

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
▶ Do not enter social security numbers on this form as it may be made public
▶ Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047
2017
Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 10-01-2017, and ending 09-30-2018

- B** Check if applicable
 Address change
 Name change
 Initial return
 Final return/terminated
 Amended return
 Application pending

C Name of organization
OSF Healthcare System

Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite
800 NE GLEN OAK AVE

City or town, state or province, country, and ZIP or foreign postal code
Peoria, IL 61603

D Employer identification number
37-0813229

E Telephone number
(309) 655-2850

G Gross receipts \$ 2,484,986,242

F Name and address of principal officer
MICHAEL M ALLEN
800 NE GLEN OAK AVE
Peoria, IL 61603

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.OSFHEALTHCARE.ORG

K Form of organization Corporation Trust Association Other ▶

L Year of formation 1880

M State of legal domicile IL

Part I Summary

1 Briefly describe the organization's mission or most significant activities
In the spirit of Christ and the example of Francis of Assisi, the Mission of OSF Healthcare is to serve persons with the greatest care and love in a community that celebrates the gift of life

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)	9
4 Number of independent voting members of the governing body (Part VI, line 1b)	6
5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	17,744
6 Total number of volunteers (estimate if necessary)	2,212
7a Total unrelated business revenue from Part VIII, column (C), line 12	6,260,712
7b Net unrelated business taxable income from Form 990-T, line 34	2,132,098

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	8,620,722	15,739,541
9 Program service revenue (Part VIII, line 2g)	2,068,613,572	2,357,884,312
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	59,545,239	49,473,868
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	41,236,810	57,192,220
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,178,016,343	2,480,289,941

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	1,153,710	3,409,838
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)	925,065,571	1,052,639,995
16a Professional fundraising fees (Part IX, column (A), line 11e)		0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 5,989,107		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	947,837,001	1,107,566,486
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	1,874,056,282	2,163,616,319
19 Revenue less expenses Subtract line 18 from line 12	303,960,061	316,673,622

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	3,296,088,110	3,759,557,955
21 Total liabilities (Part X, line 26)	2,057,198,791	2,237,524,751
22 Net assets or fund balances Subtract line 21 from line 20	1,238,889,319	1,522,033,204

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here
Signature of officer: _____ Date: 2019-08-14
MICHAEL M ALLEN CFO
Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name: Rachel Spurlock
Preparer's signature: Rachel Spurlock
Date: _____
Check if self-employed PTIN: P00520729
Firm's name: CROWE LLP
Firm's EIN: 35-0921680
Firm's address: 9600 Brownsboro Road Suite 400
Louisville, KY 402411122
Phone no: (502) 326-3996

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

OSF HEALTHCARE SYSTEM IS A CATHOLIC INTEGRATED HEALTH CARE DELIVERY SYSTEM WHICH DURING ITS FISCAL YEAR 2018 OPERATED 13 HOSPITALS, 5 HOME HEALTH AGENCIES, 4 HOSPICES, AND EMPLOYED APPROXIMATELY 857 PHYSICIANS ALL PATIENTS ARE ACCEPTED REGARDLESS OF THEIR ABILITY TO PAY ALL FACILITIES, SERVICES, PHYSICIANS AND OTHER PROFESSIONAL STAFF OF OSF HEALTHCARE SYSTEM SERVE ALL PATIENTS WITHOUT REGARD TO RACE, RELIGION, AGE, SEX, NATIONAL ORIGIN, PAYER SOURCE OR ABILITY TO PAY THE BOARD OF DIRECTORS HAS ADOPTED CHARITY CARE POLICIES AND PROCEDURES WHICH APPLY FOR ALL FACILITIES AND SERVICES OF THE CORPORATION THE AVAILABILITY OF CHARITY CARE IS COMMUNICATED TO PATIENTS IN NUMEROUS WAYS, INCLUDING USE OF FINANCIAL COUNSELORS, PATIENT INFORMATION BROCHURES, AND NOTICES ON PATIENT BILLINGS CHARITY CARE APPLICATIONS AND INSTRUCTIONS ARE AVAILABLE ON WEBSITES MAINTAINED BY THE CORPORATION AND UPON A REQUEST MADE TO ANY OF THE CORPORATION'S FACILITIES OR OFFICES

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No
If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No
If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses \$ 708,131,804 including grants of \$) (Revenue \$ 1,061,883,872)
See Additional Data

4b (Code) (Expenses \$ 680,480,367 including grants of \$) (Revenue \$ 1,063,555,248)
See Additional Data

4c (Code) (Expenses \$ 105,257,007 including grants of \$) (Revenue \$ 138,888,226)
See Additional Data










(Code) (Expenses \$ 270,745,377 including grants of \$ 3,409,838) (Revenue \$ 144,386,161)

Other program services beyond outpatient, inpatient and emergency department services include Home Health Services - Five Agencies located in Illinois and Michigan Hospice Services - Four programs located in Illinois and Michigan Residency Programs - OSF Healthcare System is affiliated with the University of Illinois and provides support for teaching of residents and fellowship programs College of Nursing Programs - Two of the corporations hospitals operate accredited colleges of nursing that offer accredited baccalaureate, masters and doctoral degrees Trauma Services (Level 1) - Two hospitals in the system are designated as Level I Trauma (Highest Level) trauma centers and two have been designated as level II Trauma Centers EMS Flight and Ground Transportation services - The corporation provides helicopter and ground transports to patients in Northern and Central Illinois Community Clinic, Outreach and other educational programs - The corporation offers two uninsured and under insured community clinics in Bloomington and Peoria Outreach programs - The corporation provides outreach programs to the community with parish nursing, perinatal outreach, and a community training center All of these programs reach at risk populations to help them with specific and everyday healthcare needs Education - The corporation provides paramedic education, EMT education, medical tech education, radiology tech education and dietetic education programs

4d Other program services (Describe in Schedule O)
(Expenses \$ 270,745,377 including grants of \$ 3,409,838) (Revenue \$ 144,386,161)

4e Total program service expenses **▶** 1,764,614,555

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include 20a through 38, covering various organizational requirements and schedules.

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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, and charitable contributions.

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 [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (9), 1b (6), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 (IL), 18 (Own website, Another's website, Upon request, Other), 19, 20 (MICHAEL ALLEN 800 NE GLEN OAK AVE PEORIA, IL 61603 (309) 655-7708).

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			
	d Related organizations	1d	13,735,326		
	e Government grants (contributions)	1e	1,478,365		
	f All other contributions, gifts, grants, and similar amounts not included above	1f	525,850		
	g Noncash contributions included in lines 1a-1f \$ _____				
	h Total. Add lines 1a-1f		15,739,541		

Program Service Revenue			Business Code				
	2a Net Patient Service Revenue		621110	2,342,593,342	2,342,593,342		
	b Consulting Revenue		523000	9,122,659	9,122,659		
	c Lab		621500	5,394,448		5,394,448	
	d Affiliated Purchasing Program		561499	643,445		643,445	
	e Related Party Loan Interest		900099	130,418		130,418	
	f All other program service revenue			0	0	0	0
	g Total. Add lines 2a-2f			2,357,884,312			

