANCE ABUSE, AND FOOD INSECURITY AS OUR PRIMARY POINTS OF FOCUS. IMPROVEMENT IN CHRONIC HEALTH CONDITIONS SHOULD BE A BY-PRODUCT OF SUCCESSFUL WORK IN THE OTHER THREE AREAS AND "POVERTY" CONSISTS OF MORE VARIABLES THAN THIS GROUP CAN ADDRESS. DURING 2019-2020, SPECIAL ATTENTION FOCUSED ON FOOD INSECURITY. PARTNERSHIPS WITH THE PROMISE ZONE, URBAN SEEDS, AND THE JUNIOR LEAGUE OF EVANSVILLE HELPED FEED THOUSANDS OF FAMILIES AND LED TO THE CREATION OF THE MAYOR'S COMMISSION ON FOOD INSECURITY. RELATED TO SUBSTANCE ABUSE, THE WOMEN'S HOSPITAL CONTINUED TO SCREEN PREGNANT WOMEN AT PRESENTATION FOR DELIVERY USING THE 5PS SCREENING TOOL. THEY SUBMIT DATA TO THE INDIANA STATE DEPARTMENT OF HEALTH TO MONITOR THE PREVALENCE OF SUBSTANCE EXPOSURE IN NEWBORNS AND MEET QUARTERLY TO IDENTIFY CHALLENGES AND OPPORTUNITIES THAT CAN BE ADDRESSED. AFTER EXAMINATION, A GROUP OF PHYSICIANS AND CLINICAL OFFICE STAFF DECIDED NOT TO EMPLOY THE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TOOL IN PRIMARY CARE PRACTICES. DEACONESS CREATED A NEW, PUBLIC-FACING WEBPAGE TO PROVIDE INFORMATION AND RESOURCES RELATED TO MENTAL HEALTH AND COPING WITH VARIOUS COVID ISSUES. ADDITIONAL MESSAGING ABOUT "CARING FOR THE CAREGIVERS" WAS SENT ON TUESDAYS AND THURSDAYS EACH WEEK TO ALL HEALTH SYSTEM STAFF. BEHAVIORAL HEALTH PROVIDERS MOVED THERAPY APPOINTMENTS ONLINE AND THE EMPLOYEE ASSISTANCE PROGRAM SAW AN INCREASE IN PARTICIPATION.WARRICK COUNTY - FROM THE FOUR ENDORSED ISSUES IDENTIFIED FOR PRIORITIZATION, THE GROUP SELECTED MENTAL HEALTH, SUBSTANCE ABUSE, AND ACCESS TO CARE AS OUR PRIMARY POINTS OF FOCUS FOR THE NEXT CHNA PERIOD. IMPROVEMENT IN CHRONIC HEALTH CONDITIONS SHOULD BE A BY-PRODUCT OF SUCCESSFUL WORK IN THE OTHER THREE AREAS. EFFORTS AND SUCCESSES MENTIONED FOR VANDERBURGH ALSO COUNT FOR WARRICK COUNTY AS THEY ARE BOTH PART OF THE DEACONESS HEALTHY SYSTEM EFFORTS. ANALYSIS OF TRANSPORTATION ISSUES WAS POSTPONED DUE TO COVID.

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
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 11: HOW THE SIGNIFICANT NEEDS ARE BEING ADDRESSED IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 11: HOW THE SIGNIFICANT NEEDS ARE BEING ADDRESSED IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
THE HEART HOSPITAL	PART V, SECTION B, LINE 11: HOW THE SIGNIFICANT NEEDS ARE BEING ADDRESSED IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 15E: MED ASSIST IS AVAILABLE TO DEACONESS HEALTH SYSTEM PATIENTS TO ASSIST WITH APPLYING FOR MEDICAID OR EXCHANGE PRODUCTS.

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
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 15E: OTHER METHOD USED FOR APPLYING FOR FINANCIAL ASSISTANCE IS THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 15E: OTHER METHOD USED FOR APPLYING FOR FINANCIAL ASSISTANCE IS THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
THE HEART HOSPITAL	PART V, SECTION B, LINE 15E: OTHER METHOD USED FOR APPLYING FOR FINANCIAL ASSISTANCE IS THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS HOSPITAL, INC.	PART V, SECTION B, LINE 16J: OTHER METHOD USED TO PUBLICIZE THE FINANCIAL ASSISTANCE POLICY: DEACONESS HOSPITAL SEEKS OUT THE PATIENTS THAT ARE SELF-PAY AND INTERVIEWS THESE PATIENTS WHILE THEY ARE IN THE FACILITY. THE FINANCIAL ASSISTANCE POLICY IS PROMOTED TO PATIENTS. DEACONESS HOSPITAL SEEKS OUT THOSE PATIENTS THAT WOULD QUALIFY FOR THE FINANCIAL ASSISTANCE POLICY. COLLECTABILITY SCORING IS ALSO COMPLETED AND ALLOWANCES ARE MADE BASED UPON THESE SCORES. DEACONESS HOSPITAL FOR FISCAL YEAR 20 IMPACTED THE LIVES OF MORE THAN 18,411 MEMBERS OF OUR COMMUNITY BY HELPING THEM OBTAIN INSURANCE OR PROVIDE ASSISTANCE FOR THE UNDERINSURED.

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
DEACONESS GATEWAY HOSPITAL	PART V, SECTION B, LINE 16J: OTHER METHOD USED TO PUBLICIZE THE FINANCIAL ASSISTANCE POLICY IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
DEACONESS CROSS POINTE	PART V, SECTION B, LINE 16J: OTHER METHOD USED TO PUBLICIZE THE FINANCIAL ASSISTANCE POLICY IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
THE HEART HOSPITAL	PART V, SECTION B, LINE 16J: OTHER METHOD USED TO PUBLICIZE THE FINANCIAL ASSISTANCE POLICY IS REPORTED THE SAME AS DEACONESS HOSPITAL, INC. (HOSPITAL FACILITY #1).

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
PART V, SECTION B, LINE 16A, FAP WEBSITE:	THE FINANCIAL ASSISTANCE POLICY (FAP) FOR ALL FOUR HOSPITAL FACILITIES IS MADE WIDELY AVAILABLE ON THE FOLLOWING WEBSITE:HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE

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
PART V, SECTION B, LINE 16B, FAP APPLICATION WEBSITE:	THE FINANCIAL ASSISTANCE POLICY (FAP) APPLICATION FOR ALL FOUR HOSPITAL FACILITIES IS MADE WIDELY AVAILABLE ON THE FOLLOWING WEBSITE:HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE

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
PART V, SECTION B, LINE 16B, FAP PLAIN LANGUAGE SUMMARY WEBSITE:	THE FINANCIAL ASSISTANCE POLICY (FAP) PLAIN LANGUAGE SUMMARY FOR ALL FOUR HOSPITAL FACILITIES IS MADE WIDELY AVAILABLE ON THE FOLLOWING WEBSITE:HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE

