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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2020

Open to Public Inspection

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

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

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

A For the 2020 calendar year, or tax year beginning 10-01-2020 , and ending 09-30-2021

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

D Employer identification number  
35-0593390  
  
E Telephone number  
(812) 450-3296  
  
G Gross receipts \$ 3,059,175,692

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

Activities & Governance

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 19  
4 Number of independent voting members of the governing body (Part VI, line 1b) . . . . . 4 13  
5 Total number of individuals employed in calendar year 2020 (Part V, line 2a) . . . . . 5 6,606  
6 Total number of volunteers (estimate if necessary) . . . . . 6 57  
7a Total unrelated business revenue from Part VIII, column (C), line 12 . . . . . 7a 16,420,970  
b Net unrelated business taxable income from Form 990-T, line 39 . . . . . 7b 190,189

Revenue

8 Contributions and grants (Part VIII, line 1h) . . . . . 18,259,180  
9 Program service revenue (Part VIII, line 2g) . . . . . 967,249,119  
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d ) . . . . . 29,721,186  
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) . . . . . 86,915,133  
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) . . . . . 1,102,144,618

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) . . . . . 1,157,407  
14 Benefits paid to or for members (Part IX, column (A), line 4) . . . . . 0  
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) . . . . . 394,333,935  
16a Professional fundraising fees (Part IX, column (A), line 11e) . . . . . 0  
b Total fundraising expenses (Part IX, column (D), line 25) ▶380,743  
17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) . . . . . 553,580,136  
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) . . . . . 949,071,478  
19 Revenue less expenses. Subtract line 18 from line 12 . . . . . 153,073,140

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . . 1,921,220,397  
21 Total liabilities (Part X, line 26) . . . . . 703,989,911  
22 Net assets or fund balances. Subtract line 21 from line 20 . . . . . 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

\*\*\*\*\*  
Signature of officer  
2022-08-15  
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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2020)

**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.

<b>4a</b>	(Code: )	(Expenses \$	192,893,756	including grants of \$	) (Revenue \$	554,331,782 )
See Additional Data						

<b>4b</b>	(Code: )	(Expenses \$	712,854,161	including grants of \$	) (Revenue \$	549,221,521 )
See Additional Data						

<b>4c</b>	(Code: )	(Expenses \$	21,473,586	including grants of \$	) (Revenue \$	7,454,020 )
See Additional Data						

(Code: )	(Expenses \$	1,696,764	including grants of \$	1,696,764 )	(Revenue \$	53,912,059 )
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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.

<b>4d</b>	Other program services (Describe in Schedule O.)					
	(Expenses \$	1,696,764	including grants of \$	1,696,764 )	(Revenue \$	53,912,059 )

<b>4e</b>	<b>Total program service expenses ▶</b>	928,918,267
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> 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	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> 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	<b>4</b> Yes	
<b>5</b> 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	<b>5</b>	No
<b>6</b> 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	<b>6</b>	No
<b>7</b> 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	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> 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	<b>9</b>	No
<b>10</b> 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	<b>10</b> Yes	
<b>11</b> 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.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</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	<b>11b</b>	No
<b>c</b> 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	<b>11c</b>	No
<b>d</b> 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	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> 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	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</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	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b> Yes	
<b>19</b> 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	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> Yes	
<b>21</b> 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	<b>21</b> Yes	

**Part IV Checklist of Required Schedules (continued)**

		Yes	No
<b>22</b>	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 . . . . .	<b>22</b>	No
<b>23</b>	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 . . . . .	<b>23</b>	Yes
<b>24a</b>	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 . . . . .	<b>24a</b>	Yes
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	No
<b>c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	<b>24c</b>	Yes
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	No
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I . . . . .	<b>25a</b>	No
<b>b</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 . . . . .	<b>25b</b>	No
<b>26</b>	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 . . . . .	<b>26</b>	No
<b>27</b>	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 . . . . .	<b>27</b>	No
<b>28</b>	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):		
<b>a</b>	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? If "Yes," complete Schedule L, Part IV . . . . .	<b>28a</b>	Yes
<b>b</b>	A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV . . . . .	<b>28b</b>	Yes
<b>c</b>	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 . . . . .	<b>28c</b>	Yes
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M . . . . .	<b>29</b>	Yes
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M . . . . .	<b>30</b>	No
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I . . . . .	<b>31</b>	No
<b>32</b>	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II . . . . .	<b>32</b>	No
<b>33</b>	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 . . . . .	<b>33</b>	Yes
<b>34</b>	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 . . . . .	<b>34</b>	Yes
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b>	Yes
<b>b</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 . . . . .	<b>35b</b>	No
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 . . . . .	<b>36</b>	No
<b>37</b>	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 . . . . .	<b>37</b>	No
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O. . . . .	<b>38</b>	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
<b>1a</b> Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	<b>1a</b>	290
<b>b</b> Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	<b>1b</b>	0
<b>c</b> Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	<b>1c</b>	Yes

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

Form **990** (2020)

**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
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 19		
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>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 13		
<b>2</b> 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?	<b>2</b>		No
<b>3</b> 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?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>		No
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> 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?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>		No
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> 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	<b>9</b>		No

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

		Yes	No
<b>10a</b> Did the organization have local chapters, branches, or affiliates?	<b>10a</b>		No
<b>b</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?	<b>10b</b>		
<b>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	<b>11a</b>	Yes	
<b>b</b> Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
<b>12a</b> Did the organization have a written conflict of interest policy? If "No," go to line 13	<b>12a</b>	Yes	
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	<b>12b</b>	Yes	
<b>c</b> Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	<b>12c</b>	Yes	
<b>13</b> Did the organization have a written whistleblower policy?	<b>13</b>	Yes	
<b>14</b> Did the organization have a written document retention and destruction policy?	<b>14</b>	Yes	
<b>15</b> 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?			
<b>a</b> The organization's CEO, Executive Director, or top management official	<b>15a</b>	Yes	
<b>b</b> Other officers or key employees of the organization	<b>15b</b>	Yes	
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
<b>16a</b> Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	<b>16a</b>		No
<b>b</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?	<b>16b</b>		

**Section C. Disclosure**

<b>17</b> List the states with which a copy of this Form 990 is required to be filed	IN
<b>18</b> 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. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O)	
<b>19</b> 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.	
<b>20</b> 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	

## 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 ☐

**a** 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.

[illegible]

**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										
<b>1b Sub-Total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>								9,724,656	4,128,632	1,348,569

**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 ▶ 438

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
EVANSVILLE SURGERY CENTER PO BOX 2185 EVANSVILLE, IN 47728	SURGICAL SERVICES	29,915,061
PROGRESSIVEHEALTH OF INDIANA 150 N ROSENBERGER AVE EVANSVILLE, IN 47712	PHYSICAL THERAPY	16,516,316
TRI STATE RADIATION ONCOLOGY 700 N BURKHARDT AVE EVANSVILLE, IN 47715	RADIATION & ONCOLOGY SERVICES	15,615,460
ORTHOALIGN LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630	MEDICAL SERVICES	14,347,979
EVOLANT 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 ▶ 381



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	260,729		
	d	Related organizations	1d			
	e	Government grants (contributions)	1e	16,835,600		
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	637,300		
	g	Noncash contributions included in lines 1a - 1f:\$	1g	40,327		
	h	Total. Add lines 1a-1f . . . . . ▶		17,733,629		
	Program Service Revenue	2a	NET PATIENT REVENUE	Business Code 900099	1,109,634,063	1,109,634,063
b						
c						
d						
e						
f		All other program service revenue.				
g		Total. Add lines 2a-2f. . . . . ▶		1,109,634,063		
Other Revenue		3	Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		14,499,623	
	4	Income from investment of tax-exempt bond proceeds ▶				
	5	Royalties . . . . . ▶				
	6a	Gross rents	(i) Real 10,972,167	(ii) Personal		
	b	Less: rental expenses	5,729,021			
	c	Rental income or (loss)	5,243,146			
	d	Net rental income or (loss) . . . . . ▶		5,243,146		5,243,146
	7a	Gross amount from sales of assets other than inventory	(i) Securities 1,819,263,594	(ii) Other		
	b	Less: cost or other basis and sales expenses	1,603,185,269	1,103		
	c	Gain or (loss)	216,078,325	-1,103		
	d	Net gain or (loss) . . . . . ▶		216,077,222		216,077,222
	8a	Gross income from fundraising events (not including \$ 260,729 of contributions reported on line 1c). See Part IV, line 18 . . . . .	8a	33,900		
	b	Less: direct expenses . . . . .	8b	124,097		
	c	Net income or (loss) from fundraising events . . . ▶		-90,197		-90,197
	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	41,018,684	41,018,684		
b	OTHER HOSPITAL SERVICES	900099	29,587,093	14,266,635	15,320,458	
c	LABORATORY SALES	621500	12,969,501		12,969,501	
d	All other revenue . . . . .		3,463,438		3,451,469	
e	Total. Add lines 11a-11d . . . . . ▶		87,038,716		11,969	
12	Total revenue. See instructions . . . . . ▶		1,450,136,202	1,164,919,382	16,420,970	251,062,221