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			47,203,354			47,203,354	
	4 Income from investment of tax-exempt bond proceeds							
	5 Royalties							
	6a Gross rents	(i) Real						
			2,678,836					
		b Less rental expenses	2,594,398					
		c Rental income or (loss)	84,438	0				
	d Net rental income or (loss)			84,438			84,438	
	7a Gross amount from sales of assets other than inventory	(i) Securities						
			2,388,085	1,984,332				
		b Less cost or other basis and sales expenses	1,338,773	763,130				
		c Gain or (loss)	1,049,312	1,221,202				
	d Net gain or (loss)			2,270,514			2,270,514	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a						
	b Less direct expenses	b						
	c Net income or (loss) from fundraising events							
	9a Gross income from gaming activities See Part IV, line 19	a						
	b Less direct expenses	b						
c Net income or (loss) from gaming activities								
10a Gross sales of inventory, less returns and allowances	a							
b Less cost of goods sold	b							
c Net income or (loss) from sales of inventory								
Miscellaneous Revenue		Business Code						
11a Insurance Credit		524298	15,939,944	15,939,944				
b Tuition		611430	14,058,414	14,058,414				
c Contract Pharmacy		621110	7,907,623	7,907,623				
d All other revenue			19,201,801	19,091,525	92,401	17,875		
e Total. Add lines 11a-11d			57,107,782					
12 Total revenue. See Instructions			2,480,289,941	2,408,713,507	6,260,712	49,576,181		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	3,115,828	3,115,828		
2 Grants and other assistance to domestic individuals See Part IV, line 22	294,010	294,010		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0	0		
4 Benefits paid to or for members	0	0		
5 Compensation of current officers, directors, trustees, and key employees	16,677,769	13,342,215	3,335,554	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	437,246	180,988	256,258	0
7 Other salaries and wages	787,326,240	613,782,973	173,449,739	93,528
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	48,584,283	34,166,978	14,417,305	0
9 Other employee benefits	140,346,804	124,015,223	16,331,581	0
10 Payroll taxes	59,267,653	42,024,824	17,242,829	0
11 Fees for services (non-employees)				
a Management	0	0	0	0
b Legal	2,811,647	0	2,811,647	0
c Accounting	901,000	0	901,000	0
d Lobbying	910,985	0	910,985	0
e Professional fundraising services See Part IV, line 17	0			0
f Investment management fees	0	0	0	0
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	97,972,476	81,282,881	16,689,595	0
12 Advertising and promotion	7,060,035	396,785	6,663,250	0
13 Office expenses	14,186,293	5,043,053	9,142,604	636
14 Information technology	33,538,427	1,101,580	32,436,258	589
15 Royalties	0	0	0	0
16 Occupancy	16,925,258	16,047,071	877,759	428
17 Travel	8,231,306	5,168,221	3,062,577	508
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0	0	0	0
19 Conferences, conventions, and meetings	1,813,478	793,973	1,018,855	650
20 Interest	40,479,008	12,810,571	27,668,437	0
21 Payments to affiliates	0	0	0	0
22 Depreciation, depletion, and amortization	106,996,425	78,581,265	28,415,160	0
23 Insurance	10,583,922	9,820,967	762,955	0
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a Medical Supplies	354,403,377	353,250,026	937,309	216,042
b Equip Rental & Maint	226,909,628	192,464,799	34,429,804	15,025
c Bad Debt	100,275,185	100,275,185	0	0
d Medicaid Fees	75,843,641	75,843,641	0	0
e All other expenses	7,724,395	811,498	1,251,196	5,661,701
25 Total functional expenses. Add lines 1 through 24e	2,163,616,319	1,764,614,555	393,012,657	5,989,107
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input checked="" type="checkbox"/> if following SOP 98-2 (ASC 958-720)	6,997,197	6,638,780	358,417	0

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing		1	
	2 Savings and temporary cash investments	150,345,942	2	174,383,682
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	488,132,199	4	448,040,909
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	0
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	34,843,640	8	46,238,403
	9 Prepaid expenses and deferred charges	48,648,614	9	48,000,136
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	2,517,443,102		
	b Less accumulated depreciation	1,329,458,206		
	11 Investments—publicly traded securities	1,033,210,946	11	1,232,348,785
	12 Investments—other securities See Part IV, line 11	0	12	
	13 Investments—program-related See Part IV, line 11	68,188,034	13	115,358,042
	14 Intangible assets	32,013,838	14	34,414,226
	15 Other assets See Part IV, line 11	439,851,769	15	472,788,876
16 Total assets. Add lines 1 through 15 (must equal line 34)	3,296,088,110	16	3,759,557,955	
Liabilities	17 Accounts payable and accrued expenses	212,729,178	17	265,646,659
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	1,092,831,347	20	1,263,249,507
	21 Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	0
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	751,638,266	25	708,628,585
	26 Total liabilities. Add lines 17 through 25	2,057,198,791	26	2,237,524,751
Net Assets or Fund Balances	27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. Unrestricted net assets	1,132,481,065	27	1,402,496,116
	28 Temporarily restricted net assets	63,521,223	28	68,313,782
	29 Permanently restricted net assets	42,887,031	29	51,223,306
	30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	1,238,889,319	33	1,522,033,204
	34 Total liabilities and net assets/fund balances	3,296,088,110	34	3,759,557,955

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	2,480,289,941
2	Total expenses (must equal Part IX, column (A), line 25)	2	2,163,616,319
3	Revenue less expenses Subtract line 2 from line 1	3	316,673,622
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,238,889,319
5	Net unrealized gains (losses) on investments	5	27,922,707
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-61,452,444
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,522,033,204

Part XII Financial Statements and Reporting

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

		Yes	No
<p>1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____</p> <p>If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O</p>			
<p>2a Were the organization's financial statements compiled or reviewed by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2a		No
<p>b Were the organization's financial statements audited by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2b	Yes	
<p>c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?</p> <p>If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O</p>	2c	Yes	
<p>3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?</p>	3a	Yes	
<p>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</p>	3b	Yes	

Additional Data

Software ID: 17005876

Software Version: 2017v2.2

EIN: 37-0813229

Name: OSF Healthcare System

Form 990 (2017)

Form 990, Part III, Line 4a:

INPATIENT SERVICES OSF HEALTHCARE SYSTEM OWNS AND OPERATES ACUTE CARE HOSPITALS IN ESCANABA, MICHIGAN, ROCKFORD, ILLINOIS, PONTIAC, ILLINOIS, BLOOMINGTON, ILLINOIS, PEORIA, ILLINOIS, GALESBURG, ILLINOIS, MONMOUTH, ILLINOIS, KEWANEE, ILLINOIS, ALTON, ILLINOIS, URBANA, ILLINOIS, AND DANVILLE, ILLINOIS AS OF THE CLOSE OF THE REPORTING PERIOD ON SEPTEMBER 30, 2018, THESE ELEVEN FACILITIES HAD A COMBINED TOTAL OF 1,752 LICENSED INPATIENT AND RESIDENT BEDS THEY HAD COMBINED TOTALS OF 69,583 INPATIENT AND RESIDENT DISCHARGES AND 320,197 INPATIENT AND RESIDENT DAYS, INCLUDING 18,052 NEWBORN INPATIENT DAYS THE NINE ACUTE CARE HOSPITALS COLLECTIVELY SERVED 57 COUNTIES PONTIAC, ILLINOIS IS A SOLE COMMUNITY HOSPITAL AND ESCANABA, MICHIGAN, KEWANEE, ILLINOIS, AND MONMOUTH, ILLINOIS ARE CRITICAL ACCESS HOSPITALS THE CORPORATION'S HOSPITALS OFFER A BROAD RANGE OF INPATIENT SERVICES THREE OF THE HOSPITALS PROVIDE OPEN HEART SURGERY SERVICES, TWO OFFER LEVEL II NEONATAL SERVICES, ONE OFFERS LEVEL III NEONATAL SERVICES (HIGHEST LEVEL), AND ONE OFFERS KIDNEY AND PANCREAS ORGAN TRANSPLANT SERVICES THE CORPORATION HAS ORGANIZED AND OPERATES COMPREHENSIVE CARDIAC AND STROKE CARE NETWORKS IN CENTRAL AND NORTHERN ILLINOIS AND OPERATES THE ONLY COMPREHENSIVE CHILDREN'S HOSPITAL IN CENTRAL ILLINOIS

Form 990, Part III, Line 4b:

OUTPATIENT SERVICES THE ELEVEN ACUTE CARE HOSPITALS OWNED AND OPERATED BY OSF HEALTHCARE SYSTEM COLLECTIVELY PROVIDED 1,506,630 OUTPATIENT VISITS DURING THE REPORTING PERIOD ENDED SEPTEMBER 30, 2018, EXCLUDING EMERGENCY DEPARTMENT VISITS THE CORPORATION'S HOSPITALS OFFER A BROAD RANGE OF OUTPATIENT THERAPEUTIC AND DIAGNOSTIC SERVICES, INCLUDING OUTPATIENT SURGERY AND ADVANCED MEDICAL IMAGING

Form 990, Part III, Line 4c:

All of the eleven acute care hospitals of the corporation provide 24-hour emergency department services. All are staffed by physicians who are predominantly (but not entirely) certified in emergency medicine by national specialty boards. The emergency departments of the corporation's acute care hospitals provided 278,476 patient visits during the reporting period ended September 30, 2018.