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

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

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

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

	Name and address	Type of Facility (describe)
1	1 - CARDIAC REHAB 4015 GATEWAY BLVD SUITE 2122 NEWBURGH, IN 47630	OUTPATIENT SERVICES
1	2 - DEACONESS FAMILY MEDICINE RESIDENCY 415 W COLUMBIA ST SUITE 110 EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
2	3 - DEACONESS HOSPITAL ANTICOAGMED THERAPY 350 W COLUMBIA ST SUITE 210 EVANSVILLE, IN 47747	OUTPATIENT SERVICES
3	4 - DEACONESS HOSPITAL BREAST CENTER 520 MARY STREET SUITE 140 EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
4	5 - DEACONESS HOSPITAL CANCER SERVICES 4055 GATEWAY BLVD NEWBURGH, IN 47630	OUTPATIENT SERVICES
5	6 - DEACONESS COMPREHENSIVE PAIN CTR-GATEWAY 4099 GATEWAY BLVD NEWBURGH, IN 47630	OUTPATIENT SERVICES
6	7 - DEACONESS COMPREHENSIVE PAIN CTR & PROG 4600 W LLOYD EXPRESSWAY SUITE A EVANSVILLE, IN 47712	OUTPATIENT SERVICES
7	8 - DEACONESS CROSS POINTE OUTPATIENT CLINIC 445 CROSS POINTE BLVD EVANSVILLE, IN 47715	OUTPATIENT PHYSICIAN CLINIC
8	9 - DEACONESS GATEWAY GASTROENTEROLOGY 4133 GATEWAY BLVD SUITE 290 NEWBURGH, IN 47630	OUTPATIENT SERVICES
9	10 - DEACONESS HOSPITAL MAMMOGRAPHY & IMAGING 421 CHESTNUT STREET EVANSVILLE, IN 47713	DIAGNOSTIC CENTER
10	11 - DEACONESS HOSPITAL INFUSION CTRPHARMACY 4111 GATEWAY BLVD NEWBURGH, IN 47630	OUTPATIENT SERVICES
11	12 - DEACONESS HOSPITAL RADIOLOGY EXPRESS 10455 ORTHOPAEDIC DRIVE NEWBURGH, IN 47630	DIAGNOSTIC CENTER
12	13 - DEACONESS HOSPITAL PHYSICAL MEDICINE 520 MARY STREET SUITE 280 EVANSVILLE, IN 47747	OUTPATIENT SERVICES
13	14 - DEACONESS HOSPITAL PHYS MED-OA 10455 ORTHOPAEDIC DRIVE NEWBURGH, IN 47630	OUTPATIENT SERVICES
14	15 - DEACONESS HOSPITAL PHYSICAL MEDICINE 4600 W LLOYD EXPRESSWAY SUITE B EVANSVILLE, IN 47715	OUTPATIENT SERVICES

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

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

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

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

	Name and address	Type of Facility (describe)
16	16 - DEACONESS PRIMARY CARE FOR SENIORS 1750 OAK HILL ROAD EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
1	17 - DEACONESS PRIMARY CARE FOR SENIORS 4498 FIRST AVENUE EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
2	18 - DEACONESS PROCEDURE CENTER 421 CHESTNUT STREET EVANSVILLE, IN 47713	OUTPATIENT SERVICES
3	19 - MIDWEST RADIOLOGICAL IMAGING 4087 GATEWAY BLVD NEWBURGH, IN 47630	DIAGNOSTIC CENTER
4	20 - DEACONESS REGIONAL LABORATORY 421 CHESNUT STREET EVANSVILLE, IN 47713	DIAGNOSTIC CENTER
5	21 - DEACONESS CLINIC GATEWAY REG LAB 4233 GATEWAY BLVD SUITE 201 NEWBURGH, IN 47630	DIAGNOSTIC CENTER
6	22 - DEACONESS HOSPITAL LAB & EKGDIABETES ED 520 MARY STREET SUITE 330 EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
7	23 - DEACONESS RADIOLOGY LAB & RADIOLOGY 8600 NORTH KENTUCKY AVENUE EVANSVILLE, IN 47725	DIAGNOSTIC CENTER
8	24 - DEACONESS REGIONAL LABORATORY 4494 N FIRST AVENUE EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
9	25 - DEACONESS HOSPITAL LAB & RADIOLOGY 4209 GATEWAY BLVD NEWBURGH, IN 47630	DIAGNOSTIC CENTER
10	26 - MT VERNON MEDICAL CENTER LAB & RADIOLOGY 1900 W FOURTH STREET MT VERNON, IN 47620	DIAGNOSTIC CENTER
11	27 - DEACONESS REGIONAL LABORATORY 4133 GATEWAY BLVD SUITE 110 NEWBURGH, IN 47630	DIAGNOSTIC CENTER
12	28 - DEACONESS SLEEP CENTER 350 W COLUMBIA STREET SUITE 100 EVANSVILLE, IN 47710	OUTPATIENT SERVICES
13	29 - DEACONESS SLEEP CENTER-EAST 7307 E COLUMBIA ST EVANSVILLE, IN 47715	DIAGNOSTIC CENTER
14	30 - DEACONESS SLEEP LAB 350 W COLUMBIA STREET SUITE LL-10 EVANSVILLE, IN 47710	DIAGNOSTIC CENTER

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

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

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

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

	Name and address	Type of Facility (describe)
31	31 - DEACONESS WEIGHT LOSS SOLUTIONS 310 W IOWA STREET EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
1	32 - DEACONESS WOUND CARE CENTER 350 W COLUMBIA STREET SUITE 350 EVANSVILLE, IN 47710	OUTPATIENT SERVICES
2	33 - DEACONESS DIABETES CENTER - EDUCATION 421 CHESNUT STREET EVANSVILLE, IN 47713	OUTPATIENT SERVICES
3	34 - DEACONESS ANTICOAGULATION CLINIC 4107 GATEWAY BLVD EVANSVILLE, IN 47630	OUTPATIENT SERVICES

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I General Information on Grants and Assistance

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

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 26

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

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

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

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

Return Reference	**Explanation**
PART I, LINE 2:	DEACONESS HOSPITAL CONFIRMS ALL RECIPIENTS OF FUNDS ARE ORGANIZATIONS WHOSE GOALS COINCIDE WITH DEACONESS' MISSION OF PROVIDING QUALITY HEALTH CARE WITH A COMPASSIONATE AND CARING SPIRIT. THE ORGANIZATIONS PROVIDE NEEDED SERVICES TO OUR COMMUNITY TO IMPROVE HEALTH AND WELLNESS FOR THE CITIZENS IN THE SURROUNDING AREA.