**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 ☒

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	1,696,764	1,696,764		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .				
<b>4</b> Benefits paid to or for members . . . . .				
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	5,550,805		5,550,805	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .				
<b>7</b> Other salaries and wages . . . . .	338,105,248	307,094,463	30,789,410	221,375
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	12,739,966	11,278,428	1,461,538	
<b>9</b> Other employee benefits . . . . .	65,849,819	55,209,943	10,639,876	
<b>10</b> Payroll taxes . . . . .	21,630,037	19,507,129	2,122,908	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .				
<b>b</b> Legal . . . . .	418,828	390	418,438	
<b>c</b> Accounting . . . . .	38,970		38,970	
<b>d</b> Lobbying . . . . .	91,455		91,455	
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees . . . . .	2,267,503		2,267,503	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	150,762,331	140,154,156	10,575,115	33,060
<b>12</b> Advertising and promotion . . . . .	1,053,320	25,386	1,027,934	
<b>13</b> Office expenses . . . . .	11,979,309	10,569,457	1,382,166	27,686
<b>14</b> Information technology . . . . .	19,531,227	11,686,626	7,844,601	
<b>15</b> Royalties . . . . .				
<b>16</b> Occupancy . . . . .	14,249,497	8,333,953	5,915,544	
<b>17</b> Travel . . . . .	258,439	203,736	54,703	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .				
<b>19</b> Conferences, conventions, and meetings . . . . .	138,000	86,733	50,599	668
<b>20</b> Interest . . . . .	11,279,949	6,660,479	4,619,470	
<b>21</b> Payments to affiliates . . . . .				
<b>22</b> Depreciation, depletion, and amortization . . . . .	51,667,726	33,259,886	18,407,791	49
<b>23</b> Insurance . . . . .	5,117,461	4,107,552	1,009,909	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL/SURGICAL SUPPLI	221,585,134	222,294,470	-709,336	
<b>b</b> MEDICAID ASSESSMENT FEE	39,736,645	39,736,645		
<b>c</b> EQUIP RENTAL/MAINTENANC	24,303,133	18,166,668	6,136,465	
<b>d</b> DUES & SUBSCRIPTIONS	854,048	345,704	480,270	28,074
<b>e</b> All other expenses	53,827,441	38,499,699	15,257,911	69,831
<b>25</b> Total functional expenses. Add lines 1 through 24e	1,054,733,055	928,918,267	125,434,045	380,743
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year	
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .			<b>1</b>		
	<b>2</b>	Savings and temporary cash investments . . . . .		222,180,059	<b>2</b>	229,670,204	
	<b>3</b>	Pledges and grants receivable, net . . . . .			<b>3</b>		
	<b>4</b>	Accounts receivable, net . . . . .		144,630,180	<b>4</b>	178,461,608	
	<b>5</b>	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 . . . . .			<b>5</b>		
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .			<b>6</b>		
	<b>7</b>	Notes and loans receivable, net . . . . .		1,785,214	<b>7</b>	1,576,444	
	<b>8</b>	Inventories for sale or use . . . . .		8,511,488	<b>8</b>	9,859,049	
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		14,069,480	<b>9</b>	16,389,635	
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b>	1,105,731,524			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b>	610,240,447	493,860,563	<b>10c</b>	495,491,077
	<b>11</b>	Investments—publicly traded securities . . . . .		844,580,684	<b>11</b>	1,073,492,234	
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		55,478,236	<b>12</b>	56,288,309	
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>		
	<b>14</b>	Intangible assets . . . . .		48,206,614	<b>14</b>	48,218,553	
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		87,917,879	<b>15</b>	124,718,932	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .		1,921,220,397	<b>16</b>	2,234,166,045		
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		100,455,955	<b>17</b>	107,353,783	
	<b>18</b>	Grants payable . . . . .			<b>18</b>		
	<b>19</b>	Deferred revenue . . . . .		1,600,383	<b>19</b>	1,759,250	
	<b>20</b>	Tax-exempt bond liabilities . . . . .		288,892,997	<b>20</b>	281,980,796	
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>		
	<b>22</b>	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 . . . . .			<b>22</b>		
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .			<b>23</b>		
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>		
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		313,040,576	<b>25</b>	248,669,735	
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		703,989,911	<b>26</b>	639,763,564	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>						
	<b>27</b>	Net assets without donor restrictions . . . . .		1,211,096,598	<b>27</b>	1,587,995,646	
	<b>28</b>	Net assets with donor restrictions . . . . .		6,133,888	<b>28</b>	6,406,835	
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>						
	<b>29</b>	Capital stock or trust principal, or current funds . . . . .			<b>29</b>		
	<b>30</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>30</b>		
	<b>31</b>	Retained earnings, endowment, accumulated income, or other funds			<b>31</b>		
	<b>32</b>	<b>Total net assets or fund balances</b> . . . . .		1,217,230,486	<b>32</b>	1,594,402,481	
<b>33</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		1,921,220,397	<b>33</b>	2,234,166,045		

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,450,136,202
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,054,733,055
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	395,403,147
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	1,217,230,486
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-18,231,152
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	1,594,402,481

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☒

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

# Additional Data

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

Form 990 (2020)

**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.

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

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

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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	33.00 ..... 24.00	X		X				1,287,715	447,940	260,327
DR LINDA BENNETT ..... VICE CHAIRMAN	3.00 ..... 2.00	X						0	0	0
DANIEL HERMANN ..... CHAIRMAN	3.00 ..... 2.00	X						0	10,200	0
SHARON REED WALKER ..... TREASURER	3.00 ..... 2.00	X						0	0	0
DAVE PAPARIELLA ..... SECRETARY	3.00 ..... 2.00	X						0	0	0
MAQBOOL AHMED MD ..... DIRECTOR	3.00 ..... 52.00	X						360	995,877	18,046
CURTIS BEGLE ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
JEROME BENKERT JR ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
SCOTT CORDTS MD ..... DIRECTOR	53.00 ..... 2.00	X						338,561	5,200	43,308
LEAH CURRY ..... 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			
MIA HINDI MD ..... DIRECTOR	3.00 ..... 52.00	X						15,500	1,499,442	41,045
TERI HOLLANDER ALBIN ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
ANTHONY KAISER MD ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
LARRY KILINSKI MD ..... DIRECTOR	3.00 ..... 52.00	X						59,478	0	0
KEVIN KOCH ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
RONALD ROCHON MD ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
JAMES RYAN III ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
ERIC SCHACH ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
JONATHAN WEINZAPFEL ..... DIRECTOR	3.00 ..... 2.00	X						0	0	0
CHERYL WATHEN ..... CHIEF FINANCIAL OFFICER	30.00 ..... 26.00			X				514,828	275,191	179,947

**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			
JAMES PORTER MD ..... PRESIDENT OF DEACONESS HEALTH SYSTEM	50.00 ..... 3.00			X				1,122,932	4,091	189,162
CHERONA HAJEWSKI ..... CHIEF NURSING OFFICER	50.00 ..... 0.00			X				569,623	0	111,714
LYNN LINGAFELTER ..... CHIEF OPERATION OFFICER	50.00 ..... 5.00			X				672,051	56,152	147,424
JOANN WOOD MD ..... CHIEF MEDICAL OFFICER	50.00 ..... 3.00			X				133,600	22,500	22,198
MARC FLORENCE ..... VICE PRESIDENT	50.00 ..... 8.00			X				436,801	73,545	114,628
BRADLEY SCHEU MD ..... VICE PRESIDENT	2.00 ..... 53.00			X				6,248	566,054	54,498
JENNIFER CHIOUSANO ..... CHIEF NURSING OFFICER	50.00 ..... 0.00			X				0	0	0
RAGHAV GUPTA MD ..... ANESTHESIOLOGIST	50.00 ..... 0.00					X		1,087,862	0	35,118
VENKATESH MADADI MD ..... ANESTHESIOLOGIST	50.00 ..... 0.00					X		983,093	0	44,959
PAUL MICK MD ..... ANESTHESIOLOGIST	50.00 ..... 0.00					X		967,734	0	26,659

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			
RAJESH PATEL MD ..... ANESTHESIOLOGIST	50.00 ..... 0.00					X		761,478	0	30,511
MARK MURRAY MD ..... ANESTHESIOLOGIST	50.00 ..... 0.00					X		758,497	0	21,564
LINDA WHITE ..... FORMER CEO EMERITA, FOUNDATION EXEC. DIRECTOR	30.00 ..... 30.00						X	8,295	172,440	7,461

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

OMB No. 1545-0047

2020

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 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations . . . . .
- g Provide the following information about the supported organization(s).

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

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

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge..						
<b>4 Total.</b> Add lines 1 through 3						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . .						
<b>6 Public support.</b> Subtract line 5 from line 4.						
Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>7</b> Amounts from line 4. . .						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13 First 5 years.</b> 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 <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage						
<b>14</b> Public support percentage for 2020 (line 6, column (f) divided by line 11, column (f)) . . . . .					<b>14</b>	
<b>15</b> Public support percentage for 2019 Schedule A, Part II, line 14 . . . . .					<b>15</b>	
<b>16a 33 1/3% support test—2020.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>						
<b>b 33 1/3% support test—2019.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>						
<b>17a 10%-facts-and-circumstances test—2020.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>						
<b>b 10%-facts-and-circumstances test—2019.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>						
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ <input type="checkbox"/>						

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
<b>c</b> Add lines 7a and 7b. .						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>9</b> Amounts from line 6. . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b> Add lines 10a and 10b.						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) . .						
<b>14 First 5 years.</b> 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 <b>stop here.</b> . . . . . ► <input type="checkbox"/>						

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

<b>15</b> Public support percentage for 2020 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

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

<b>17</b> Investment income percentage for <b>2020</b> (line 10c, column (f) divided by line 13, column (f)) . . . . .	<b>17</b>	
<b>18</b> Investment income percentage from <b>2019</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	

**19a 33 1/3% support tests—2020.** 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—2019.** 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 box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

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

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 lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described in 11a above?		
c A 35% controlled entity of a person described in line 11a or 11b above? If "Yes" to 11a, 11b, or 11c, provide detail in Part VI.		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the officers, 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.		
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.		

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).		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer lines 2a and 2b below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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.		
b Did the activities described in line 2a 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.		
3 Parent of Supported Organizations. Answer lines 3a and 3b 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? If "Yes" or "No" provide details in Part VI.		
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.		