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			
Sister Diane Marie McGrew OSF President and Treasurer	40 8	X		X				5,200	0	0
Sister Judith Ann Duvall OSF Chairperson	40 8	X		X				5,200	0	0
Robert C Sehring Vice Chairperson CEO	40 8	X		X				849,531	0	68,240
Kevin D Schoeplein Partial Year - Vice Chairperson CEO	40 8	X		X				1,721,678	0	258,783
Sister Theresa Ann Brazeau OSF Secretary	40 8	X		X				5,200	0	0
Sister Agnes Joseph Williams OSF Assistant Secretary	40 8	X		X				5,200	0	0
Sister Rose Therese Mann OSF Board Member	40 8	X						0	0	0
Gerald J McShane MD Board Member	40 7	X						695,330	0	64,289
Sister M Mikela Meidl FSGM Board Member	40 8	X						0	0	0
Brian Silverstein MD Board Member	1 7	X						45,000	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			
Michael M Allen CFO	40 0 7 0			X			560,425	0	53,654
Anthony M Avellino MD Partial Year - CEO NSSL/INI	40 0 6 0			X			976,761	0	60,536
Kenneth E Berkovitz MD Partial Year - CEO CVSL	40 0 6 0			X			722,055	0	42,012
Chad E Boore Chief Executive Officer Eastern Region	40 0 6 0			X			317,270	0	39,387
Robert L Brandfass SVP Chief Legal Officer	40 0 6 0			X			519,421	0	64,040
Michelle D Conger Chief Strategy Officer	40 0 6 0			X			449,874	0	38,959
Roxanna Crosser Chief Executive Officer Western Region	40 0 6 0			X			314,792	0	40,905
Michael A Cruz MD Chief Executive Officer Central Region	40 0 6 0			X			597,403	0	67,230
John R Evancho SVP Chief Compliance Officer	40 0 6 0			X			256,009	0	45,584
Thomas G Hammerton President OSF Healthcare Foundation Chief Development Officer	40 0 8 0			X			362,569	0	46,481

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			
Stephen E Hippler MD Chief Clinical Officer	40 0 6 0			X				541,637	0	67,183
John C Horne SVP Chief Supply Chain Officer	40 0 6 0			X				345,142	0	51,666
Divya-Devi Joshi CEO Children SL	40 0 6 0			X				497,362	0	26,209
James J Mormann Chief Information Officer	40 0 6 0			X				544,589	0	60,270
David A Schertz Partial Year - CEO Northern Region	40 0 6 0			X				579,694	0	43,726
Dwight D Stapleton Vice President Clinical Specialty Services	40 0 6 0			X				400,979	0	27,523
Jeffrey M Tillery SVP Chief Transformation Officer	40 0 6 0			X				513,402	0	61,306
Lori L Wiegand Chief Nursing Officer	40 0 6 0			X				382,846	0	61,596
Leon A Yeh MD VP CMO Emergency Serv	40 0 6 0			X				523,837	0	59,971
Iftekhar U Ahmad MD Physician	40 0 0					X		864,341	0	41,321

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			
Mete Korkmaz MD Oncologist	40 0 0					X		844,728	0	64,404
James L McGee MD Physician	40 0 0					X		943,056	0	57,567
Ekanka Mukhopadhyay MD Physician	40 0 0					X		591,904	0	58,442
Anthony C Zalduendo MD Physician	40 0 0					X		663,537	0	65,271
Daniel E Baker Former CFO	0 0 0 0						X	2,154,132	0	160,530
Kenneth J Natzke Former CEO East Region	0 0 0 0						X	528,533	0	47,343

SCHEDULE A
(Form 990 or 990EZ)

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.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization
OSF Healthcare System

Employer identification number

37-0813229

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 **section 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), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6	Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					12	

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

Section C. Computation of Public Support Percentage

14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2016 Schedule A, Part II, line 14	15	

- 16a 33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c	Add lines 7a and 7b						
8	Public support. (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9	Amounts from line 6						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c	Add lines 10a and 10b						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from 2016 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2017. 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—2016. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a	<input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c	<input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2	Activities Test Answer (a) and (b) below.		
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
3	Parent of Supported Organizations Answer (a) and (b) below.		
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

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

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2017 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7			
\$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, 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 2017 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 2018. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

Additional Data

Software ID: 17005876

Software Version: 2017v2.2

EIN: 37-0813229

Name: OSF Healthcare System

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

Facts And Circumstances Test

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.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017
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 OSF Healthcare System	Employer identification number 37-0813229
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

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

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a Volunteers?		No	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c Media advertisements?		No	
d Mailings to members, legislators, or the public?	Yes		0
e Publications, or published or broadcast statements?		No	
f Grants to other organizations for lobbying purposes?		No	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		595,822
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i Other activities?	Yes		315,163
j Total Add lines 1c through 1i			910,985
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
Schedule C, Part II-A, Line 1b, Column (a) SCH C, PART II-B LINE 1B	THE ONLY COST OF MAILING RELATED TO LOBBYING EXPENSES IS RELATED TO THE COST OF STAMPS THE TOTAL EXPEDITURES RELATED TO MAILING IS MINOR AND THE ACTUAL DOLLAR AMOUNT IS NOT READILY AVAILABLE
Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY	LINE 1I INCLUDES LOBBYING EXPENSES PAID TO VARIOUS NATIONAL HEALTH ASSOCIATIONS AS PART OF DUES AND SUBSCRIPTIONS IN THE AMOUNT OF \$315,163 LINE 1G INCLUDES DIRECT CONTACT WITH LEGISLATORS, THEIR STAFFS, GOVERNMENT OFFICIALS, AND LEGISLATIVE BODIES RELATING TO THE HOSPITAL, PHYSICIAN PAYMENT REFORM, CRITICAL ACCESS, MDH HOSPITAL RATE PROTECTION, ACO ACTIVITIES AND ADOPTION IN MEDICARE THIS AMOUNTED TO \$595,822
Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY	LINE 1I INCLUDES LOBBYING EXPENSES PAID TO VARIOUS NATIONAL HEALTH ASSOCIATIONS AS PART OF DUES AND SUBSCRIPTIONS IN THE AMOUNT OF \$315,163 LINE 1G INCLUDES DIRECT CONTACT WITH LEGISLATORS, THEIR STAFFS, GOVERNMENT OFFICIALS, AND LEGISLATIVE BODIES RELATING TO THE HOSPITAL, PHYSICIAN PAYMENT REFORM, CRITICAL ACCESS, MDH HOSPITAL RATE PROTECTION, ACO ACTIVITIES AND ADOPTION IN MEDICARE THIS AMOUNTED TO \$595,822

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.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2017
Open to Public Inspection

Name of the organization
OSF Healthcare System

Employer identification number
37-0813229

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

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

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

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|--|--------|
| c Beginning balance | |
| d Additions during the year | |
| e Distributions during the year | |
| f Ending balance | |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	87,218,699	73,130,258	58,445,819	51,788,138	37,314,439
b Contributions	18,736,098	5,667,852	8,839,845	9,619,258	10,574,853
c Net investment earnings, gains, and losses	6,534,121	9,778,204	7,180,954	-1,943,315	4,207,377
d Grants or scholarships	188,034	231,331	619,990	81,000	91,480
e Other expenditures for facilities and programs	1,458,266	1,126,284	716,370	937,262	217,051
f Administrative expenses					
g End of year balance	110,842,618	87,218,699	73,130,258	58,445,819	51,788,138