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL INC

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ALBION FELLOWS BACON CENTER PO BOX 3164 EVANSVILLE, IN 47731	31-1029051	501(C)(3)	10,800				CAPITAL CAMPAIGN & GENERAL SUPPORT
AMERICAN CANCER SOCIETY 5250 VOGEL RD SUITE A EVANSVILLE, IN 47715	13-1788491	501(C)(3)	10,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN HEART ASSOCIATION 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	7,500				GENERAL SUPPORT
AMERICAN RED CROSS 29 S STOCKWELL RD EVANSVILLE, IN 47714	53-0196605	501(C)(3)	10,900				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BOYS & GIRLS CLUB OF EVANSVILLE PO BOX 6311 EVANSVILLE, IN 47719	35-1007558	501(C)(3)	13,000				GENERAL SUPPORT & HEALTHY HABITS PROGRAM
CHEMO BUDDIES 3699 EPWORTH RD NEWBURGH, IN 47630	45-3043243	501(C)(3)	10,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CITY OF EVANSVILLE PARKS SPECIAL DISTRICT 1 NW MARTIN LUTHER KING BLVD ROOM 300 EVANSVILLE, IN 47708	35-6001021		142,857				AQUATIC CENTER CAPITAL CAMPAIGN
COMMUNITY PATIENT SAFETY COALITION 13113 BROWNING ROAD EVANSVILLE, IN 47725	61-1646052	501(C)(3)	18,752				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DREAM CENTER EVANSVILLE PO BOX 4793 EVANSVILLE, IN 47724	35-2061699	501(C)(3)	11,000				GENERAL SUPPORT & POP-UP STORE-COVID
ECHO COMMUNITY HEALTH CARE 315 MULBERRY STREET EVANSVILLE, IN 47713	35-1791786	501(C)(3)	30,000				FAMILY PRACTCE - MULTICULTURAL CLINIC

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ECONOMIC DEVELOPMENT COALITION OF SOUTHWEST INDIANA 318 MAIN STREET SUITE 400 EVANSVILLE, IN 47708	32-0152563	501(C)(6)	25,000				ONE REGION-ONE ECONOMY-ONE VOICE CAMPAIGN
EVANSVILLE REGIONAL BUSINESS COMMITTEE INC ONE VECTREN SQUARE EVANSVILLE, IN 47708	03-0408032	501(C)(3)	15,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EVANSVILLE VANDERBURGH SCHOOL CORP 1 SE NINTH STREET EVANSVILLE, IN 47708	35-1071682	501(C)(3)	7,250				CLASSROOM SUPPLIES
EVANSVILLE-AREA TRAILS COALITION INC PO BOX 5644 EVANSVILLE, IN 47716	27-1556835	501(C)(3)	18,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EVANSVILLE-VANDERBURGH COUNTY CONVENTION & VISITORS COMMISSION 4300 HECKEL ROAD EVANSVILLE, IN 47725	47-2582515	501(C)(3)	25,000				SUPPORT HEALTH TRAIL
HABITAT FOR HUMANITY OF EVANSVILLE 1401 N FARES AVENUE EVANSVILLE, IN 47711	35-1602775	501(C)(3)	50,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
INDIANA UNIVERSITY FOUNDATION PO BOX 500 BLOOMINGTON, IN 47402	35-6018940	501(C)(3)	100,000				IUSM-EVANSVILLE FURNITURE & FIXTURE FUND
ISAIAH 117 HOUSE 1705 STATE LINE RD PO BOX 842 ELIZABETHTON, TN 37643	82-0631497	501(C)(3)	15,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
JUNIOR ACHIEVEMENT OF SW INDIANA 431 E DIAMOND AVENUE EVANSVILLE, IN 47711	35-6048156	501(C)(3)	27,940				ADOPT A SCHOOL PROGRAM & GENERAL SUPPORT
OAKLAND CITY UNIVERSITY 138 N LUCRETIA STREET OAKLAND CITY, IN 47660	35-0869063	501(C)(3)	50,000				CAPITAL CAMPAIGN

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
OTHERS 5000			95,081				GENERAL SUPPORT
SOUTHERN INDIANA GRADUATE MEDICAL EDUCATION CONSORTIUM INC 515 WALNUT STREET SUITE 4134 EVANSVILLE, IN 47708	47-2044966	501(C)(3)	150,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
TRI-STATE FOOD BANK 801 E MICHIGAN STREET EVANSVILLE, IN 47711	35-1539870	501(C)(3)	100,000				CAPITAL CAMPAIGN
UNITED CARING SHELTERS 324 NW SIXTH STREET EVANSVILLE, IN 47708	35-1892153	501(C)(3)	30,000				HOMELESS MEDICAL RESPITE & GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNITED WAY OF SOUTHWESTERN INDIANA PO BOX 18 EVANSVILLE, IN 47701	35-0868069	501(C)(3)	25,000				GENERAL SUPPORT
WARRICK COUNTY COUNCIL ON AGING INC 150 WEST STATE ROAD 62 BOONVILLE, IN 47601	35-1342279	501(C)(3)	5,055				CAPITAL CAMPAIGN

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WARRICK WELLNESS PATHWAYS LLC PO BOX 906 NEWBURGH, IN 47629	46-4049559	501(C)(3)	50,000				SUPPORT HEALTH TRAIL
YOUTH FIRST 111 SE THIRD STREET STE 405 EVANSVILLE, IN 47708	35-2050168	501(C)(3)	15,000				GENERAL SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
YWCA 118 VINE ST EVANSVILLE, IN 47708	35-0869075	501(C)(3)	10,000				GENERAL SUPPORT

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Schedule J (Form 990)

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☑ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☑ Compensation committee	☐ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☑ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		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**	Yes	
b	Any related organization?	**6b**	Yes	
	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 accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	SOCIAL CLUB DUES ARE PAID FOR LINDA WHITE AND SHAWN MCCOY FOR ORGANIZATION BUSINESS ONLY. ANY PERSONAL USE OF THE CLUB MUST BE PAID BY THE EMPLOYEES.
PART I, LINE 4B	SEVERANCE, NONQUALIFIED, AND EQUITY-BASED PAYMENTS: SEVERANCE NONQUALIFIED EQUITY-BASED SHAWN MCCOY $-0- $19,000 $-0- JAMES PORTER, MD 0 19,000 0 CHERONA HAJEWSKI 0 19,000 0 DAVID RYON, MD 0 19,000 0 VENKATESH MADADI, MD 0 19,000 0 RAGHAV GUPTA, MD 0 19,000 0 NIRMAL JOSHI, MD 0 19,000 0 CHERYL WATHEN 0 19,000 0 LYNN LINGAFELTER 0 19,000 0 MAQBOOL AHMED, MD 0 19,000 0 MARC FLORENCE 0 19,000 0 HERMAN BLANTON, MD 0 19,000 0 PART I, 4B: SHAWN MCCOY: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $182,870 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $158,381 CHERYL WATHEN: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $100,184 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $97,768 JAMES PORTER: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $122,487 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $386,524 CHERONA HAJEWSKI: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $51,936 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $3,732 LYNN LINGAFELTER: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $77,613 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $60,449 HERMAN BLANTON: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $71,513 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $207,708 MARC FLORENCE: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $52,390 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $42,296 LINDA WHITE: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF $0 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF $11,215
PART I, LINE 6	COMPENSATION CONTINGENT UPON NET EARNINGS: INCENTIVE COMPENSATION PAYMENTS MADE BY THE ORGANIZATION ARE BASED UPON SUCCESSFUL ACHIEVEMENT OF ESTABLISHED INPATIENT SATISFACTION MEASURES, OUTPATIENT SATISFACTION MEASURES, COMPLIANCE WITH PUBLICLY REPORTED QUALITY INDICATORS, OPERATING MARGIN AS WELL AS OTHER TECHNICAL AND PERSONAL FUNCTIONAL GOALS OF BOTH THE ORGANIZATION AND RELATED ORGANIZATIONS. DEACONESS HOSPITAL'S INCENTIVE COMPENSATION PROGRAMS ARE FORMULATED TO REWARD BEHAVIOR THAT BALANCES PATIENT NEEDS AND EFFICIENT DELIVERY OF PATIENT CARE TO ENSURE THE BEST OUTCOMES ARE ACHIEVED.