<b>Part V</b> <b>Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations</b>			
<b>1</b> <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 ( <i>explain in <b>Part VI</b></i> ). <b>See instructions.</b> All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in <b>Part VI</b></i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	8
9	Distributable amount for 2020 from Section C, line 6	9
10	Line 8 amount divided by Line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
1	Distributable amount for 2020 from Section C, line 6		
2	Underdistributions, if any, for years prior to 2020 (reasonable cause required-- explain in Part VI). See instructions.		
3	Excess distributions carryover, if any, to 2020:		
a	From 2015. . . . .		
b	From 2016. . . . .		
c	From 2017. . . . .		
d	From 2018. . . . .		
e	From 2019. . . . .		
f	Total of lines 3a through e		
g	Applied to underdistributions of prior years		
h	Applied to 2020 distributable amount		
i	Carryover from 2015 not applied (see instructions)		
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.		
4	Distributions for 2020 from Section D, line 7: \$		
a	Applied to underdistributions of prior years		
b	Applied to 2020 distributable amount		
c	Remainder. Subtract lines 4a and 4b from line 4.		
5	Remaining underdistributions for years prior to 2020, 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 2020. 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 2021. Add lines 3j and 4c.		
8	Breakdown of line 7:		
a	Excess from 2016. . . . .		
b	Excess from 2017. . . . .		
c	Excess from 2018. . . . .		
d	Excess from 2019. . . . .		
e	Excess from 2020. . . . .		

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

Facts And Circumstances Test

**SCHEDULE C**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

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

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

OMB No. 1545-0047

**2020**

**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 DEACONESS HOSPITAL INC	Employer identification number 35-0593390
--	--

**Part I-A**

**Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

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

**Part I-B**

**Complete if the organization is exempt under section 501(c)(3).**

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

<b>1</b>	Enter the amount directly expended by the filing organization for section 527 exempt function activities	▶ \$
<b>2</b>	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	▶ \$
<b>3</b>	Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b	▶ \$
<b>4</b>	Did the filing organization file <b>Form 1120-POL</b> for this year?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>5</b>	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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....		
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....		
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....		
<b>d</b> Other exempt purpose expenditures .....		
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....		
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>	
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.	
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....		
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....		
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....		
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? .....	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	

**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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
<b>a</b>	Volunteers? .....		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? .....		No	
<b>c</b>	Media advertisements? .....		No	
<b>d</b>	Mailings to members, legislators, or the public? .....		No	
<b>e</b>	Publications, or published or broadcast statements? .....		No	
<b>f</b>	Grants to other organizations for lobbying purposes? .....		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body? .....		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		No	
<b>i</b>	Other activities? .....	Yes		12,000
<b>j</b>	Total. Add lines 1c through 1i .....			12,000
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? .....			

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

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

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

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

**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.

SCHEDULE D  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2020

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 FASB 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 FASB 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 FASB ASC 958 relating to these items:

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

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

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

Cat. No. 52283D

Schedule D (Form 990) 2020

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

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 . . . .

☐

b

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

	Amount
1c	
1d	
1e	
1f	

1c

Beginning balance . . . . .

1d

Additions during the year . . . . .

1e

Distributions during the year . . . . .

1f

Ending balance . . . . .

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 . . . . .	8,745,525	8,037,280	7,914,040	7,389,906	6,877,438
b	Contributions . . . . .	1,100	1,075	1,075	120	1,200
c	Net investment earnings, gains, and losses	1,041,502	867,885	195,423	606,614	705,719
d	Grants or scholarships . . . . .					
e	Other expenditures for facilities and programs . . . . .	154,521	160,715	73,258	82,600	194,451
f	Administrative expenses . . . . .					
g	End of year balance . . . . .	9,633,606	8,745,525	8,037,280	7,914,040	7,389,906

2

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

a

Board designated or quasi-endowment ▶ 13.000 %

b

Permanent endowment ▶ 87.000 %

c

Term endowment ▶

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

3a

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

(i) Unrelated organizations . . . . .

(ii) Related organizations . . . . .

b

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

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

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value	
1a	Land . . . . .	6,328,718	17,787,616	24,116,334	
b	Buildings . . . . .	54,284,953	693,634,273	391,285,853	356,633,373
c	Leasehold improvements				
d	Equipment . . . . .		296,088,442	218,954,594	77,133,848
e	Other . . . . .		37,607,522		37,607,522
Total.	Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				495,491,077



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 _____		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
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)		
(10)		
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) RELATED ORGANIZATION RECEIVABLES	76,712,324
(2) OTHER ASSETS	16,619,729
(3) RIGHT OF USE ASSET	31,386,879
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) . . . . . ▶	124,718,932

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	80,606,365
(3) RELATED ORGANIZATION PAYABLES	4,102,458
(4) TAXABLE BOND- SERIES 2016	48,300,000
(5) DEBT ISSUE COSTS	-128,957
(6) RIGHT OF USE ASSETS	31,419,150
(7) MEDICARE ADVANCED FUNDING	77,544,186
(8) CARES ACT LIABILITY	38,311
(9) ESTIMATED THIRD PARTY SETTLEMENT	6,788,222
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	248,669,735

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

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.**

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.**

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

**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 SYSTEM AND RECOGNIZE A TAX LIABILITY IF THE SYSTEM 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 SYSTEM AND HAS CONCLUDED THAT AS OF SEPTEMBER 30, 2021 AND 2020, 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 SYSTEM 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.

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

1. (a) Description of Liability	(b) Book Value
ACCRUED RETIREMENT BENEFITS	80,606,365
RELATED ORGANIZATION PAYABLES	4,102,458
TAXABLE BOND- SERIES 2016	48,300,000
DEBT ISSUE COSTS	-128,957
RIGHT OF USE ASSETS	31,419,150
MEDICARE ADVANCED FUNDING	77,544,186
CARES ACT LIABILITY	38,311
ESTIMATED THIRD PARTY SETTLEMENT	6,788,222





**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.

Revenue		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		<u>DH PARTY OF YR</u> (event type)	<u>DH CLASSIC</u> (event type)	(total number)	(add col. (a) through col. (c))
Revenue	<b>1</b> Gross receipts . . . . .	164,514	130,115		294,629
	<b>2</b> Less: Contributions . . . . .	146,114	114,615		260,729
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	18,400	15,500		33,900
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .		5,985		5,985
	<b>6</b> Rent/facility costs . . . . .	10,834	27,577		38,411
	<b>7</b> Food and beverages . . . . .	20,461	273		20,734
	<b>8</b> Entertainment . . . . .	17,100	1,570		18,670
	<b>9</b> Other direct expenses . . . . .	17,147	23,150		40,297
	<b>10</b> Direct expense summary. Add lines 4 through 9 in column (d) . . . . . ▶				124,097
	<b>11</b> Net income summary. Subtract line 10 from line 3, column (d) . . . . . ▶				-90,197

**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.

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col.(a) through col.(c))
Direct Expenses	<b>1</b> Gross revenue . . . . .				
	<b>2</b> Cash prizes . . . . .				
	<b>3</b> Noncash prizes . . . . .				
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .				
	<b>6</b> Volunteer labor . . . . .	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	<b>7</b> Direct expense summary. Add lines 2 through 5 in column (d) . . . . . ▶				
	<b>8</b> 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>11</b>	Does the organization conduct gaming activities with nonmembers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>12</b>	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>13</b>	Indicate the percentage of gaming activity conducted in:		
<b>a</b>	The organization's facility	<b>13a</b>	%
<b>b</b>	An outside facility	<b>13b</b>	%
<b>14</b>	Enter the name and address of the person who prepares the organization's gaming/special events books and records:		
	Name ► .....		
	Address ► .....		
<b>15a</b>	Does the organization have a contract with a third party from whom the organization receives gaming revenue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>b</b>	If "Yes," enter the amount of gaming revenue received by the organization ► \$ ..... and the amount of gaming revenue retained by the third party ► \$ .....		
<b>c</b>	If "Yes," enter name and address of the third party:		
	Name ► .....		
	Address ► .....		
<b>16</b>	Gaming manager information:		
	Name ► .....		
	Gaming manager compensation ► \$ .....		
	Description of services provided ► .....		
	<input type="checkbox"/> Director/officer	<input type="checkbox"/> Employee	<input type="checkbox"/> Independent contractor
<b>17</b>	Mandatory distributions:		
<b>a</b>	Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>b</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](http://www.irs.gov/Form990EZ) for instructions and the latest information.

OMB No. 1545-0047

2020

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

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) . . . . .			13,320,785		13,320,785	1.260 %
b Medicaid (from Worksheet 3, column a) . . . . .			205,393,987	162,917,887	42,476,100	4.030 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d Total Financial Assistance and Means-Tested Government Programs . . . . .			218,714,772	162,917,887	55,796,885	5.290 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			1,015,465	0	1,015,465	0.100 %
f Health professions education (from Worksheet 5) . . . . .			9,438,012	2,469,784	6,968,228	0.660 %
g Subsidized health services (from Worksheet 6) . . . . .			272,381	4,943	267,438	0.030 %
h Research (from Worksheet 7) . . . . .			0	0		
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			2,408,074	44,526	2,363,548	0.220 %
j Total. Other Benefits . . . . .			13,133,932	2,519,253	10,614,679	1.010 %
k Total. Add lines 7d and 7j . . . . .			231,848,704	165,437,140	66,411,564	6.300 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development			10,000		10,000	0 %
<b>3</b> Community support			26,160		26,160	0 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members			5,000		5,000	0 %
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development			16,890		16,890	0 %
<b>9</b> Other						
<b>10 Total</b>			58,050		58,050	0 %

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. . . . .	<b>2</b>	10,951,935	
<b>3</b> 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. . . . .	<b>3</b>		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME) . . . . .	<b>5</b>	242,171,297	
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	<b>6</b>	221,305,096	
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	<b>7</b>	20,866,201	
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:			
<input type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input checked="" type="checkbox"/> Other	

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year? . . . . .	<b>9a</b>	Yes	
<b>b</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 . . . . .	<b>9b</b>	Yes	

**Part IV Management Companies and Joint Ventures**

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**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?