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 48 %
 - b** Permanent endowment ▶ 41 5 %
 - c** Temporarily restricted endowment ▶ 10 5 %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | Yes | No |
|--|---------------|----|
| (i) unrelated organizations | 3a(i) | No |
| (ii) related organizations | 3a(ii) | No |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		43,585,888		43,585,888
b Buildings		1,517,991,483	678,776,334	839,215,149
c Leasehold improvements		33,351,907	25,942,364	7,409,543
d Equipment		851,290,277	624,739,508	226,550,769
e Other		71,223,547	0	71,223,547
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				1,187,984,896

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

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

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

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

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

(a) Description	(b) Book value
(1) WORKERS COMP ESCROW DEPOSITS	5,475,561
(2) THIRD PARTY WITHHOLDINGS	16,803,393
(3) DUE FROM FOUNDATION	1,026,340
(4) ASSETS - LIMITED OR RESTRICTED	119,537,088
(5) FUNDS LIMITED AS TO USE	197,089,446
(6) OTHER ACCOUNTS	74,443,846
(7) 457B DEFERRED COMPENSATION	58,413,202
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15.)	472,788,876

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	
ESTIMATED SELF INSURANCE LIAB	152,088,502
RETIRE OBLIG - ASBESTOS	13,407,228
ACCRUED PENSION LIABILITY	324,354,893
MARKET VALUATION OF SWAP	30,070,779
THIRD PARTY SETTLEMENT PAYABLE	130,293,981
457B DEFERRED COMPENSATION	58,413,202
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25.)	708,628,585

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID: 17005876

Software Version: 2017v2.2

EIN: 37-0813229

Name: OSF Healthcare System

Supplemental Information

Return Reference	Explanation
Schedule D, Part V, Line 4 Intended uses of endowment funds	THE ORGANIZATION'S ENDOWMENT FUNDS ARE USED TO PROVIDE SCHOLARSHIPS TO NURSING STUDENTS, A CQUIRE EQUIPMENT AND SUPPORT PROGRAMS OF VARIOUS MEDICAL DEPARTMENTS OF THE OSF HEALTHCARE SYSTEM HOSPITALS

Supplemental Information

Return Reference	Explanation
Schedule D, Part X, Line 2 FIN 48 (ASC 740) footnote	OSF IS A NOT-FOR-PROFIT CORPORATION AS DESCRIBED BY SECTION 501(c)(3) OF THE INTERNAL REVENUE CODE AND IS EXEMPTED FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(C)(3) OF THE CODE SFI AND VARIOUS SUBSIDIARIES ARE FOR-PROFIT CORPORATIONS THAT RECOGNIZE INCOME TAXES UNDER THE ASSET-AND-LIABILITY METHOD DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE CONSOLIDATED FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING THE ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN INCOME IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE UNDER ASC SUBTOPIC 740-10, ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES -AN INTERPRETATION OF FASB STATEMENT NO 109, OSF MUST RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION THE TAX BENEFITS RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS FROM SUCH A POSITION ARE MEASURED BASED ON THE LARGEST BENEFIT THAT HAS A GREATER THAN 50% LIKELIHOOD OF BEING REALIZED UPON ULTIMATE SETTLEMENT AS OF SEPTEMBER 30, 2018 AND 2017, OSF DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service
 Name of the organization
 OSF Healthcare System

Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

Employer identification number
 37-0813229

OMB No 1545-0047
2017
Open to Public Inspection

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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>12500</u> %	3a Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>60000</u> %	3b Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			28,452,015	0	28,452,015	1 32 %
b Medicaid (from Worksheet 3, column a)			442,220,399	367,442,764	74,777,635	3 46 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0 %
d Total Financial Assistance and Means-Tested Government Programs	0	0	470,672,414	367,442,764	103,229,650	4 77 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			5,905,612	676,851	5,228,761	0 24 %
f Health professions education (from Worksheet 5)			80,523,917	31,328,027	49,195,890	2 27 %
g Subsidized health services (from Worksheet 6)			31,356,554	16,950,709	14,405,845	0 67 %
h Research (from Worksheet 7)			2,205,632	1,095,157	1,110,475	0 05 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			4,282,632		4,282,632	0 20 %
j Total. Other Benefits	0	0	124,274,347	50,050,744	74,223,603	3 43 %
k Total. Add lines 7d and 7j	0	0	594,946,761	417,493,508	177,453,253	8 20 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing					0	0 %
2 Economic development					0	0 %
3 Community support					0	0 %
4 Environmental improvements					0	0 %
5 Leadership development and training for community members					0	0 %
6 Coalition building					0	0 %
7 Community health improvement advocacy			472,346		472,346	0.02 %
8 Workforce development					0	0 %
9 Other					0	0 %
10 Total	0	0	472,346	0	472,346	0.02 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1 Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2 20,206,227	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3 0	
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5 574,143,621
6 Enter Medicare allowable costs of care relating to payments on line 5.	6 601,942,636
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7 -27,799,015
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 None				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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)
 SAINT FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

SAINT FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

SAINT FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

SAINT FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

SAINT ANTHONY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

SAINT ANTHONY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

SAINT ANTHONY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
 OSF HEART OF MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

OSF HEART OF MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>(HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

OSF HEART OF MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

OSF HEART OF MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

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

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

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

OSF SACRED HEART MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>(HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>(HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

OSF SACRED HEART MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

OSF SACRED HEART MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ 5

Community Health Needs Assessment		Yes	No
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ST JOSEPH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
 OSF SAINT ANTHONY'S HEALTH CENTER

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ **6**

Community Health Needs Assessment

		Yes	No
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

OSF SAINT ANTHONY'S HEALTH CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>600 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

OSF SAINT ANTHONY'S HEALTH CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

OSF SAINT ANTHONY'S HEALTH CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ 7

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

ST MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125 0</u> % and FPG family income limit for eligibility for discounted care of <u>400 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

ST MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ST MARY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
 SAINT JAMES 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): _____ **8**

Community Health Needs Assessment		Yes	No
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

SAINT JAMES HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125 0</u> % and FPG family income limit for eligibility for discounted care of <u>400 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

SAINT JAMES HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

SAINT JAMES 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
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
ST FRANCIS 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): _____ 9

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
6b	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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
10b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

ST FRANCIS HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0</u> % and FPG family income limit for eligibility for discounted care of <u>400 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https://www.osfhealthcare.org/billing/financial-assistance/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

ST FRANCIS HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ST FRANCIS 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
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ **10**

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

OSF SAINT LUKE MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125 0</u> % and FPG family income limit for eligibility for discounted care of <u>400 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

OSF SAINT LUKE MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

OSF SAINT LUKE MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ **11**

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/ABOUT/COMMUNITY-HEALTH/</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____		No
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	Yes	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

OSF HOLY FAMILY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>125 0</u> % and FPG family income limit for eligibility for discounted care of <u>400 0</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance discount		
g	<input checked="" type="checkbox"/> Residency		
h	<input checked="" 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) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW.OSFHEALTHCARE.ORG/BILLING/FINANCIAL-ASSISTANCE/</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

OSF HOLY FAMILY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

OSF HOLY FAMILY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information *(continued)*