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL 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				
1SHAWN MCCOY CEO OF DEACONESS HEALTH SYSTEM, INC.	(i)	399,881	211,960	164,898	111,693	18,712	907,144	79,190
	(ii)	407,500	0	9,800	96,953	18,712	532,965	79,190
1MAQBOOL AHMED MD DIRECTOR	(i)	0	0	720	0	0	720	0
	(ii)	824,804	36,593	9,991	16,845	2,185	890,418	0
2SCOTT CORDTS MD DIRECTOR	(i)	239,814	44,865	25,907	21,116	24,184	355,886	0
	(ii)	0	0	3,800	0	0	3,800	0
3BARRY PHILLIPS MD DIRECTOR	(i)	0	0	7,650	0	0	7,650	0
	(ii)	341,895	75,763	6,597	22,822	24,025	471,102	0
4DAVID RYON MD DIRECTOR	(i)	293,260	92,012	61,795	19,533	25,489	492,089	0
	(ii)	0	0	10,450	0	0	10,450	0
5CHERYL WATHEN CHIEF FINANCIAL OFFICER	(i)	251,595	97,740	103,581	84,900	18,829	556,645	48,884
	(ii)	259,972	0	10,200	54,972	18,829	343,973	48,884
6JAMES PORTER MD PRESIDENT OF DEACONESS HEALTH SYSTEM	(i)	584,653	132,813	389,394	153,362	33,389	1,293,611	386,524
	(ii)	0	0	2,400	0	0	2,400	0
7CHERONA HAJEWSKI CHIEF NURSING OFFICER	(i)	318,084	60,843	63,739	91,118	27,557	561,341	55,668
	(ii)	0	0	0	0	0	0	0
8LYNN LINGAFELTER CHIEF OPERATION OFFICER	(i)	389,906	79,399	63,400	101,561	15,513	649,779	60,449
	(ii)	44,052	0	4,000	0	12,499	60,551	0
9HERMAN BLANTON MD CHIEF MEDICAL OFFICER	(i)	320,976	76,849	212,113	73,033	9,469	692,440	207,708
	(ii)	81,762	0	0	13,742	9,469	104,973	0
10MARC FLORENCE VICE PRESIDENT	(i)	252,364	59,474	45,884	69,893	16,475	444,090	42,296
	(ii)	65,209	0	0	2,030	16,475	83,714	0
11CAROLYN MORTON PHARMACY AND LAB DIRECTOR	(i)	195,372	28,229	1,403	15,615	28,122	268,741	0
	(ii)	0	0	0	0	0	0	0
12SUSAN BRUMLEY IMAGING AND CARDIOVASCULAR SERVICES	(i)	169,052	21,981	1,405	13,060	25,874	231,372	0
	(ii)	0	0	0	0	0	0	0
13RAGHAV GUPTA MD ANESTHESIOLOGIST	(i)	368,545	576,275	36,026	15,262	24,969	1,021,077	0
	(ii)	0	0	0	0	0	0	0
14VENKATESH MADADI MD ANESTHESIOLOGIST	(i)	800,896	0	70,596	27,164	25,152	923,808	0
	(ii)	0	0	0	0	0	0	0
15NIRMAL JOSHI MD ANESTHESIOLOGIST	(i)	568,177	0	231,174	22,236	27,782	849,369	0
	(ii)	0	0	0	0	0	0	0
16DAVID FISH MD ANESTHESIOLOGIST	(i)	634,375	0	130,952	16,845	24,231	806,403	0
	(ii)	0	0	0	0	0	0	0
17RYAN NEAL MD ANESTHESIOLOGIST	(i)	666,795	5,000	85,544	15,262	25,491	798,092	0
	(ii)	0	0	0	0	0	0	0
18LINDA WHITE FORMER CEO EMERITA, FOUNDATION EXEC.	(i)	123,371	16,242	56,452	6,720	7,353	210,138	11,215
	(ii)	0	0	4,800	0	0	4,800	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	INDIANA FINANCE AUTHORITY-2016A	35-1602316	45506DXT7	10-05-2016	109,999,091	NEW MONEY PROJECTS		X		X		X
B	INDIANA FINANCE AUTHORITY-2015A	35-1602316	45506DUL7	07-09-2015	49,772,341	03/6/2009 REFUNDING		X		X		X
C	INDIANA FINANCE AUTHORITY-2013C	35-1602316	45471ALU4	07-23-2013	40,180,000	3/26/09 REFUNDING		X		X		X
D	INDIANA FINANCE AUTHORITY-2013B	35-1602316		03-05-2013	21,440,000	5/27/04 REFUNDING		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired		830,000	2,235,000	7,880,000
2	Amount of bonds legally defeased				
3	Total proceeds of issue	111,373,335	49,772,341	40,180,000	21,440,000
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds	4,660,332			
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	935,528	601,847	180,000	125,000
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds	2,885,418			
10	Capital expenditures from proceeds	102,892,057			
11	Other spent proceeds		49,170,494	40,000,000	21,315,000
12	Other unspent proceeds				
13	Year of substantial completion	2018			

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

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X			X		X		X
b	Exception to rebate?		X		X		X	X	
c	No rebate due?		X	X		X			X
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X		X	X	
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X	X	
b	Name of provider							FIFTH THIRD	
c	Term of hedge								1600.0000000000 %
d	Was the hedge superintegrated?								X
e	Was the hedge terminated?								X

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
DATE REBATE COMPUTATION PERFORMED	ISSUER NAME: INDIANA FINANCE AUTHORITY-2013A DATE THE REBATE COMPUTATION WAS PERFORMED: 06/22/2015 ISSUER NAME: INDIANA FINANCE AUTHORITY-2012B DATE THE REBATE COMPUTATION WAS PERFORMED: 06/22/2015

Return Reference	Explanation
PART II, LINE 11:	THE OTHER SPENT PROCEEDS ARE THE REFUNDING PROCEEDS OF THE ISSUE THAT ARE NO LONGER IN ESCROW.