3

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)  
DEACONESS HOSPITAL INC**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**1****Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

DEACONESS HOSPITAL INC			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input checked="" type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): SEE PART V			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): SEE PART V			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> 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
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

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

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

DEACONESS HOSPITAL INC

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

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

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

2

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C. . . . .	<b>6b</b>	Yes
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

DEACONESS GATEWAY HOSPITAL			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input checked="" type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): SEE PART V			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): SEE PART V			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> 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
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

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

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

DEACONESS GATEWAY HOSPITAL

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

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**

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

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

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

3

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	No
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .	<b>2</b>	No
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	Yes
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>HTTP://WWW.DEACONESS.COM/CHNA</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

DEACONESS CROSS POINTE			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input checked="" type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): SEE PART V			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): SEE PART V			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): SEE PART V			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> 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
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

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

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

DEACONESS CROSS POINTE

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

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

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

[illegible]

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 31

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 <a href="http://www.deaconess.com/chna">HTTP://WWW.DEACONESS.COM/CHNA</a>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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 \$2,960.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F):	BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING PERCENTAGE IN THIS COLUMN IS \$0.00.



**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.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 2:	<p>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.</p>

## 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.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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 11 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 2021 MEDICARE COST REPORT.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3:	<p>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 <a href="https://www.deaconess.com/for-you/patients-and-visitors/patients/financial-assistance">WWW.DEACONESS.COM</a>. <a href="https://www.deaconess.com/for-you/patients-and-visitors/patients/financial-assistance">HTTPS://WWW.DEACONESS.COM/FOR-YOU/PATIENTS-AND-VISITORS/PATIENTS/FINANCIAL-ASSISTANCE</a>. 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.</p>



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 4:	<p>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 180,136 PERSONS IS SIMILAR TO THE STATEWIDE POPULATION, WITH ABOUT 80.6% OF THE POPULATION BEING WHITE, 9.8% BLACK/AFRICAN AMERICAN, 1.4% ASIAN, AND THE REMAINDER BEING OF OTHER OR 2 OR MORE RACES. HOWEVER, VANDERBURGH COUNTY REPORTS A 3.5% HISPANIC POPULATION COMPARED TO 8.2% 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 2021 COUNTY HEALTH RANKINGS, VANDERBURGH COUNTY RANKS 82 OUT OF 92 INDIANA COUNTIES FOR HEALTH OUTCOMES AND 47 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 9 OUT OF 92 INDIANA COUNTIES FOR HEALTH OUTCOMES AND 6 OUT OF 92 INDIANA COUNTIES FOR HEALTH FACTORS ON THE 2021 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 90% OF PEOPLE THERE IDENTIFY AS WHITE COMPARED TO 77% FOR INDIANA. ONLY 1.7% OF THE POPULATION IS LISTED AS BLACK/AFRICAN AMERICAN AND 2.2% AS HISPANIC. THAT'S COMPARED TO STATE AVERAGES OF 9.6% AND 8.2% RESPECTIVELY. WARRICK COUNTY IS ALSO MORE RURAL THAN THE AVERAGE INDIANA COUNTY (29.3% RURAL IN WARRICK COUNTY COMPARED TO 27.6% STATE AVERAGE).</p>

Form and Line Reference	Explanation
PART VI, LINE 5:	<p>THE COVID-19 PANDEMIC WAS PRIMARY PRIORITY AND THE CONSTANT CONCERN THROUGHOUT THE YEAR AS WE PERSEVERED THROUGH TWO SIGNIFICANT COVID-19 WAVES, RECORD PATIENT ADMISSIONS AND TRANS FERS, AND A HISTORIC VACCINATION EFFORT. DEACONESS CONTINUED TO LEAD THE COVID-19 RESPONSE FOR SOUTHWEST INDIANA AND NEIGHBORING COUNTIES IN KENTUCKY AND ILLINOIS.THE PUBLIC AND BU SINESSES TRUSTED US AS WE SHARED THE MOST CURRENT INFORMATION ABOUT COVID INPATIENT NUMBER S, TESTING, VACCINES, AND THE CONSTANTLY CHANGING REGULATIONS. AND OUR COPING WEBPAGE THAT LINKED PEOPLE TO A VARIETY OF RESOURCES ABOUT MENTAL AND EMOTIONAL HEALTH CONTINUED TO BE A RESOURCE USED BY THE PUBLIC.COVID-19 VACCINES (FIRST PFIZER, VIA EMERGENCY USE AUTHORIZ ATION, BECAME AVAILABLE TO HEALTHCARE WORKERS IN MID-DECEMBER, AND MORE THAN 600 FRONTLINE EMPLOYEES GETTING VACCINATED ON THE FIRST DAY THEY BECAME AVAILABLE. THOUSANDS MORE EMPLO YEES RECEIVED THEIR FIRST DOSE BEFORE THE END OF THE YEAR. MULTIPLE PUBLIC VACCINATION SIT ES WERE CREATED IN AN EFFORT TO MEET DEMAND, AND EMPLOYEES FROM ALL OVER THE SYSTEM STEPPE D IN TO ASSIST. ONLINE SCHEDULES FILLED QUICKLY AND WAIT LISTS WERE CREATED FOR "EXTRA DOS ES" AT THE END OF THE DAY. BY THE END OF MARCH 2021, DEACONESS HAD GIVEN 100,000 DOSES. IN ADDITION TO THE VACCINE SITES, OUR DRIVE-THRU TEST SITES REMAINED BUSY DURING THE WAVES, AS DEACONESS REGIONAL LAB PROCESSED 232,096 PCR TESTSTHE HIGHEST ONE-DAY TESTING NUMBER WA S 1,514. MONOCLONAL ANTIBODY TREATMENT CONTINUED TO BE AVAILABLE FOR THOSE AT HIGH-RISK OF HOSPITALIZATION WITH MORE THAN 4,000 INFUSIONS BEING GIVEN THROUGHOUT THE YEAR.ADDITIONAL LY, WE CREATED AND DISTRIBUTED WRITTEN AND VISUAL CONTENT THAT ADDRESSED SPECIFIC ISSUES A ND CONCERNS OUR COMMUNITY HAD REGARDING COVID-19.E-NEWSLETTER ARTICLES:FEBRUARY 2021: -COV ID-19 VACCINE: FREQUENTLY ASKED QUESTIONS-PARENTING A NEW BABY IN THE PANDEMICJULY 2021: - COVID-19 VARIANTS AND VACCINESAUGUST 2021:-CHILDREN AND THE COVID-19 VACCINESEPT 2021:-IF I'VE ALREADY HAD COVID, WHY SHOULD I GET VACCINATED?SOCIAL MEDIA POSTS:10/16/2020 - DR. BR AD SCHEU ON COVID-19 AND THE FLU11/3/2020 - FB LIVE: COVID-19 UPDATE WITH DR. JAMES PORTER AND DR. DAVID RYON11/9/2020 - DO YOUR PART: AREA HEALTHCARE PROVIDERS CALL ON PEOPLE TO M ASK UP AND SOCIAL DISTANCE11/16/2020 - DR. GINA HUHNKE DISCUSSES THE SERIOUSNESS OF COVID-1911/18/2020 - DO YOUR PART: AREA HEALTHCARE PROVIDERS CALL ON PEOPLE TO MASK UP AND SOCIA L DISTANCE 11/21/2020 - AN IMPORTANT MESSAGE FROM DEACONESS COVID-19 FRONTLINE WORKERS11/2 3/2020 - FB LIVE: COVID-19 UPDATE WITH SHAWN MCCOY AND DR. BRAD SCHEU11/30/2020 - DO YOUR PART: AREA HEALTHCARE PROVIDERS CALL ON PEOPLE TO MASK UP AND SOCIAL DISTANCE12/3/2020 - D O YOUR PART: AREA HEALTHCARE PROVIDERS CALL ON PEOPLE TO MASK UP AND SOCIAL DISTANCE12/3/2 020 - DO YOUR PART: AREA HEALTHCARE PROVIDERS CALL ON PEOPLE TO MASK UP AND SOCIAL DISTANC E12/15/2020 - FB LIVE: COVID-19 UPDATE WITH DR. JAMES PORTER AND JEFF STARKEY, PHARMD12/22 /2020 - FB LIVE: COVID-19 UPDATE WITH DR. JAMES PORTER AND ANNA GIBSON, PHARMD1/18/2020 - DR. BRAD SCHEU EXPLAINS WHY HE CHOSE TO GET THE COVID-19 VACCINE2/3/2021 - FB LIVE: COVID- 19 UPDATE WITH DR. JAMES PORTER AND JEFF STARKEY, PHARMD 2/17/2021 - DR. SARAH RUST DISCUS SES PARENTING NEWBORNS DURING A PANDEMIC2/23/2021 - DR. GINA HUHNKE DISCUSSES MONOCLONAL A NTIBODIES AND TREATMENT2/25/2021 - FB LIVE: COVID-19 UPDATE WITH DR. JAMES PORTER AND DR. APRIL ABBOTT 3/9/2021 - DR. BRAD SCHEU DISCUSSES THE IMPORTANCE OF SCHEDULING HEALTH SCREE NINGS DURING THE PANDEMIC4/1/2021 - DR. BRAD SCHEU TALKS ABOUT VACCINATIONS IN YOUNG ADULT S4/21/2021 - DR. BRAD SCHEU TALKS ABOUT THE IMPORTANCE OF WEARING MASKS WHILE AT DEACONESS FACILITIES6/10/2021 - DR. JAMES PORTER TALKS ABOUT SCHEDULING AND MAINTAINING HEALTH SCRE ENINGS DURING THE PANDEMIC7/17/2021 - FB LIVE: COVID VACCINE AND CHILDREN 12+ PANEL DISCUS SION WITH DR. JAMES PORTER, DR. MAJED KOLEILAT, DR. GARRET KOON AND DR. CAPRI WEYER7/12/20 21 - COVID-19 VACCINE UPDATE WITH DR. BRAD SCHEU8/3/2021 - FB LIVE: COVID-19 UPDATE PANEL DISCUSSION WITH DR. JAMES PORTER, DR. BRAD SCHEU, DR. APRIL ABBOTT AND BRIAN SPENCER, PHAR MD 8/18/2021 - DR. GINA HUHNKE ON VISITING THE ER DURING THE COVID-19 SURGE8/24/2021 - DR. MATT GILBERT DISCUSSES VISITING THE ER DURING THE COVID-19 SURGESCREENING MAMMOGRAMS VIA MOBILE BREAST CENTER:2020 - NUMBER SCREENEDOCTOBER - 317NOVEMBER - 234DECEMBER - 2042021 - NUMBER SCREENEDJANUARY - 101FEBRUARY - 114MARCH - 152APRIL - 164MAY - 161JUNE - 177JULY - 257AUGUST - 243SEPTEMBER - 211PATIENT CARE:-MEDICATION ASSISTANCE AND FAMILY MEDICINE RES IDENCY CLINIC; DEACONESS PROVIDES FREE AND REDUCED CARE WITHIN OUR HOSPITAL BUILDINGS. THR OUGH OUR MEDICATION ASSISTANCE PROGRAM (MAP) AND OUR FAMILY PRACTICE RESIDENCY CLINIC, PAT IENTS CAN ACCESS THE HIGH QUALITY HEALTH CARE THEY NEED IN CONVENIENT LOCATIONS AND AT A P RICE THEY CAN AFFORD. IN FY20-21, OUR RESIDENTS TREATED MORE THAN 17,000 PATIENTS AT A COS T TO THE HOSPITAL OF \$2.7 MILLION. SIMILARLY, THE</p>