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 51

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
Schedule H, Part I, Line 3c FACTORS OTHER THEN FPG	<p>-CATASTROPHIC CHARITY ASSISTANCE REGARDLESS OF INCOME OR ASSET LEVELS FOR MEDICALLY NECESSARY SERVICES WHICH EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT DUE IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES CATASTROPHIC CHARITY IS MORE GENEROUS</p> <p>-PRESUMPTIVE CHARITY PROVIDES A FINANCIAL DISCOUNT OF 100% OF BILLED CHARGES WHEN THERE ARE NO INSURANCE BENEFITS AND THE PATIENT SATISFIES ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF, DECEASED WITH NO ESTATE, AND HOMELESS FOR OSF HOSPITALS THAT ARE NOT CRITICAL ACCESS OR RURAL HOSPITALS, ENROLLMENT IN ANY ONE OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF FEDERAL POVERTY INCOME GUIDELINES ESTABLISHES A PRESUMPTIVE CHARITY CATEGORY, WIC, SNAP, IL FREE LUNCH AND BREAKFAST PROGRAM, LIHEAP, RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES, AND ENROLLMENT IN AN ORGANIZED COMMUNITY-BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW-INCOME FINANCIAL STATUS AS CRITERIA FOR MEMBERSHIP -ALL PATIENTS RECEIVE THE GREATEST DISCOUNT AVAILABLE UNDER ANY OF THE OSF PROGRAMS NO ASSET TESTS ARE USED -EXCEPT AS OTHERWISE NOTED, THESE POLICIES APPLY BOTH TO UNINSURED PATIENTS AND TO INSURED PATIENTS WITH RESPECT TO THE PATIENT RESPONSIBILITY AMOUNT</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>Schedule H, Part VI, Line 4 COMMUNITY INFORMATION</p>	<p>OSF SAINT ANTHONY'S HEALTH CENTER ("SAINT ANTHONY'S - ALTON") IS LOCATED IN ALTON, ILLINOIS THE HEALTH CENTER PROVIDES GENERAL HEALTH SERVICES TO RESIDENTS WITHIN ITS GEOGRAPHIC COMMUNITY, INCLUDING ACUTE INPATIENT SERVICES AND AMBULATORY SERVICES SUCH AS CANCER CARE, SURGICAL SERVICES, CARDIAC CARE AND REHABILITATION SAINT ANTHONY'S - ALTON IS A DUAL CAMPUS (INCLUDING OSF SAINT CLARE HOSPITAL), SINGLE LICENSE, 140-LICENSED ACUTE CARE BED AND 30 BED SKILLED NURSING CARE HOSPITAL SAINT ANTHONY'S - ALTON SERVES THE FOLLOWING COMMUNITIES IN MADISON COUNTY IN SOUTHWESTERN ILLINOIS ALTON, BETHALTO, EAST ALTON, FOSTER TOWNSHIP, GODFREY, HARTFORD, ROXANA, SOUTH ROXANA, WOOD RIVER AND WOOD RIVER TOWNSHIP THE CORPORATION COMMENCED OWNERSHIP AND OPERATIONS OF SAINT ANTHONY'S - ALTON ON NOVEMBER 1, 2014 AS NOTED IN THE CHNA, OSF SAINT ANTHONY'S HEALTH CENTER IS LOCATED IN MADISON COUNTY IN ILLINOIS MADISON COUNTY IS A PART OF THE METRO-EAST REGION OF THE ST LOUIS METRO AREA AND ITS POPULATION IN 2014 WAS 266,560 FOR MADISON COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$53,633 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 14 4% OSF HEART OF MARY MEDICAL CENTER IS A 206-BED COMPREHENSIVE HEALTH CARE FACILITY SERVING CHAMPAIGN-URBANA, ILLINOIS ITS ROOTS DATE BACK TO 1919 WHEN IT WAS FOUNDED BY THE SERVANTS OF THE HOLY HEART OF MARY THE STAFF OF NEARLY 700 PROVIDES STATE-OF-THE-ART THERAPEUTIC, DIAGNOSTIC, MEDICAL, SURGICAL, AND SUPPORT SERVICES OSF HEART OF MARY HAS BEEN RECOGNIZED FOR ITS TREATMENT OF HEART FAILURE, STROKE, PERINATAL CARE AND TOTAL KNEE AND HIP PLACEMENT, IN ADDITION TO BEING HOME TO THE AREA'S ONLY ADULT BEHAVIORAL HEALTH UNIT IN A HOSPITAL SETTING ITS DESIGN INCORPORATES A HOLISTIC APPROACH TO CARE, MUCH LIKE ITS BLESSED BEGINNINGS BIRTHING CENTER THAT INCLUDES HOME-LIKE BIRTHING SUITS AS NOTED IN THE CHNA, THE CENSUS BUREAU ESTIMATED THE POPULATION TO BE 208,419 RESIDENTS, A 3 6% INCREASE SINCE 2010 CLOSE TO 20% OF CHAMPAIGN COUNTY RESIDENTS LIVE IN POVERTY, AND 54% OF CHILDREN ATTENDING PUBLIC SCHOOLS WERE ELIGIBLE FOR FREE OR REDUCED PRICE LUNCHES VIOLENT CRIME IN CHAMPAIGN COUNTY IS MUCH HIGHER THAN THE STATE AND NATIONAL AVERAGES THE LEADING CAUSE OF DEATH IN CHAMPAIGN COUNTY IS CANCER, WITH A RATE OF 129 8 PER 100,000 POPULATIONS OSF SACRED HEART MEDICAL CENTER IS A 174-BED COMPREHENSIVE HEALTH CARE FACILITY SERVING DANVILLE, ILLINOIS IT WAS ESTABLISHED IN 1882 BY THE FRANCISCAN SISTERS OF THE SACRED HEART THE STAFF OF NEARLY 500 PROVIDES STATE-OF-THE ART THERAPEUTIC, DIAGNOSTIC, MEDICAL, SURGICAL, AND SUPPORT SERVICE TO PATIENTS AND THEIR FAMILIES PERFORMANCE ON NATIONAL PATIENT SAFETY GOALS, AND JOINT COMMISSION CORE MEASURES ARE CONSISTENTLY EXAMINED, WITH DATA REPORTED PUBLICLY KEY SERVICES INCLUDE A 24-HOUR PHYSICIAN-STAFFED EMERGENCY DEPARTMENT, THE ONLY FULL-SERVICE CANCER CENTER IN VERMILION COUNTY, CARDIOVASCULAR TESTING, DIAGNOSTICS, TREATMENT, AND REHABILITATION, BIRTHING CENTER, SLEEP CENTER, PRIMARY STROKE CENTER, AND MORE AS NOTED IN THE CHNA, VERMILION COUNTY'S POPULATION CONTINUES TO DROP THERE WAS A 5 5% DECREASE IN TOTAL POPULATION FROM 2000-2015 VERMILION COUNTY HAS A HIGHER PERCENTAGE OF PERSONS WITH DISABILITIES THAN ILLINOIS AND THE UNITED STATES ACCORDING TO THE 2016 ILLINOIS POVERTY REPORT, 19% OF VERMILION COUNTY'S POPULATION WAS LIVING AT OR ABOVE POVERTY LEVEL IN 2014 FOR THE SCHOOL YEAR 2015-2016, VERMILION COUNTY HAD A VERY HIGH PERCENTAGE OF 64 48% OF CHILDREN WHO QUALIFIED FOR FREE AND REDUCED LUNCH THE MEDIAN HOUSEHOLD INCOME IS \$42,548, WHICH IS LOWER THAN ILLINOIS' MEDIAN INCOME OF \$57,444</p>