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
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OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	INDIANA FINANCE AUTHORITY-2013A	35-1602316	45471AKY7	03-05-2013	71,336,168	5/27/04 AND 3/26/09 REFUNDING		X		X		X
B	INDIANA FINANCE AUTHORITY-2012B	35-1602316		11-20-2012	13,005,000	1/17/1992 REFUNDING		X		X		X
C	INDIANA FINANCE AUTHORITY-2011A	35-1602316	45471AES7	12-02-2011	20,667,197	3/15/99 REFUNDING		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	3,295,000	9,605,000	8,190,000	
2	Amount of bonds legally defeased				
3	Total proceeds of issue	71,336,168	13,005,000	20,667,197	
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	729,538	103,657	397,197	
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds	70,606,631	12,901,343	20,270,000	
12	Other unspent proceeds				
13	Year of substantial completion				

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

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

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

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

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

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

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
See Additional Data Table					

Part V Supplemental Information

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

Return Reference	Explanation
SCH L, PART IV, ABBREVIATION:	BD MBR = BOARD MEMBERCOMP. = REPORTABLE COMPENSATIONSRVS. = SERVICES
SCH L, PART V, RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:	INTERESTED PERSON: ABBY PAPARIELLARELATIONSHIP: DAUGHTER OF DAVE PAPARIELLAINTERESTED PERSON: BRITTNEY PHIPPSRELATIONSHIP: DAUGHTER OF DAVE PAPARIELLAINTERESTED PERSON: EVANSVILLE SURGICAL ASSOCIATES RELATIONSHIP: BOARD MEMBER BRUCE ADYE IS A MEMBER OF ESA. EVANSVILLE SURGICAL ASSOCIATES PROVIDES TRAUMA COVERAGE AS WELL AS OTHER MEDICAL SERVICES.INTERESTED PERSON: SOUTH WESTERN COMMUNICATIONSRELATIONSHIP: BOARD MEMBER KEVIN KOCH IS THE CHAIRMAN OF SOUTH WESTERN COMMUNICATIONS. SOUTH WESTERN COMMUNICATIONS PROVIDES MEDICAL SERVICES.INTERESTED PERSON: JESSICA COXRELATIONSHIP: DAUGHTER TO LYNN LINGAFELTERINTERESTED PERSON: JOAN MCCOYRELATIONSHIP: WIFE OF SHAWN MCCOYINTERESTED PERSON: MARY BETH COLERELATIONSHIP: SISTER TO STEPHEN TITZERINTERESTED PERSON: MISTY ADYERELATIONSHIP: WIFE OF BOARD MEMBER BRUCE ADYEINTERESTED PERSON: OLD NATIONAL BANKRELATIONSHIP: BOARD MEMBER JAMES RYAN IS THE CFO OF OLD NATIONAL BANK. OLD NATIONAL BANK PROVIDES INVESTMENT MANAGEMENT SERVICES.INTERESTED PERSON: SHERRI MCCOYRELATIONSHIP: SISTER OF SHAWN MCCOYINTERESTED PERSON: UNIVERSITY OF SOUTHERN INDIANARELATIONSHIP: BOARD MEMBER RON ROCHON IS PRESIDENT OF UNIVERSITY OF SOUTHERN INDIANA. DEACONESS HOSPITAL PROVIDES GENERAL SUPPORT AND HEALTH PROFESSION SCHOLARSHIPS TO THE UNIVERSITY.INTERESTED PERSON: LINDA HOOVERRELATIONSHIP: MOTHER-IN-LAW OF DOUG WELPINTERESTED PERSON: LAUREN WATHERNRELATIONSHIP: DAUGHTER TO CHERYL WATHEN

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL INC

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ABBY PAPARIELLA	SEE PART V	58,398	COMP.		No
(1) BRITTNEY PHIPPS	SEE PART V	57,084	COMP.		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(3) EVANSVILLE SURGICAL ASSOCIATES	SEE PART V	3,578,295	MEDICAL SERVICES		No
(1) SOUTH WESTERN COMMUNICATIONS	SEE PART V	293,329	ORTHOTIC SUPPLIES		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(5) JESSICA COX	SEE PART V	112,772	COMP.		No
(1) JOAN MCCOY	SEE PART V	52,656	COMP.		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(7) MARY BETH COLE	SEE PART V	40,389	COMP.		No
(1) MISTY ADYE	SEE PART V	44,186	COMP.		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(9) OLD NATIONAL BANK	SEE PART V	267,979	INVESTMENT MANAGEMENT FEES		No
(1) SHERRI MCCOY	SEE PART V	22,528	COMP.		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of transaction	**(d)** Description of transaction	**(e)** Sharing of organization's revenues?	
				Yes	**No**
(11) UNIVERSITY OF SOUTHERN INDIANA	SEE PART V	34,689	SUPPORT		No
(1) LINDA HOOVER	SEE PART V	10,125	COMP.		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(13) LAUREN WATHEN	SEE PART V	11,691	COMP.		No

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art				
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded				
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (OTHER)	X	0	52,895	FMV
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