Form and Line Reference	Explanation
PART VI, LINE 5:	<p>MAP SERVICED 2,235 INDIVIDUALS FOR 3,688 UNIQUE MEDICATIONS/PRESCRIPTIONS PROVIDED AT A TO TAL DOLLAR VALUE OF MORE THAN \$66.5 MILLION IN FREE DRUGS TO PATIENTS. AN ADDITIONAL \$417, 702 IN COPAY/FOUNDATION ASSISTANCE WAS ALSO PROVIDED.-BEHAVIORAL HEALTH AND SUICIDE PREVEN TION; STAFF FROM DEACONESS CROSS POINTE EDUCATED OVER 14,000 PEOPLE IN THE SURROUNDING COM MUNITY ABOUT BEHAVIORAL HEALTH, RELATED RESOURCES, AND SUICIDE PREVENTION.LOCAL SPONSORSHI PS:IN FY20-21, DEACONESS SPONSORED PROGRAMS AND ACTIVITIES FOR MORE THAN 170,000 PEOPLE, C ONTRIBUTING \$1.4 MILLION IN SUPPORT OF CLUBS, GROUPS, SOCIAL SERVICE ORGANIZATIONS, AND OT HERS STRIVING TO MAKE OUR COMMUNITY A BETTER PLACE.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 6:	<p>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.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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

[illegible]

**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.	<p>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 INCLUSION OF INDIVIDUALS WHO DIRECTLY OR INDIRECTLY REPRESENTED THE NEEDS OF THREE IMPORTANT GROUPS: 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 SERVED BY THE HOSPITAL, AND 3) THE BROADER COMMUNITY AT LARGE AND THOSE WHO REPRESENT THE BROAD INTERESTS AND NEEDS OF THE COMMUNITY SERVED. KEY PARTNER ORGANIZATIONS INCLUDED: -THE UNIVERSITY 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 OF PUBLIC HEALTH. FACULTY AND STUDENTS COLLABORATED WITH THE HOSPITAL THROUGHOUT THE SURVEY PROCESS. -INDIANA UNIVERSITY CENTER FOR SURVEY RESEARCH. FACULTY AND STAFF PROVIDED IN- DEPTH TECHNICAL ASSISTANCE AND GUIDANCE THROUGHOUT THE SURVEY PROCESS, AND WORKED CLOSELY WITH THE HOSPITALS AND THE UNIVERSITY OF EVANSVILLE TO FIELD THE COMMUNITY HEALTH SURVEY. SURVEY PROCESS AND METHODS - 8 KEY PARTNER ORGANIZATIONS -MEASURES MATTER, LLC. MEASURES MATTER IS A COMMUNITY-BASED RESEARCH CONSULTING FIRM BASED IN BLOOMINGTON, INDIANA AND PALM SPRINGS, CALIFORNIA. MEASURES MATTER CONDUCTED AN INDEPENDENT ANALYSIS OF THE SURVEY DATA AND ALSO FACILITATED THE PRIORITIZATION PROCESS WITH THE HOSPITAL AND ITS PARTNERS. -COUNTY HEALTH DEPARTMENTS. REPRESENTATIVES OF THE VANDERBURGH COUNTY HEALTH DEPARTMENT WERE PARTNERS 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. ADDITIONALLY, GIVEN THAT THE SURVEY PROCESS WAS COORDINATED IN CONJUNCTION WITH MULTIPLE OTHER HOSPITAL SYSTEMS AND LOCAL ORGANIZATIONS THROUGHOUT THE STATE, OTHER HEALTH DEPARTMENTS INVOLVED IN THE PROCESS INCLUDED THOSE FROM TIPPECANOE, CLAY, FOUNTAIN, WARREN, HOWARD, JENNINGS, 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, DEACONESS LISA MEYER, ST. VINCENT EVVASHLEY TENBARGE, ST. VINCENT EVVLORI GRIMM, DEACONESS THE WOMEN'S HOSPITAL DR. KEN SPEAR, VANDERBURGH COUNTY HEALTH DEPARTMENT JILL BUTTRY, DEACONESS ANDREA HAYS, WELBORN BAPTIST FOUNDATION AMY CANTERBURY, UNITED WAY OF SWIDR. CHAD PERKINS, ST. VINCENT EVVSANDEE STRADER-MCMILLEN, ECHO HEALTH PAM HIGHT, DEACONESS JANET RAISOR, ST. VINCENT EVVDR. MARIA DEL</p>

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

Form and Line Reference	Explanation
DEACONESS HOSPITAL, INC.	RIO HOOVER, ST. VINCENT EVVSABRINA JONES, ST. VINCENT EVVSCOTT BRANAM, DEACONESS CROSS POI NTEASHLEY JOHNSON, DEACONESSJENNA ALVIA ST. VINCENT WARRICKDR. CARRIE ANN LAWRENCE, IU SCH OOL OF 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.	
<b>Section C. Supplemental Information for Part V, Section B.</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
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.	
<b>Section C. Supplemental Information for Part V, Section B.</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).

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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.

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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
DEACONESS HOSPITAL, INC.	<p>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 2020-2021, SPECIAL ATTENTION CONTINUED TO BE FOCUSED ON FOOD INSECURITY WITH PARTNERSHIPS WITH THE FEED EVANSVILLE, PROMISE ZONE, URBAN SEEDS, AND THE JUNIOR LEAGUE OF EVANSVILLE, AND A 5-YEAR \$500,000 PLEDGE TO SUPPORT THE TRI-STATE FOOD BANK. RELATED TO SUBSTANCE ABUSE, THE WOMEN'S HOSPITAL CONTINUED TO SCREEN PREGNANT WOMEN AT PRESENTATION FOR DELIVERY USING THE SPS 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 CONTINUED TO USE ITS PUBLIC-FACING WEBPAGE, WHICH WAS CREATED IN EARLY 2020 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 CONTINUED PROVIDING 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. WHILE AN ANALYSIS OF COUNTY-WIDE TRANSPORTATION ISSUES CONTINUED TO BE POSTPONED DUE TO COVID, DEACONESS WAS PROUD TO SUPPORT AND SPONSOR LOCAL ORGANIZATIONS, SUCH AS CHEMO BUDDIES AND KOMEN EVANSVILLE, THAT OFFER TRANSPORTATION ASSISTANCE TO PATIENTS TO GET TO AND FROM THEIR TREATMENTS. IN ADDITION, THE MATERNAL AND NEONATAL TRANSPORT TEAM ACQUIRED A NEW STATE-OF-THE-ART AMBULANCE FOR TRANSPORTING EXPECTANT MOTHERS WITH OBSTETRIC EMERGENCIES AND HIGH-RISK PREGNANCIES, AS WELL AS PREMATURE AND SICK NEWBORNS IN NEED OF CRITICAL CARE.</p>

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
<b>Section C. Supplemental Information for Part V, Section B.</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.	
<b>Section C. Supplemental Information for Part V, Section B.</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
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
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.	
<b>Section C. Supplemental Information for Part V, Section B.</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
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: <a href="https://www.deaconess.com/pay-my-bill/financial-assistance">HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE</a>

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

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

Form and Line Reference	Explanation
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: <a href="https://www.deaconess.com/pay-my-bill/financial-assistance">HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE</a>