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Form and Line Reference	Explanation
<p>Schedule H, Part V, Section B, Line 11 SAINT FRANCIS MEDICAL CENTER</p>	<p>THE FOLLOWING ACTIVITIES AND INITIATIVES HELPED TO SUPPORT THE IDENTIFIED GOALS FOR MENTAL HEALTH FROM 2016 TO 2018 DEPRESSION SCREENING TOOLS WERE IMPLEMENTED * A DEPRESSION SCREENING TOOL WAS UTILIZED IN THE OSF MEDICAL GROUP OFFICES THIS TOOL WAS USED FOR SCREENING PURPOSES ON ALL INPATIENTS IF THIS TOOL SCREEN WAS POSITIVE, AN ADDITIONAL LEVEL OF SCREENING WAS COMPLETED BASELINES WERE ESTABLISHED FOR PATIENTS TREATED FOR MENTAL HEALTH PATIENTS TREATED BY OSF SAINT FRANCIS MEDICAL CENTER ADULT BEHAVIORAL HEALTH PROGRAM INCLUDE * 6,203 IN FY16 * 6,155 IN FY17 * 7,023 IN FY18 PATIENTS TREATED WITHIN OSF MEDICAL GROUP PSYCH OFFICES INCLUDE * 10,738 IN FY16 * 11,952 IN FY17 * 11,272 IN FY18 THE BEHAVIORAL HEALTH OPERATIONS COUNCIL FOR THE OSF SYSTEM MEETS MONTHLY TO PLAN AND IMPLEMENT TACTICS RELATED TO BEHAVIORAL HEALTH CARE COORDINATION AND TELE-PSYCH A WEB BASED RESOURCE CALLED SILVER CLOUD WAS LAUNCHED IN 2017 SILVER CLOUD OFFERS SECURE, IMMEDIATE ACCESS TO ONLINE SUPPORTED COGNITIVE BEHAVIORAL THERAPY PROGRAMS, TAILORED TO THE INDIVIDUAL'S SPECIFIC NEEDS SINCE ITS LAUNCH IN APRIL 2017, THERE WERE 547 SILVER CLOUD USERS IN THE PEORIA REGION IN COLLABORATION WITH HEARTLAND HEALTH SERVICES, TELE-PSYCHIATRY SERVICES HAVE BEEN PROVIDED TO HEARTLAND HEALTH CLINIC AND OSF COMMUNITY CLINIC PATIENTS FROM OCTOBER 2017 TO DECEMBER 2018, 150+ TELE-PSYCH VISITS OCCURRED AND 100+ REFERRALS RECEIVED A STRIVE TRAUMA RECOVERY PROGRAM PROVIDED FREE, COMPREHENSIVE PSYCHOLOGICAL SERVICES AS WELL AS RESOURCE MANAGEMENT AND SUPPORT SERVICES FOR INDIVIDUALS 14 AND OLDER WHO HAVE BEEN A VICTIM OF TRAUMA FROM A CRIME THAT HAS OCCURRED IN THE PREVIOUS 3 YEARS THE PROGRAM OFFERS ASSESSMENTS, COUNSELING AND CASE MANAGEMENT FOR BOTH INPATIENTS AND OUTPATIENTS THIS WAS A GRANT-FUNDED PROGRAM PROVIDED IN COLLABORATION WITH PEORIA PUBLIC SCHOOLS, CHILDREN'S HOME, AREA POLICE DEPARTMENTS, LOCAL DOMESTIC VIOLENCE SHELTERS, LEGAL SERVICES AND OTHER COMMUNITY AGENCIES THE PROGRAM WAS IMPLEMENTED IN THE FALL OF 2018 SINCE ITS IMPLEMENTATION, 52 PATIENT ENCOUNTERS HAVE OCCURRED IN 2018 THE PROGRAM HAS GROWN SIGNIFICANTLY TO 269 PATIENT ENCOUNTERS BEING COMPLETED IN THE FIRST TWO QUARTERS OF 2019 VARIOUS OTHER COMMUNITY EVENTS FOCUSING ON MENTAL HEALTH OCCURRED INCLUDING PARENT TRAINING ON SUICIDE AWARENESS AND MENTAL HEALTH TRAINING FOR STAFF OF DISTRICT 150</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 8 Adoption of Implementation Strategy	<p>OSF Sacred Heart Medical Center The Organization commenced operating the Hospital on February 1, 2018 The Organization will adopt implementation strategies on or before February 15, 2021 related to the Community Health Needs Assessment to be conducted on or before September 30, 2020 A copy of the Community Health Plan prepared in 2017 by Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, is published on the Hospital facility's website and includes a 5-year strategic plan developed in collaboration with the Vermilion County Board of Health and the community partners on the Community Advisory Committee prior to the date the Organization commenced operating the Hospital HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/</p> <p>OSF Heart of Mary Medical Center The Organization commenced operating the Hospital on February 1, 2018 The Organization will adopt implementation strategies on or before February 15, 2021 related to the Community Health Needs Assessment to be conducted on or before September 30, 2020 A copy of the Community Health Plan prepared in 2018 by Presence Covenant Medical Center in Champaign County, Illinois, and now known as OSF Heart of Mary Medical Center, is published on the Hospital facility's website and includes objectives and strategies adopted prior to the date the Organization commenced operating the Hospital HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 10 most recently adopted implementation strategy	OSF Sacred Heart Medical Center THE PRIOR HEALTH SYSTEM ADOPTED IT'S IMPLEMENTATIONS STRATEGY IN 2017 OSF HEALTHCARE SYSTEM WILL ADOPT IMPLEMENTATION STRATEGIES RELATED TO THIS COMMUNITY HEALTH NEEDS ASSESSMENT ON OR BEFORE FEBRUARY 15, 2021 TO MEET OUR REGULATORY REQUIREMENTS OSF Heart of Mary Medical Center THE PRIOR HEALTH SYSTEM ADOPTED IT'S IMPLEMENTATIONS STRATEGY IN 2017 OSF HEALTHCARE SYSTEM WILL ADOPT IMPLEMENTATION STRATEGIES RELATED TO THIS COMMUNITY HEALTH NEEDS ASSESSMENT ON OR BEFORE FEBRUARY 15, 2021 TO MEET OUR REGULATORY REQUIREMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7 Costing Methodology used to calculate financial assistance	COSTS REPORTED ON LINES 7A, B and C ARE CALCULATED USING THE RATIO OF PATIENT CARE COST TO CHARGES DERIVED FROM WORKSHEET 2 COSTS REPORTED ON LINES 7 E, F, G, H AND I ARE COSTS DERIVED FROM GENERAL LEDGER ACCOUNTS AND HOSPITAL DEPARTMENTS COST CENTER REPORTS WHICH INCLUDE BOTH DIRECT AND INDIRECT COSTS LESS REVENUE LINE 7G REPRESENTS ALL PAYERS EXCLUDING MEDICARE, MEDICAID AND SELF PAY PART I, LINE 7G NET COSTS (TOTAL EXPENSE LESS REVENUE) OF PHYSICIAN CLINICS ARE INCLUDED AS SUBSIDIZED HEALTH SERVICES ON PART I, LINE 7G PART I, LINE 7, COLUMN F BAD DEBT EXPENSE IN THE AMOUNT OF \$100,275,185 IS INCLUDED ON FORM 990, PART IX, LINE 24C, COLUMN (A), BUT WAS SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES IN SCHEDULE H, PART I, LINE 7, COLUMN (F)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part II Community Building Activities	THESE COSTS INCLUDE THE DEDICATED STAFF TIME WORKING WITH COMMUNITY AGENCIES TO SUPPORT POLICIES AND PROGRAMS THAT IMPROVE THE HEALTH CARE ACCESS AND TRANSPORTATION OF RESOURCES TO ITS COMMUNITY MEMBERS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>Schedule H, Part III, Line 2 Bad debt expense - methodology used to estimate amount</p>	<p>IN GENERAL, AND IN ACCORDANCE WITH MEDICARE REGULATIONS, PATIENT ACCOUNT BALANCES ARE WRITTEN OFF TO BAD DEBT EXPENSE AFTER REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED AND THE ACCOUNT HAS BEEN SENT TO A COLLECTION AGENCY OR LAW FIRM PATIENTS' ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IN EVALUATING THE COLLECTABILITY OF PATIENTS' ACCOUNTS RECEIVABLE, OSF ANALYZES PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR BAD DEBTS MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, OSF ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY FOR RECEIVABLES ASSOCIATED WITH