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

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

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

Return Reference	Explanation

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 1, ORGANIZATION'S MISSION:	DEACONESS HOSPITAL PROVIDES QUALITY HEALTHCARE SERVICES WITH A COMPASSIONATE AND CARING SP IRIT TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE. AT DEACONESS HOSPITAL, OUR VAL UES ARE BASED ON OUR COMMITMENT TO QUALITY. WE DEFINE QUALITY AS THE CONTINUOUS IMPROVEMEN T OF SERVICES TO MEET THE NEEDS AND EXCEED THE EXPECTATIONS OF THE CUSTOMERS WE SERVE. OUR VALUES ARE QUALITY IN EVERYTHING WE DO, RESPECT FOR ALL PEOPLE, EFFICIENCY AND EFFECTIVEN ESS IN THE USE OF RESOURCES, INNOVATION TOWARD CONTINUOUS SYSTEMS IMPROVEMENT, PARTNERSHIP WITH THOSE WE SERVE AND WITH SUPPLIERS, EDUCATION FOR CONTINUOUS GROWTH AND KNOWLEDGE AND PRIDE IN WORKMANSHIP. TO ACCOMPLISH ITS MISSION, DEACONESS HOSPITAL IS COMMITTED TO IMPRO VING THE QUALITY OF LIFE FOR THE PEOPLE OF THE TRI-STATE BY DEMONSTRATING EXCELLENCE IN HE ALTHCARE SERVICES, PROVIDING ACCESS TO HEALTHCARE, PROVIDING CHARITY CARE TO THOSE IN NEED ,PROMOTING HEALTHY LIFESTYLES, OFFERING SPIRITUAL AND PSYCHOLOGICAL SUPPORT, SUPPORTING HE ALTH RELATED EDUCATION, AND ADVANCING HEALTH KNOWLEDGE THROUGH RESEARCH.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	PROGRAM SERVICES ACCOMPLISHMENT 1: PATIENT SERVICE REVENUE. DEACONESS HOSPITAL IS A MAJOR REFERRAL CENTER FOR A 26 COUNTY TRI-STATE AREA IN SOUTHWESTERN INDIANA, WESTERN KENTUCKY A ND SOUTHEASTERN ILLINOIS. THE HOSPITAL AND ITS FACILITIES ARE LOCATED ON FOUR CAMPUSES WHI CH INCLUDE THE MAIN 28-ACRE CAMPUS ON THE NEAR NORTH SIDE OF EVANSVILLE IN VANDERBURGH COU NTY; THE 63-ACRE GATEWAY CAMPUS LOCATED IN WARRICK COUNTY ON THE EASTERN BORDER OF VANDERB URGH COUNTY; AND TWO OTHER EASTSIDE EVANSVILLE LOCATIONS FOR PSYCHIATRIC BEHAVIORAL SERVIC ES AND REHABILITATION SERVICES. THE HOSPITAL OPERATES A MAIN CAMPUS WITH A TOTAL OF 267 BE DS CONSISTING OF 38 INTENSIVE CARE BEDS, 16 CARDIAC INTENSIVE CARE BEDS, 41 CARDIAC BEDS, 23 ONCOLOGY/ PULMONOLOGY BEDS, 44 ORTHOPAEDIC/ NEUROLOGICAL BEDS, 44 MEDICAL/ SURGICAL BED S, 39 MEDICAL RENAL BEDS, AND 18 BEDS DEDICATED TO PATIENTS IN OBSERVATION. IN ADDITION, T HE HOSPITAL PROVIDES A FULL-ARRAY OF COMPREHENSIVE OUTPATIENT AND AMBULATORY SERVICES ON I TS MAIN CAMPUS AND OTHER SPECIFIC SERVICES AT MULTIPLE SITES WITHIN ITS PRIMARY AND SECOND ARY SERVICE AREAS. THE HOSPITAL OPERATES THE 278 BED DEACONESS GATEWAY HOSPITAL WHICH WAS OPENED IN JANUARY 2006, ON THE GATEWAY CAMPUS CONSISTING OF 13 ADULT INTENSIVE CARE BEDS, 17 PEDIATRIC AND PEDIATRIC INTENSIVE CARE BEDS, 16 NEUROSURGICAL BEDS, 48 ORTHOPAEDIC BEDS , 48 NEURO INTENSIVE CARE BEDS, 32 SURGICAL ONCOLOGY BEDS, 48 GENERAL MED/ TELEMETRY BEDS, 24 CARDIAC BEDS, AND 32 BEDS DEDICATED TO PATIENTS IN OBSERVATION. THE ORTHOPEDIC NEUROSC IENCE HOSPITAL OPENED ON THE GATEWAY CAMPUS IN MAY OF 2018. THE HOSPITAL OWNS AND OPERATES DEACONESS CROSS POINTE, A FREE-STANDING, 60 BED INPATIENT PSYCHIATRIC HOSPITAL LOCATED AP PROXIMATELY 7 MILES EAST OF THE MAIN CAMPUS IN EVANSVILLE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4B	PROGRAM SERVICES ACCOMPLISHMENT 2: CHARITY CARE/ SUBSIDIZED CARE. DEACONESS HOSPITAL MAKES A DISTINCTION BETWEEN CHARITY CARE AND BAD DEBT. IN DETERMINING AN INDIVIDUAL OR FAMILY'S ABILITY TO PAY, DEACONESS HOSPITAL EVALUATES WHETHER OR NOT THE RESPONSIBLE PARTY HAS SUF FICIENT RESOURCES AVAILABLE FOR PAYMENT. IF AN INDIVIDUAL IS DETERMINED TO NOT HAVE SUFFIC IENT RESOURCES TO PAY, THEY ARE CONSIDERED ELIGIBLE FOR CHARITY CARE AND WILL NOT BE PROCE SSED THROUGH EITHER INTERNAL OR EXTERNAL COLLECTIONS. ACCOUNTS OF CHARITY CARE PATIENTS WH O ARE UNABLE TO PAY DO NOT RESULT IN BAD DEBT AND ARE NOT COLLECTED UPON. DEACONESS HOSPIT AL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS BELOW COST. RECOGNIZING ITS M ISSION TO THE COMMUNITY, SERVICES ARE PROVIDED TO BOTH MEDICARE AND MEDICAID PATIENTS. TO THE EXTENT OF REIMBURSEMENT IS BELOW COST, DEACONESS HOSPITAL ABSORBS THESE COSTS IN MEETI NG ITS MISSION TO THE COMMUNITY. IN SUPPORT OF ITS MISSION, DEACONESS HOSPITAL PROVIDED $1 8.2 MILLION OF CHARITY CARE AND $42.5 MILLION OF SUBSIDIZED SERVICES TO THE MEDICAID PROGR AM, AND $97.3 MILLION OF SUBSIDIZED SERVICES TO THE MEDICARE PROGRAM.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4C	PROGRAM SERVICES ACCOMPLISHMENT 3: GRADUATE MEDICAL EDUCATION, MEDICAL EDUCATION & COMMUNI TY BENEFITS. DEACONESS HOSPITAL PLAYS AN ACTIVE ROLE IN MEDICAL EDUCATION, OPERATING A THR EE YEAR FAMILY MEDICINE RESIDENCY PROGRAM AND A POST-GRADUATE PHARMACY RESIDENCY PROGRAM. DEACONESS HOSPITAL ALSO PROVIDES CONTINUING MEDICAL EDUCATION PROGRAMS FOR ATTENDING PHYSI CIANS, OTHER HEALTH PROFESSIONALS, OTHER ALLIED HEALTH PROGRAMS, COMMUNITY HEALTH PROGRAMS AND A CHAPLAIN RESIDENCY PROGRAM. IN ADDITION TO EDUCATIONAL SERVICES, DEACONESS HOSPITAL PROVIDED $10.1 MILLION IN COMMUNITY BENEFIT ACTIVITIES (ALL ON A COST BASIS), SERVING A M INIMUM OF 996,563 PEOPLE WITHIN THE TRI-STATE AREA.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	CLASS OF MEMBERS OR STOCKHOLDERS: DEACONESS HEALTH SYSTEM, INC. IS THE SOLE CORPORATE MEMBER OF DEACONESS HOSPITAL, INC.