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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: <a href="https://www.deaconess.com/pay-my-bill/financial-assistance">HTTPS://WWW.DEACONESS.COM/PAY-MY- BILL/FINANCIAL-ASSISTANCE</a>

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 LAB & RADIOLOGY 120 SE 4TH STREET SUITE 1100 EVANSVILLE, IN 47708	DIAGNOSTIC CENTER
10 11 - DEACONESS HOSPITAL INFUSION CTRPHARMACY 4111 GATEWAY BLVD NEWBURGH, IN 47630	OUTPATIENT SERVICES
11 12 - DEACONESS MIDWEST RADIOLOGICAL IMAGING 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

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

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

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

Name and address	Type of Facility (describe)
<b>16</b> 16 - DEACONESS PRIMARY CARE FOR SENIORS 1750 OAK HILL ROAD EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
<b>1</b> 17 - DEACONESS PRIMARY CARE FOR SENIORS 4498 FIRST AVENUE EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC
<b>2</b> 18 - DEACONESS PROCEDURE CENTER 421 CHESTNUT STREET EVANSVILLE, IN 47713	OUTPATIENT SERVICES
<b>3</b> 19 - DEACONESS HOSPITAL RADIOLOGY EXPRESS 4087 GATEWAY BLVD NEWBURGH, IN 47630	DIAGNOSTIC CENTER
<b>4</b> 20 - DEACONESS CLINIC GATEWAY REG LAB 4233 GATEWAY BLVD SUITE 201 NEWBURGH, IN 47630	DIAGNOSTIC CENTER
<b>5</b> 21 - DEACONESS HOSPITAL LAB & EKGDIABETES ED 520 MARY STREET SUITE 330 EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
<b>6</b> 22 - DEACONESS RADIOLOGY LAB & RADIOLOGY 8600 NORTH KENTUCKY AVENUE EVANSVILLE, IN 47725	DIAGNOSTIC CENTER
<b>7</b> 23 - DEACONESS REGIONAL LABORATORY 4494 N FIRST AVENUE EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
<b>8</b> 24 - DEACONESS HOSPITAL LAB & RADIOLOGY 4209 GATEWAY BLVD NEWBURGH, IN 47630	DIAGNOSTIC CENTER
<b>9</b> 25 - MT VERNON MEDICAL CENTER LAB & RADIOLOGY 1900 W FOURTH STREET MT VERNON, IN 47620	DIAGNOSTIC CENTER
<b>10</b> 26 - DEACONESS REGIONAL LABORATORY 4133 GATEWAY BLVD SUITE 110 NEWBURGH, IN 47630	DIAGNOSTIC CENTER
<b>11</b> 27 - DEACONESS SLEEP CENTER 350 W COLUMBIA STREET SUITE 100 EVANSVILLE, IN 47710	OUTPATIENT SERVICES
<b>12</b> 28 - DEACONESS SLEEP CENTER-EAST 7307 E COLUMBIA ST EVANSVILLE, IN 47715	DIAGNOSTIC CENTER
<b>13</b> 29 - DEACONESS SLEEP LAB 350 W COLUMBIA STREET SUITE LL-10 EVANSVILLE, IN 47710	DIAGNOSTIC CENTER
<b>14</b> 30 - DEACONESS WEIGHT LOSS SOLUTIONS 310 W IOWA STREET EVANSVILLE, IN 47710	OUTPATIENT PHYSICIAN CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
<b>31</b> 31 - DEACONESS WOUND CARE CENTER 350 W COLUMBIA STREET SUITE 350 EVANSVILLE, IN 47710	OUTPATIENT SERVICES

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

Schedule I  
(Form 990)

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2020

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 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 . . . . . 25

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
AMERICAN RED CROSS 29 S STOCKWELL RD EVANSVILLE, IN 47714	53-0196605	501(C)(3)	86,000				GENERAL SUPPORT & BIOMEDICAL FUNDRAISING
AURORA INC 1001 MARY STREET EVANSVILLE, IN 47710	35-1759576	501(C)(3)	15,000				HOMELESS OUTREACH

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)	12,500				GENERAL SUPPORT & HEALTHY HABITS PROGRAM
CANCER PATHWAYS MIDWEST INC 5740 VOGEL ROAD EVANSVILLE, IN 47715	29-1932741	501(C)(3)	18,481				GENERAL SUPPORT & INTEGRATIVE ONCOLOGY PROGRAM

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
CHEMO BUDDIES 3700 BELLEMEADE AVE EVANSVILLE, IN 47714	45-3043243	501(C)(3)	12,280				GENERAL SUPPORT & SHUTTLE BUS SPONSORSHIP
CITY OF EVANSVILLE PARKS SPECIAL DISTRICT 1 NW MARTIN LUTHER KING BLVD ROOM 300 EVANSVILLE, IN 47708	35-6001021		285,714				AQUATIC CENTER 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
ECHO COMMUNITY HEALTH CARE 315 MULBERRY STREET EVANSVILLE, IN 47713	35-1791786	501(C)(3)	30,000				FAMILY PRACTCE - MULTICULTURAL CLINIC
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

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 REGIONAL BUSINESS COMMITTEE INC ONE VECTREN SQUARE EVANSVILLE, IN 47708	03-0408032	501(C)(3)	15,000				GENERAL SUPPORT
EVANSVILLE VANDERBURGH SCHOOL CORP 1 SE NINTH STREET EVANSVILLE, IN 47708	35-1071682	501(C)(3)	6,150				CLASSROOM SUPPLIES

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)	50,000				SUPPORT HEALTH TRAIL
FAIRFIELD MEMORIAL HOSPITAL FOUNDATION 303 NW 11TH STREET FAIRFIELD, IL 62837	37-1185754	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
GOLF GIVES BACK ONE VECTREN SQUARE EVANSVILLE, IN 47708	81-4223347	501(C)(3)	8,000				GENERAL SUPPORT
HABITAT FOR HUMANITY OF EVANSVILLE 560 E DIAMOND AVENUE EVANSVILLE, IN 47711	35-1602775	501(C)(3)	100,000				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)	200,000				IUSM-EVANSVILLE FURNITURE & FIXTURE FUND
ISAIAH 117 HOUSE 1705 STATE LINE RD PO BOX 842 ELIZABETHTON, TN 37643	82-0631497	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
IVY TECH FOUNDATION 3501 N 1ST AVENUE EVANSVILLE, IN 47710	23-7073977	501(C)(3)	50,000				GENERAL SUPPORT & SCHOLARSHIPS
JUNIOR ACHIEVEMENT OF SW INDIANA 431 E DIAMOND AVENUE EVANSVILLE, IN 47711	35-6048156	501(C)(3)	14,000				INSPIRING OUR YOUTH & 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
OTHERS 5000			159,817				GENERAL SUPPORT
RONALD MCDONALD HOUSE CHARITIES OF THE OHIO VALLEY 3540 WASHINGTON AVENUE EVANSVILLE, IN 47714	35-1748468	501(C)(3)	24,000				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
SOUTHERN INDIANA GRADUATE MEDICAL EDUCATION CONSORTIUM INC 515 WALNUT STREET SUITE 4134 EVANSVILLE, IN 47708	47-2044966	501(C)(3)	100,000				GENERAL SUPPORT
TRI-STATE FOOD BANK 2504 LYNCH ROAD EVANSVILLE, IN 47711	35-1539870	501(C)(3)	200,000				END HUNGER NOW 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
UNITED CARING SHELTERS 324 NW SIXTH STREET EVANSVILLE, IN 47708	35-1892153	501(C)(3)	65,000				HOMELESS MEDICAL RESPITE & GENERAL SUPPORT
UNITED WAY OF SOUTHWESTERN INDIANA PO BOX 18 EVANSVILLE, IN 47701	35-0868069	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
UNIVERSITY OF EVANSVILLE 1800 LINCOLN AVENUE EVANSVILLE, IN 47722	35-0868074	501(C)(3)	50,000				CERTIFIED REGISTERED NURSE ANESTHETIST PROGRAM
YMCA OF SW INDIANA INC 516 COURT STREET EVANSVILLE, IN 47708	35-0869074	501(C)(3)	12,000				GENERAL SUPPORT & 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
YOUTH FIRST 111 SE THIRD STREET STE 405 EVANSVILLE, IN 47708	35-2050168	501(C)(3)	17,000				GENERAL SUPPORT
YWCA 118 VINE ST EVANSVILLE, IN 47708	35-0869075	501(C)(3)	12,200				GENERAL SUPPORT

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2020
		Open to Public Inspection
Department of the Treasury Internal Revenue Service	For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990. ▶ Go to <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for instructions and the latest information.	
Name of the organization DEACONESS HOSPITAL INC		Employer identification number 35-0593390

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



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

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

[illegible]