PATIENT RESPONSIBILITY (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE PATIENTS ARE SCREENED AGAINST THE OSF FINANCIAL ASSISTANCE POLICY AND UNINSURED DISCOUNT POLICY FOR ANY REMAINING PATIENT RESPONSIBILITY BALANCE, OSF RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BAD DEBT EXPENSE OF \$100,275,185 ON FORM 990, PART IX, LINE 24C IS BASED UPON ACCRUAL ACCOUNTING REQUIRED BY GENERALLY ACCEPTED ACCOUNTING PRINCIPLES THIS AMOUNT CONSEQUENTLY DIFFERS FROM THE BAD DEBT EXPENSE OF \$20,166,684 ON SCHEDULE H, PART III, LINE 2 WHICH REQUIRES THE ORGANIZATION TO REPORT AGGREGATE BAD DEBT AT COST BAD DEBT EXPENSE REPORTED ON PART III, LINE 2 IS THEREFORE CALCULATED BY MULTIPLYING GROSS CHARGES WRITTEN OFF TO BAD DEBT EXPENSE TIMES THE RATIO OF PATIENT CARE COST-TO-CHARGES DERIVED FROM WORKSHEET 2 DISCOUNTS, INCLUDING ANY APPLICABLE THIRD PARTY PAYER CONTRACTUAL ALLOWANCES AND ANY CHARITY CARE DISCOUNTS (VALUED AT GROSS CHARGES), ARE APPLIED TO PATIENT ACCOUNT GROSS CHARGES TO DETERMINE THE ACCOUNT BALANCE BEFORE PATIENT PAYMENTS THE AGGREGATE AMOUNT OF ALL PATIENT PAYMENTS IS THEN APPLIED TO THE ACCOUNT BALANCE WHEN DETERMINATION IS MADE THAT NO FURTHER AMOUNTS CAN BE COLLECTED IN ACCORDANCE WITH THE CORPORATION'S BAD DEBT POLICY, THE REMAINING BALANCE IS WRITTEN OFF TO BAD DEBT EXPENSE PRESUMPTIVE CHARITY CHARGES MAY BE ADJUSTED TO PROVIDE FOR A CHARITY DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO AN UNINSURED PATIENT WHO ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA PRESUMPTIVE CHARITY CATEGORIES FOR ALL OSF HOSPITALS -HOMELESSNESS, -DECEASED WITH NO ESTATE, -MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF, OR -CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE FOR OSF HOSPITAL'S THAT ARE NOT CRITICAL ACCESS HOSPITALS OR RURAL HOSPITALS, ENROLLMENT IN ANY OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL ESTABLISH A PRESUMPTIVE CHARITY CATEGORY -WOMEN, INFANTS AND CHILDREN NUTRITION PROGRAM (WIC), -SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), -ILLINOIS FREE LUNCH AND BREAKFAST PROGRAM, -LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP), -ENROLLMENT IN AN ORGANIZED COMMUNITY-BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW-INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP, OR -RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES THEREFORE, THE CORPORATION DOES NOT BELIEVE THAT BAD DEBT EXPENSE REPORTED ON PART III, LINE 2 INCLUDES ANY AMOUNTS THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO WOULD LIKELY QUALIFY UNDER THE CORPORATION'S FINANCIAL ASSISTANCE POLICY</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 4 Bad debt expense - financial statement footnote	PLEASE SEE PAGE 20 AND 21 OF NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 8 Community benefit & methodology for determining medicare costs	100% OF THE MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT OSF IS COMMITTED TO SERVING PATIENTS, REGARDLESS OF ABILITY TO PAY OR IF THE PAYMENTS TO BE RECEIVED WILL BE LESS THAN THE COST TO PROVIDE THE SERVICE, WHICH IS THE CASE FOR MEDICARE AND MEDICAID PATIENTS THE MEDICARE ALLOWABLE COSTS ON LINE 6 PART III HAVE BEEN CALCULATED BY MULTIPLYING MEDICARE CHARGES BY THE PATIENT CARE COST TO CHARGE RATIO DERIVED FROM WORKSHEET 2 THE AMOUNT IS COMPARED TO TOTAL MEDICARE PAYMENTS RECEIVED INCLUDING DSH AND IME PAYMENTS THIS SHORTFALL SHOULD BE TREATED AS A COMMUNITY BENEFIT SINCE IT REFLECTS UNREIMBURSED COSTS TO THE HEALTH SYSTEM FOR PROVIDING MEDICAL SERVICES TO THE MEDICARE RESIDENTS OF THE COMMUNITY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b Collection practices for patients eligible for financial assistance	THE CORPORATION HAS A FAIR BILLING/COLLECTION POLICY WHICH APPLIES FOR ALL PATIENTS THE POLICY INCLUDES -REQUIRED INFORMATION PROVIDED IN BILLS TO PATIENTS (INCLUDING A REQUIREMENT THAT INFORMATION BE PROVIDED ON HOW THE PATIENT MAY APPLY FOR FINANCIAL ASSISTANCE) -PROCESS FOR PATIENTS TO INQUIRE ABOUT OR DISPUTE A BILL, INCLUDING TOLL-FREE TELEPHONE NUMBER, ADDRESS, CONTACT NAME, AND E-MAIL ADDRESS -REQUIREMENTS FOR TIMELY RESPONSE TO PATIENT INQUIRIES -CONDITIONS WHICH MUST BE SATISFIED BEFORE PATIENT MAY BE SENT TO A COLLECTION AGENCY OR ATTORNEY -LEGAL ACTION FOR NON-PAYMENT OF A PATIENT BILL MAY NOT BE INITIATED UNTIL AN AUTHORIZED HOSPITAL OFFICIAL HAS DETERMINED THAT ALL CONDITIONS IN THE CORPORATION'S POLICY (INCLUDING ALL OF THE FOREGOING POLICY PROVISIONS) HAVE BEEN SATISFIED FOR INITIATING LEGAL ACTION -LEGAL ACTION MAY NOT BE PURSUED AGAINST UNINSURED PATIENTS WHO HAVE CLEARLY DEMONSTRATED THAT THEY HAVE NEITHER SUFFICIENT INCOME NOR ASSETS TO MEET THEIR FINANCIAL OBLIGATIONS - EVEN IF SUCH PATIENTS DO NOT APPLY FOR FINANCIAL ASSISTANCE -THE CORPORATION SHALL NOT OBTAIN A BODY ATTACHMENT AGAINST ANY PATIENT OR GUARANTOR -THE CORPORATION SHALL NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTIONS, SUCH AS SUBMITTING REPORTS TO CREDIT AGENCIES BEFORE REASONABLE EFFORTS TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE HAVE BEEN COMPLETED -IF A PATIENT RECEIVES AN APPLICATION FOR FINANCIAL ASSISTANCE BUT FAILS TO RETURN IT, OSF WILL TRY TO USE SECONDARY SOURCES TO DETERMINE THE PATIENT'S ELIGIBILITY FOR NONCOMPLIANT CHARITY BEFORE PURSUING LEGAL ACTION FOR NONPAYMENT IF A COMPLETE APPLICATION IS RECEIVED DURING THE APPLICATION PERIOD, OSF WILL SUSPEND EXTRAORDINARY COLLECTION ACTIONS AND MAKE A DETERMINATION OF ELIGIBILITY FOR ASSISTANCE IF THE PATIENT IS ELIGIBLE FOR FINANCIAL ASSISTANCE, OSF WILL ISSUE APPROPRIATE REFUNDS AND REVERSE ANY EXTRAORDINARY COLLECTION ACTIONS TAKEN, AS MORE FULLY DESCRIBED IN THE OSF FAIR BILLING - COLLECTION POLICY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16a FAP website	- SAINT FRANCIS MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT ANTHONY MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HEART OF MARY MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - OSF SACRED HEART MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - ST JOSEPH MEDICAL CENTER Line 16a URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT ANTHONY'S HEALTH CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST MARY MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT JAMES HOSPITAL Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST FRANCIS HOSPITAL Line 16a URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT LUKE MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HOLY FAMILY MEDICAL CENTER Line 16a URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/,