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	ELECTION OF GOVERNING BODY: THE BOARD OF DIRECTORS MAY ELECT ONE OR MORE NON-MEDICAL STAFF MEMBERS OF THE GOVERNING BODY THROUGH AN APPROVED ELECTION AND APPROVAL PROCESS. THE ELEC TION AND APPROVAL PROCESS FOR NON-MEDICAL STAFF MEMBERS BEGINS WITH A RECOMMENDATION BY TH E GOVERNANCE COMMITTEE FOR MEMBERSHIP TO THE BOARD OF DIRECTORS. THAT RECOMMENDATION IS TH EN REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS. DEPENDING ON THE DECISION REACHED BY T HE BOARD OF DIRECTORS, MEMBERSHIP MAY OR MAY NOT BE GRANTED TO THAT INDIVIDUAL. MEDICAL ST AFF EXECUTIVE COUNCIL LEADERSHIP ARE APPOINTED TO BOARD OF DIRECTOR MEMBERSHIP THROUGH THE IR POSITION AS ELECTED MEDICAL STAFF LEADERS. THROUGH THE ELECTION PROCESS OF THE MEDICAL STAFF EXECUTIVE COUNCIL, THEIR APPOINTMENT IS CONFIRMED AND APPROVED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990 REVIEW PROCESS: THE PROCESS THAT DEACONESS HOSPITAL UTILIZES TO PRESENT THE FORM 990 TO ITS GOVERNING BODY PRIOR TO FILING IS TO PRESENT THE FORM 990 TO THE CFO AND CEO OF THE ORGANIZATION FOR REVIEW. AFTER THIS REVIEW IS PERFORMED AND ALL QUESTIONS ARE ANSWERED, THE FORM 990 IS PRESENTED TO THE BOARD OF DIRECTORS OF DEACONESS HEALTH SYSTEM AT THE BOARD MEETING PRIOR TO THE FILING DATE OF THE FORM 990. ANY ADDITIONAL QUESTIONS ARE ANSWERED AND THE FINAL FILING IS THEN COMPLETED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	COMPLIANCE WITH CONFLICT OF INTEREST POLICY: CONFLICT OF INTEREST REVIEW AND COMPLIANCE AC TIVITIES ARE CONDUCTED THROUGHOUT THE YEAR UNDER THE DIRECTION OF DEACONESS HOSPITAL'S COR PORATE COMPLIANCE OFFICER. UPON APPOINTMENT AND, ANNUALLY, THEREAFTER, OFFICERS, DIRECTORS , TRUSTEES, AND KEY EMPLOYEES, ALSO KNOWN AS INTERESTED PERSONS, ARE REQUIRED TO COMPLETE "THE CONFLICTS OF INTEREST QUESTIONNAIRE AND/OR "THE DISCLOSURE QUESTIONNAIRE". THESE DOCU MENTS SERVE TO ENSURE INTERESTED PERSONS OR COMMITTEE MEMBERS WITH BOARD DELEGATED POWERS HAVE AN APPROPRIATE AND TIMELY MANNER IN WHICH TO DISCLOSE ANY POTENTIAL CONFLICTS. CONFLI CTS ARE CONSIDERED WITH RESPECT TO OUTSIDE INTEREST, INVESTMENTS, OUTSIDE ACTIVITIES, AND BUSINESS INTERESTS AMONG THE INTERESTED PERSONS AS WELL AS THEIR FAMILY MEMBERS. ON A PERI ODIC BASIS, REVIEWS OCCUR TO ENSURE DEACONESS HOSPITAL OPERATES IN A MANNER CONSISTENT WIT H ITS CHARITABLE PURPOSE. SUBJECTS THAT ARE REVIEWED ON A PERIODIC BASIS INCLUDE COMPENSAT ION, PHYSICIAN RELATIONSHIPS, PARTNERSHIP AND JOINT VENTURE ARRANGEMENTS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	COMPENSATION FOR TOP OFFICIALS AND OTHER OFFICERS: DEACONESS HOSPITAL UTILIZES A COMPENSATION COMMITTEE TO APPROVE EXECUTIVE, DIRECTOR AND PHYSICIAN COMPENSATION AS WELL AS EXECUTIVE AND PHYSICIAN BENEFITS PROGRAMS. THE COMPENSATION COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS AND MUST MEET THE INDEPENDENCE REQUIREMENTS OF THE SEC. THE COMMITTEE HAS THE POWER AND AUTHORITY TO: 1. ANNUALLY REVIEW AND APPROVE AND RECOMMEND TO THE BOARD OF DIRECTORS FOR ITS FINAL APPROVAL FOR THE CEO AND EACH OTHER EXECUTIVE OFFICER OF THE SYSTEM ALL ELEMENTS OF EXECUTIVE COMPENSATION. 2. MONITOR BROADLY THE STRUCTURE, PHILOSOPHY OR COMPETITIVENESS OF THE SYSTEM'S GENERAL HIRING OR COMPENSATION PRACTICES. 3. OVERSEE THE ESTABLISHMENT AND ADMINISTRATION OF THE COMPANY'S BROAD-BASED BENEFIT PLANS AND PROGRAMS 4. REVIEW OR APPROVE SIGNIFICANT AMENDMENTS OR CHANGES TO THE PLANS AND PROGRAMS. 5. RETAIN AND TERMINATE ANY COMPENSATION CONSULTANT TO BE USED TO ASSIST IN THE EVALUATION OF DIRECTOR, CEO OR EXECUTIVE OFFICE COMPENSATION 6. SOLE AUTHORITY TO APPROVE THE CONSULTANT'S FEES AND OTHER RETENTION TERMS. 7. OBTAIN ADVICE AND ASSISTANCE FROM INTERNAL OR EXTERNAL LEGAL, ACCOUNTING OR OTHER ADVISORS. 8. APPROVE ALL PHYSICIAN AND PHYSICIAN RELATED CONTRACTS. 9. MAKE REGULAR REPORTS TO THE BOARD.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	GOVERNING DOCUMENTS DISCLOSURE EXPLANATION: DEACONESS HOSPITAL'S ARTICLES OF INCORPORATION ARE AVAILABLE ON THE SECRETARY OF STATE'S WEBSITE. DEACONESS HOSPITAL IS PART OF A CONSOL IDATED FINANCIAL STATEMENT WHICH IS AVAILABLE WITH THE PUBLIC DISCLOSURE COPY OF THE IRS F ORM 990. ALSO, AS REQUIRED BY LAW, THE HOSPITAL SUBMITS ITS CONSOLIDATED FINANCIAL STATEME NTS TO THE INDIANA DEPARTMENT OF HEALTH WHICH ARE PUBLISHED ON ITS WEBSITE. GOVERNING DOCU MENTS, ASIDE FROM THE ARTICLES OF INCORPORATION, AND THE CONFLICT OF INTEREST POLICY ARE N OT AVAILABLE FOR PUBLIC INSPECTION.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PROFESSIONAL FEES: PROGRAM SERVICE EXPENSES 122,557,289. MANAGEMENT AND GENERAL EXPENSES 2 ,328,130. FUNDRAISING EXPENSES 20,525. TOTAL EXPENSES 124,905,944. PROFESSIONAL FEES- PHYS ICIANS: PROGRAM SERVICE EXPENSES 14,444,033. MANAGEMENT AND GENERAL EXPENSES 89,693. FUNDR AISING EXPENSES 0. TOTAL EXPENSES 14,533,726.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	CHANGE IN PENSION LIABILITY -10,305,811. FOUNDATION MONIES GRANTED FROM RESTRICTION -1,086 ,878. CHANGE IN GENERAL FUND EQUITY -73,184,847. CHANGE IN UNREALIZED GAIN/LOSS ON INVESTM ENTS/SWAP 45,448,496.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2C, OVERSIGHT OF AUDIT:	THE BOARD OF DIRECTORS ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF THE FINANCIAL STATEMENTS AND SELECTION OF THE INDEPENDENT ACCOUNTANT; AND NO PROCESSES HAVE CHANGED FROM PRIOR YEAR.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
DEACONESS HOSPITAL INC