**Part III Supplemental Information**

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

Return Reference	Explanation
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- \$19,500 \$-0- JAMES PORTER, MD 0 19,500 0 CHERONA HAJEWSKI 0 19,500 0 VENKATESH MADADI, MD 0 19,500 0 RAGHAV GUPTA, MD 0 19,500 0 CHERYL WATHEN 0 19,500 0 LYNN LINGAFELTER 0 19,500 0 MAQBOOL AHMED, MD 0 19,500 0 MARC FLORENCE 0 19,500 0 MIA HINDI 0 19,500 0 BRADLEY SCHEU 0 19,500 0 PAUL MICK 0 18,058 0 SEVERANCE NONQUALIFIED EQUITY-BASED RAJESH PATEL \$-0- \$19,500 \$-0- MARK MURRAY 0 19,500 0 PART I, 4B: SHAWN MCCOY: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$194,912 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$513,438 CHERYL WATHEN: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$100,294 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$100,563 JAMES PORTER: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$122,390 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$316,206 CHERONA HAJEWSKI: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$51,816 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$88,798 LYNN LINGAFELTER: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$93,097 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$66,902 JOANN WOOD SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$15,621 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$0 MARC FLORENCE: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$59,084 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$43,602 BRADLEY SCHEU: SUPPLEMENTAL ACCUMULATION ACCOUNT CONTRIBUTIONS OF \$11,788 SUPPLEMENTAL ACCUMULATION ACCOUNT PAYOUT OF \$0
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	(i)	451,449	316,050	520,216	116,510	19,760	1,423,985	256,719
	(ii)	439,940	0	8,000	104,297	19,760	571,997	256,719
1MAQBOOL AHMED MD DIRECTOR	(i)	0	0	360	0	0	360	0
	(ii)	789,016	46,412	160,449	17,292	754	1,013,923	0
2SCOTT CORDTS MD DIRECTOR	(i)	255,661	51,498	31,402	17,292	26,016	381,869	0
	(ii)	0	0	5,200	0	0	5,200	0
3MIA HINDI MD DIRECTOR	(i)	0	0	15,500	0	0	15,500	0
	(ii)	1,059,796	139,778	299,868	12,969	28,076	1,540,487	0
4CHERYL WATHEN CHIEF FINANCIAL OFFICER	(i)	270,709	139,230	104,889	84,752	19,923	619,503	50,282
	(ii)	266,991	0	8,200	55,349	19,923	350,463	50,282
5JAMES PORTER MD PRESIDENT OF DEACONESS HEALTH SYSTEM	(i)	613,687	189,484	319,761	153,695	35,212	1,311,839	316,206
	(ii)	891	0	3,200	0	255	4,346	0
6CHERONA HAJEWSKI CHIEF NURSING OFFICER	(i)	335,091	86,671	147,861	91,118	20,596	681,337	140,613
	(ii)	0	0	0	0	0	0	0
7LYNN LINGAFELTER CHIEF OPERATION OFFICER	(i)	468,988	132,157	70,906	98,560	27,233	797,844	66,902
	(ii)	51,352	0	4,800	18,605	3,026	77,783	0
8JOANN WOOD MD CHIEF MEDICAL OFFICER	(i)	106,391	24,802	2,407	10,186	5,262	149,048	0
	(ii)	22,500	0	0	5,435	1,315	29,250	0
9MARC FLORENCE VICE PRESIDENT	(i)	294,480	94,867	47,454	65,303	28,588	530,692	43,602
	(ii)	73,545	0	0	13,590	7,147	94,282	0
10BRADLEY SCHEU MD VICE PRESIDENT	(i)	0	6,248	0	0	0	6,248	0
	(ii)	354,827	178,517	32,710	20,434	34,064	620,552	0
11RAGHAV GUPTA MD ANESTHESIOLOGIST	(i)	383,232	657,253	47,377	8,646	26,472	1,122,980	0
	(ii)	0	0	0	0	0	0	0
12VENKATESH MADADI MD ANESTHESIOLOGIST	(i)	889,477	14,591	79,025	17,292	27,667	1,028,052	0
	(ii)	0	0	0	0	0	0	0
13PAUL MICK MD ANESTHESIOLOGIST	(i)	773,467	74,474	119,793	8,646	18,013	994,393	0
	(ii)	0	0	0	0	0	0	0
14RAJESH PATEL MD ANESTHESIOLOGIST	(i)	695,001	14,591	51,886	0	30,511	791,989	0
	(ii)	0	0	0	0	0	0	0
15MARK MURRAY MD ANESTHESIOLOGIST	(i)	650,917	15,098	92,482	8,646	12,918	780,061	0
	(ii)	0	0	0	0	0	0	0
16LINDA WHITE FORMER CEO EMERITA, FOUNDATION EXEC.	(i)	8,295	0	0	0	0	8,295	0
	(ii)	151,625	16,535	4,280	2,457	5,004	179,901	0

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

Schedule K  
(Form 990)

Supplemental Information on Tax-Exempt Bonds

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

OMB No. 1545-0047  
**2020**  
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 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 . . . . .			1,195,000		3,535,000		9,175,000	
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							
		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 2019, 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 2019, 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)

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

**Part IV Arbitrage**

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
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 3, COLUMN A:	THE TOTAL PROCEEDS OF THE ISSUE EXCEED THE ISSUE PRICE DUE THE INVESTMENT EARNINGS ON THE PROJECT FUND.

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



Return Reference	Explanation
PART IV, LINE 2C, COLUMN C:	A REBATE CALCULATION WAS COMPLETED, WITH NO REBATE DUE, ON JUNE 22, 2015.

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

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
DEACONESS HOSPITAL INC

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

OMB No. 1545-0047

2020

Open to Public  
Inspection

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 . . . . .	4,105,000		11,250,000		9,275,000			
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 . . . . .								
		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 2019, 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 2019, 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)

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

**Part IV Arbitrage**

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

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

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

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization DEACONESS HOSPITAL INC	Employer identification number 35-0593390
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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?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	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 COMPENSATIONSRSVS. = 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: SOUTH WESTERN COMMUNICATIONSRELATIONSHIP: BOARD MEMBER KEVIN KOCH IS THE CHAIRMAN OF SOUTH WESTERN COMMUNICATIONS. SOUTH WESTERN COMMUNICATIONS PROVIDES TELECOMMUNICATION SERVICES.INTERESTED PERSON: JESSICA COXRELATIONSHIP: DAUGHTER TO LYNN LINGAFELTERINTERESTED PERSON: JOAN MCCOYRELATIONSHIP: WIFE OF SHAWN MCCOYINTERESTED PERSON: OLD NATIONAL BANKRELATIONSHIP: BOARD MEMBER JAMES RYAN IS THE CEO 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: 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	73,686	COMP.		No
(1) BRITTNEY PHIPPS	SEE PART V	27,209	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) JESSICA COX	SEE PART V	284,946	COMP.		No
(1) JOAN MCCOY	SEE PART V	56,369	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
(5) LAUREN WATHEN	SEE PART V	61,619	COMP.		No
(1) OLD NATIONAL BANK	SEE PART V	17,167	INVESTMENT MANAGEMENT FEES		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) SHERRI MCCOY	SEE PART V	21,262	COMP.		No
(1) SOUTH WESTERN COMMUNICATIONS	SEE PART V	300,529	TELECOMMUNICATION SERVICES		No

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

<b>(a)</b> Name of interested person	<b>(b)</b> Relationship between interested person and the organization	<b>(c)</b> Amount of transaction	<b>(d)</b> Description of transaction	<b>(e)</b> Sharing of organization's revenues?	
				<b>Yes</b>	<b>No</b>
(9) UNIVERSITY OF SOUTHERN INDIANA	SEE PART V	60,204	SUPPORT		No

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

OMB No. 1545-0047

2020

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	40,327	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

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

Yes

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.

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

Cat. No. 51227J

Schedule M (Form 990) (2020)

**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

Name of the organization  
DEACONESS HOSPITAL INC

**Supplemental Information to Form 990 or 990-EZ**

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

**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 SPIRIT TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE. AT DEACONESS HOSPITAL, OUR VALUES ARE BASED ON OUR COMMITMENT TO QUALITY. WE DEFINE QUALITY AS THE CONTINUOUS IMPROVEMENT 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 EFFECTIVENESS 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 IMPROVING THE QUALITY OF LIFE FOR THE PEOPLE OF THE TRI-STATE BY DEMONSTRATING EXCELLENCE IN HEALTHCARE SERVICES, PROVIDING ACCESS TO HEALTHCARE, PROVIDING CHARITY CARE TO THOSE IN NEED, PROMOTING HEALTHY LIFESTYLES, OFFERING SPIRITUAL AND PSYCHOLOGICAL SUPPORT, SUPPORTING HEALTH RELATED EDUCATION, AND ADVANCING HEALTH KNOWLEDGE THROUGH RESEARCH.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>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 AND SOUTHEASTERN ILLINOIS. THE HOSPITAL AND ITS FACILITIES ARE LOCATED ON FOUR CAMPUSES WHICH INCLUDE THE MAIN 28-ACRE CAMPUS ON THE NEAR NORTH SIDE OF EVANSVILLE IN VANDERBURGH COUNTY; THE 63-ACRE GATEWAY CAMPUS LOCATED IN WARRICK COUNTY ON THE EASTERN BORDER OF VANDERBURGH COUNTY; AND TWO OTHER EASTSIDE EVANSVILLE LOCATIONS FOR PSYCHIATRIC BEHAVIORAL SERVICES AND REHABILITATION SERVICES. THE HOSPITAL OPERATES A MAIN CAMPUS WITH A TOTAL OF 263 BEDS 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 BEDS, 39 MEDICAL RENAL BEDS, AND 18 BEDS DEDICATED TO PATIENTS IN OBSERVATION. IN ADDITION, THE HOSPITAL PROVIDES A FULL-ARRAY OF COMPREHENSIVE OUTPATIENT AND AMBULATORY SERVICES ON ITS MAIN CAMPUS AND OTHER SPECIFIC SERVICES AT MULTIPLE SITES WITHIN ITS PRIMARY AND SECONDARY SERVICE AREAS. THE HOSPITAL OPERATES THE 278 BED DEACONESS GATEWAY HOSPITAL WHICH WAS OPENED IN JANUARY 2006, ON THE GATEWAY CAMPUS CONSISTING OF 18 ADULT INTENSIVE CARE BEDS, 12 PEDIATRIC AND PEDIATRIC INTENSIVE CARE BEDS, 14 NEUROSURGICAL BEDS, 50 ORTHOPAEDIC BEDS, 50 NEURO INTENSIVE CARE BEDS, 32 SURGICAL ONCOLOGY BEDS, 46 GENERAL MED/ TELEMETRY BEDS, 24 CARDIAC BEDS, AND 32 BEDS DEDICATED TO PATIENTS IN OBSERVATION. THE ORTHOPEDIC NEUROSCIENCE 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 APPROXIMATELY 7 MILES EAST OF THE MAIN CAMPUS IN EVANSVILLE.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4B	<p>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 SUFFICIENT RESOURCES AVAILABLE FOR PAYMENT. IF AN INDIVIDUAL IS DETERMINED TO NOT HAVE SUFFICIENT RESOURCES TO PAY, THEY ARE 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. DEACONESS HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS BELOW COST. RECOGNIZING ITS MISSION 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 MEETING ITS MISSION TO THE COMMUNITY. IN SUPPORT OF ITS MISSION, DEACONESS HOSPITAL PROVIDED \$12.9 MILLION OF CHARITY CARE AND \$189.5 MILLION OF SUBSIDIZED SERVICES TO THE MEDICAID PROGRAM, AND \$505.4 MILLION OF SUBSIDIZED SERVICES TO THE MEDICARE PROGRAM.</p>



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4C	PROGRAM SERVICES ACCOMPLISHMENT 3: GRADUATE MEDICAL EDUCATION, MEDICAL EDUCATION & COMMUNITY BENEFITS. DEACONESS HOSPITAL PLAYS AN ACTIVE ROLE IN MEDICAL EDUCATION, OPERATING A THREE YEAR FAMILY MEDICINE RESIDENCY PROGRAM AND A POST-GRADUATE PHARMACY RESIDENCY PROGRAM. DEACONESS HOSPITAL ALSO PROVIDES CONTINUING MEDICAL EDUCATION PROGRAMS FOR ATTENDING PHYSICIANS, OTHER HEALTH PROFESSIONALS, OTHER ALLIED HEALTH PROGRAMS, COMMUNITY HEALTH PROGRAMS AND A CHAPLAIN RESIDENCY PROGRAM. IN ADDITION TO EDUCATIONAL SERVICES, DEACONESS HOSPITAL PROVIDED \$11.1 MILLION IN COMMUNITY BENEFIT ACTIVITIES (ALL ON A COST BASIS), SERVING A MINIMUM OF 544,376 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 ELECTION AND APPROVAL PROCESS FOR NON-MEDICAL STAFF MEMBERS BEGINS WITH A RECOMMENDATION BY THE GOVERNANCE COMMITTEE FOR MEMBERSHIP TO THE BOARD OF DIRECTORS. THAT RECOMMENDATION IS THEN REVIEWED AND APPROVED BY THE BOARD OF DIRECTORS. DEPENDING ON THE DECISION REACHED BY THE BOARD OF DIRECTORS, MEMBERSHIP MAY OR MAY NOT BE GRANTED TO THAT INDIVIDUAL. MEDICAL STAFF EXECUTIVE COUNCIL LEADERSHIP ARE APPOINTED TO BOARD OF DIRECTOR MEMBERSHIP THROUGH THEIR 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**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 12C	COMPLIANCE WITH CONFLICT OF INTEREST POLICY: CONFLICT OF INTEREST REVIEW AND COMPLIANCE ACTIVITIES ARE CONDUCTED THROUGHOUT THE YEAR UNDER THE DIRECTION OF DEACONESS HOSPITAL'S CORPORATE 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 DOCUMENTS 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. CONFLICTS 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 PERIODIC BASIS, REVIEWS OCCUR TO ENSURE DEACONESS HOSPITAL OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABLE PURPOSE. SUBJECTS THAT ARE REVIEWED ON A PERIODIC BASIS INCLUDE COMPENSATION, PHYSICIAN RELATIONSHIPS, PARTNERSHIP AND JOINT VENTURE ARRANGEMENTS.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	<p>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.</p>

## 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 CONSOLIDATED FINANCIAL STATEMENT WHICH IS AVAILABLE WITH THE PUBLIC DISCLOSURE COPY OF THE IRS FORM 990. ALSO, AS REQUIRED BY LAW, THE HOSPITAL SUBMITS ITS CONSOLIDATED FINANCIAL STATEMENTS TO THE INDIANA DEPARTMENT OF HEALTH WHICH ARE PUBLISHED ON ITS WEBSITE. GOVERNING DOCUMENTS, ASIDE FROM THE ARTICLES OF INCORPORATION, AND THE CONFLICT OF INTEREST POLICY ARE NOT AVAILABLE FOR PUBLIC INSPECTION.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PROFESSIONAL FEES: PROGRAM SERVICE EXPENSES 124,220,085. MANAGEMENT AND GENERAL EXPENSES 10,562,908. FUNDRAISING EXPENSES 33,060. TOTAL EXPENSES 134,816,053. PROFESSIONAL FEES- PHYSICIANS: PROGRAM SERVICE EXPENSES 15,934,071. MANAGEMENT AND GENERAL EXPENSES 12,207. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 15,946,278.



## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	CHANGE IN PENSION LIABILITY 41,940,979. FOUNDATION MONIES GRANTED FROM RESTRICTION -585,155. CHANGE IN GENERAL FUND EQUITY -59,586,976.

**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.

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

OMB No. 1545-0047

2020

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.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) REGIONAL EMERGENCY DEPARTMENT 600 MARY ST EVANSVILLE, IN 47710 46-3509500	HEALTHCARE	IN			DEACONESS HOSPITAL
(2) READY DEVELOPMENT OF INDIANA 600 MARY ST EVANSVILLE, IN 47747 47-2040018	REAL ESTATE	IN		5,036,521	DEACONESS HOSPITAL
(3) BASELINE INVESTORS LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
(4) 533 COLUMBIA LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
(5) INVESTORS PROPERTY DEVELOPMENT LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL
(6) 7307 E COLUMBIA LLC 600 MARY ST EVANSVILLE, IN 47710	REAL ESTATE	IN			DEACONESS HOSPITAL

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> DEACONESS HEALTH PLANS LLC 350 W COLUMBIA SUITE 400 EVANSVILLE, IN 47710 38-3492529	PREFERRED PROVIDER NETWORK	IN	DEACONESS HOSPITAL	RELATED	1,006,757	2,563,932		No			No	95.150 %
<b>(2)</b> PROGRESSIVE HEALTH OF IN LLC 150 N ROSENBERGER EVANSVILLE, IN 47712 20-8480988	OUTPATIENT	IN	DEACONESS HOSPITAL	RELATED	3,685,819	2,448,320		No			No	51.000 %
<b>(3)</b> TRI-STATE RADIATION ONCOLOGY 1500 ROSECRANS AVENUE MANHATTAN BEACH, CA 90266 26-3706834	OUTPATIENT	DE	DEACONESS HOSPITAL	RELATED	5,811,807	7,614,460		No			No	51.000 %
<b>(4)</b> MAINSPRING MANAGERS LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 46-4601001	NEUROLOGY SERVICES	IN	DEACONESS HOSPITAL	RELATED	976,181	848,339		No			No	51.000 %
<b>(5)</b> VASCMED LLC 600 MARY STREET EVANSVILLE, IN 47747 47-2578168	VASCULAR SERVICES	IN	DEACONESS HOSPITAL	RELATED	819,150	1,003,518		No			No	51.000 %
<b>(6)</b> ORTHOALIGN LLC 4011 GATEWAY BLVD NEWBURGH, IN 47630 81-2816013	HEALTHCARE	IN	DEACONESS HOSPITAL	RELATED	2,134,477	2,180,947		No			No	51.000 %
<b>(7)</b> HEALTHCARE RESOURCE SOLUTIONS 600 MARY STREET EVANSVILLE, IN 47747 83-3275390	HEALTHCARE	IN	N/A					No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
<b>(1)</b> 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.

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

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

1a

No

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

1b

No

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

1c

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) DEACONESS HEALTH PLANS LLC	P	102,344	
(2) MAINSPRING	Q	62,651	

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

[illegible]

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

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

Return Reference	Explanation

Additional Data

Software ID:  
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		5,036,521	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?
						YesNo
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) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
DEACONESS HEALTH PLANS LLC  350 W COLUMBIA SUITE 400 EVANSVILLE, IN 47710 38-3492529	PREFERRED PROVIDER NETWORK	IN	DEACONESS HOSPITAL	RELATED	1,006,757	2,563,932		No			No	95.150 %
PROGRESSIVE HEALTH OF IN LLC  150 N ROSENBERGER EVANSVILLE, IN 47712 20-8480988	OUTPATIENT	IN	DEACONESS HOSPITAL	RELATED	3,685,819	2,448,320		No			No	51.000 %
TRI-STATE RADIATION ONCOLOGY  1500 ROSECRANS AVENUE MANHATTAN BEACH, CA 90266 26-3706834	OUTPATIENT	DE	DEACONESS HOSPITAL	RELATED	5,811,807	7,614,460		No			No	51.000 %
MAINSRING MANAGERS LLC  4011 GATEWAY BLVD NEWBURGH, IN 47630 46-4601001	NEUROLOGY SERVICES	IN	DEACONESS HOSPITAL	RELATED	976,181	848,339		No			No	51.000 %
VASCMED LLC  600 MARY STREET EVANSVILLE, IN 47747 47-2578168	VASCULAR SERVICES	IN	DEACONESS HOSPITAL	RELATED	819,150	1,003,518		No			No	51.000 %
ORTHOALIGN LLC  4011 GATEWAY BLVD NEWBURGH, IN 47630 81-2816013	HEALTHCARE	IN	DEACONESS HOSPITAL	RELATED	2,134,477	2,180,947		No			No	51.000 %
HEALTHCARE RESOURCE SOLUTIONS  600 MARY STREET EVANSVILLE, IN 47747 83-3275390	HEALTHCARE	IN	N/A					No			No	