Employer identification number
35-0593390

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

See Additional Data Table

(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	(g) Section 512(b)(13) controlled entity? No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) DEACONESS HEALTH PLANS LLC 350 W COLUMBIA SUITE 400 EVANSVILLE, IN 47710 38-3492529	PREFERRED PROVIDER NETWORK	IN	DEACONESS HOSPITAL	RELATED	855,637	2,415,274		No			No	95.150 %
(2) PROGRESSIVE HEALTH OF IN LLC 150 N ROSENBERGER EVANSVILLE, IN 47712 20-8480988	OUTPATIENT	IN	DEACONESS HOSPITAL	RELATED	4,030,642	2,402,905		No			No	51.000 %
(3) TRI-STATE RADIATION ONCOLOGY 1500 ROSECRANS AVENUE MANHATTAN BEACH, CA 90266 26-3706834	OUTPATIENT	DE	DEACONESS HOSPITAL	RELATED	7,251,859	7,313,158		No			No	51.000 %
(4) MAINSPRING MANAGERS LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 46-4601001	NEUROLOGY SERVICES	IN	DEACONESS HOSPITAL	RELATED	1,023,448	1,191,493		No			No	51.000 %
(5) VASCMED LLC 600 MARY STREET EVANSVILLE, IN 47747 47-2578168	VASCULAR SERVICES	IN	DEACONESS HOSPITAL	RELATED	687,137	940,419		No			No	51.000 %
(6) ORTHOALIGN LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 81-2816013	HEALTHCARE	IN	DEACONESS HOSPITAL	RELATED	1,917,521	1,128,913		No			No	51.000 %
(7) HEALTHCARE RESOURCE SOLUTIONS 600 MARY STREET EVANSVILLE, IN 47747 83-3275390	HEALTHCARE	IN	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)TRI-STATE MEDICAL MANAGEMENT INC 600 MARY STREET EVANSVILLE, IN 47747 35-1875888	PHYSICIAN MANAGEMENT	IN	DEACONESS HOSPITAL	C			100.000 %	Yes	

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)MAINSPRING MANAGERS LLC	P	412,278	
(2)VASCMED LLC	P	194,068	
(3)ORTHOALIGN LLC	P	527,825	
(4)DEACONESS HEALTH PLANS LLC	P	162,719	

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 35-0593390
Name: DEACONESS HOSPITAL INC

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary Activity	(c) Legal Domicile (State or Foreign Country)	(d) Total income	(e) End-of-year assets	(f) Direct Controlling Entity
REGIONAL EMERGENCY DEPARTMENT 600 MARY ST EVANSVILLE, IN 47710 46-3509500	HEALTHCARE	IN			DEACONESS HOSPITAL
READY DEVELOPMENT OF INDIANA 600 MARY ST EVANSVILLE, IN 47747 47-2040018	REAL ESTATE	IN		5,264,019	DEACONESS HOSPITAL
HEART HOSPITAL AT DEACONESS GATEWAY LLC 4007 GATEWAY BLVD NEWBURGH, IN 47630 26-1766835	HOSPITAL	DE			DEACONESS HOSPITAL
BASELINE INVESTORS LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
533 COLUMBIA LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
INVESTORS PROPERTY DEVELOPMENT LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
7307 E COLUMBIA LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL

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
600 MARY STREET EVANSVILLE, IN 47747 35-1532889	HEALTHCARE	IN	501(C)(3)	LINE 12A, I	N/A		No
421 CHESNUT STREET EVANSVILLE, IN 47713 26-3083364	HEALTHCARE	IN	501(C)(3)	LINE 3	DEACONESS HEALTH SYSTEM		No
600 MARY STREET EVANSVILLE, IN 47747 81-0693478	HEALTHCARE	IL	501(C)(3)	LINE 10	DEACONESS HEALTH SYSTEM		No
610 E WALNUT ST EVANSVILLE, IN 47713 46-5223267	HEALTHCARE	IN	501(C)(3)	LINE 10	DEACONESS HEALTH SYSTEM		No
600 MARY STREET EVANSVILLE, IN 47747 82-4503095	HEALTHCARE	IN	501(C)(3)	LINE 3	DEACONESS HEALTH SYSTEM		No
600 MARY STREET EVANSVILLE, IN 47747 83-0966826	HEALTHCARE	IN	501(C)(3)	LINE 10	DEACONESS HEALTH SYSTEM		No
PO BOX 48 HENDERSON, KY 42419 61-0461753	HEALTHCARE	KY	501(C)(3)	LINE 3	DEACONESS HEALTH SYSTEM		No
1808 SHERMAN DR PRINCETON, IN 47670 35-0877575	HEALTHCARE	IN	501(C)(3)	LINE 3	DEACONESS HEALTH SYSTEM		No
1305 NORTH ELM ST HENDERSON, KY 42420 61-0944432	SUPPORT METHODIST HEALTH	KY	501(C)(3)	LINE 10	N/A		No
4604 US HWY 60 WEST MORGANFIELD, KY 42437 61-1230297	SUPPORT METHODIST HEALTH	KY	501(C)(3)	LINE 10	N/A		No
1808 SHERMAN DRIVE PRINCETON, IN 47670 35-0950175	SUPPORT GIBSON HOSPITAL	IN	501(C)(3)	LINE 12A, I	DEACONESS GIBSON HOSPITAL		No

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	
DEACONESS HEALTH PLANS LLC 350 W COLUMBIA SUITE 400 EVANSVILLE, IN 47710 38-3492529	PREFERRED PROVIDER NETWORK	IN	DEACONESS HOSPITAL	RELATED	855,637	2,415,274		No			No	95.150 %
PROGRESSIVE HEALTH OF IN LLC 150 N ROSENBERGER EVANSVILLE, IN 47712 20-8480988	OUTPATIENT	IN	DEACONESS HOSPITAL	RELATED	4,030,642	2,402,905		No			No	51.000 %
TRI-STATE RADIATION ONCOLOGY 1500 ROSECRANS AVENUE MANHATTAN BEACH, CA 90266 26-3706834	OUTPATIENT	DE	DEACONESS HOSPITAL	RELATED	7,251,859	7,313,158		No			No	51.000 %
MAINSPRING MANAGERS LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 46-4601001	NEUROLOGY SERVICES	IN	DEACONESS HOSPITAL	RELATED	1,023,448	1,191,493		No			No	51.000 %
VASCMED LLC 600 MARY STREET EVANSVILLE, IN 47747 47-2578168	VASCULAR SERVICES	IN	DEACONESS HOSPITAL	RELATED	687,137	940,419		No			No	51.000 %
ORTHOALIGN LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 81-2816013	HEALTHCARE	IN	DEACONESS HOSPITAL	RELATED	1,917,521	1,128,913		No			No	51.000 %
HEALTHCARE RESOURCE SOLUTIONS 600 MARY STREET EVANSVILLE, IN 47747 83-3275390	HEALTHCARE	IN	N/A									