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16b FAP Application website	- SAINT FRANCIS MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT ANTHONY MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HEART OF MARY MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - OSF SACRED HEART MEDICAL CENTER Line 16b URL (HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - ST JOSEPH MEDICAL CENTER Line 16b URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT ANTHONY'S HEALTH CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST MARY MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT JAMES HOSPITAL Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST FRANCIS HOSPITAL Line 16b URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT LUKE MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HOLY FAMILY MEDICAL CENTER Line 16b URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/,

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Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16c FAP plain language summary website	- SAINT FRANCIS MEDICAL CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT ANTHONY MEDICAL CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HEART OF MARY MEDICAL CENTER Line 16c URL (HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - OSF SACRED HEART MEDICAL CENTER Line 16c URL (HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINACIAL-ASSISTANCE/, - ST JOSEPH MEDICAL CENTER Line 16c URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT ANTHONY'S HEALTH CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST MARY MEDICAL CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - SAINT JAMES HOSPITAL Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - ST FRANCIS HOSPITAL Line 16c URL https //www osfhealthcare org/billing/financial-assistance/, - OSF SAINT LUKE MEDICAL CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/, - OSF HOLY FAMILY MEDICAL CENTER Line 16c URL HTTPS //WWW OSFHEALTHCARE ORG/BILLING/FINANCIAL-ASSISTANCE/,

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2 Needs assessment	THE CORPORATION COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS PREVIOUSLY STATED THE CHNA IS UPDATED EVERY 3 YEARS AND CORRESPONDING IMPLEMENTATION STRATEGY IS REFRESHED YEARLY NOT ONLY DOES THE IMPLEMENTATION STRATEGY PLAN GET REFRESHED YEARLY, BUT EACH ACTION ITEM HAS A RESPONSIBLE PARTY INVOLVED TO GET THE WORK ASSOCIATED WITH THE NEED ACCOMPLISHED LEADERSHIP WITHIN OSF SIT ON VARIOUS COMMUNITY ADVISORY BOARDS TO STAY CONNECTED TO THE OTHER AGENCIES WITHIN THE COMMUNITY THIS WORK ALIGNS WITH OUR MISSION STATEMENT TO SERVE PERSONS WITH THE GREATEST CARE AND LOVE IN A COMMUNITY THAT CELEBRATES THE GIFT OF LIFE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3 Patient education of eligibility for assistance	THE CORPORATION INFORMS AND EDUCATES PATIENTS AND PERSONS WHO ARE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY FOR ASSISTANCE UNDER GOVERNMENT PROGRAMS AND THE CORPORATION'S FINANCIAL ASSISTANCE POLICY, IN ENGLISH AND IN ANY OTHER LANGUAGE SPOKEN BY POPULATIONS WITH LIMITED ENGLISH PROFICIENCY THAT CONSTITUTE THE LESSER OF 1,000 INDIVIDUALS OR 5% OF THE COMMUNITY OF THE HOSPITAL, IN THE FOLLOWING WAYS -SIGNS ARE POSTED IN PATIENT REGISTRATION AREAS (INCLUDING EMERGENCY DEPARTMENT REGISTRATION) INFORMING PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE, THE AVAILABILITY OF FINANCIAL ASSISTANCE COUNSELORS, AND HOW TO OBTAIN A COPY OF THE OSF FINANCIAL ASSISTANCE POLICY AND APPLICATION -A PLAIN LANGUAGE SUMMARY OF THE OSF FINANCIAL ASSISTANCE POLICY IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS AND INCLUDED IN THE BILLING STATEMENT MAILED PRIOR TO INITIATING EXTRAORDINARY COLLECTION ACTIONS IN ADDITION, THE PLAIN LANGUAGE SUMMARY AND APPLICATION ARE PROVIDED TO REFERRING STAFF PHYSICIANS -OSF MAKES REASONABLE EFFORTS TO ORALLY NOTIFY PATIENTS ABOUT THE FINANCIAL ASSISTANCE POLICY AND HOW TO OBTAIN ASSISTANCE IN APPLYING -A NOTICE OF AVAILABILITY OF THE CORPORATION'S FINANCIAL ASSISTANCE AND UNINSURED PATIENT DISCOUNT POLICIES IS PROMINENTLY AVAILABLE ON THE CORPORATION'S WEB SITE (AND SEPARATE WEB SITES OF ITS HOSPITAL FACILITIES) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM AND INSTRUCTIONS WITH THE PLAIN LANGUAGE SUMMARY ARE AVAILABLE FOR DOWNLOAD -A NOTE REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE (TOGETHER WITH CONTACT PHONE NUMBERS) APPEARS ON EVERY PATIENT BILLING STATEMENT AS WELL AS THE WEBSITE WHERE COPIES OF THE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY MAY BE OBTAINED -FINANCIAL ASSISTANCE COUNSELORS ARE AVAILABLE IN PERSON AND BY PHONE TO ASSIST PATIENTS IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION AND IN DETERMINING ELIGIBILITY AND APPLYING FOR GOVERNMENT PROGRAM BENEFITS, INCLUDING MEDICAID -THE CORPORATION'S FINANCIAL ASSISTANCE POLICY IS FILED WITH THE ILLINOIS ATTORNEY GENERAL AND IS AVAILABLE TO THE PUBLIC

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community Information	<p>THE FOLLOWING DEMOGRAPHICS WERE TAKEN FROM THE 2016 CHNA, THESE DEMOGRAPHICS WILL BE UPDATED IN NEXT YEAR'S REPORT SAINT FRANCIS MEDICAL CENTER IS A 629-LICENSED BED TERTIARY ACUTE CARE TEACHING HOSPITAL LOCATED NEAR DOWNTOWN PEORIA, ILLINOIS FOUNDED IN 1877, OSF SAINT FRANCIS MEDICAL CENTER WAS THE FIRST HOSPITAL ESTABLISHED BY THE CONGREGATION TODAY OSF SAINT FRANCIS MEDICAL CENTER IS THE LARGEST MEDICAL CENTER IN ILLINOIS LOCATED OUTSIDE OF COOK COUNTY, WITH A MEDICAL STAFF OF MORE THAN 863 PHYSICIANS, 5,642 EMPLOYEES A TEACHING AFFILIATE OF THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA, OSF SAINT FRANCIS MEDICAL CENTER IS THE PEORIA AREA'S ONLY LEVEL 1 TRAUMA CENTER AND TERTIARY CARE MEDICAL CENTER OSF SAINT FRANCIS MEDICAL CENTER IS ALSO HOME TO THE CHILDREN'S HOSPITAL OF ILLINOIS, OSF SAINT FRANCIS HEART HOSPITAL AND THE ILLINOIS NEUROLOGICAL INSTITUTE IN ADDITION TO PROVIDING THE FULL RANGE OF PRIMARY, SECONDARY AND TERTIARY SERVICES, OSF SAINT FRANCIS MEDICAL CENTER PROVIDES CERTAIN SPECIALIZED SERVICES, INCLUDING LEVEL I (HIGHEST LEVEL) TRAUMA SERVICES, LIFE FLIGHT HELICOPTER TRANSPORT SERVICES (USING THE HELICOPTERS LEASED BY OSF AVIATION), ADULT AND PEDIATRIC OPEN HEART SURGERY, PANCREAS AND KIDNEY TRANSPLANTATION SERVICES, NEUROSURGERY AND NEUROLOGY, LEVEL III (HIGHEST LEVEL) PERINATAL SERVICES, RADIATION ONCOLOGY (INCLUDING GAMMA KNIFE AND THE VARIAN TRILOGY UNIT), AND SPECIALIZED SERVICES OF THE CHILDREN'S HOSPITAL OF ILLINOIS (WHICH IS OPERATED AS A PART OF OSF SAINT FRANCIS MEDICAL CENTER) AS NOTED IN THE CHNA, SAINT FRANCIS MEDICAL CENTER PRIMARILY SERVES THOSE IN THE COUNTIES OF PEORIA, TAZEWELL, AND WOODFORD PEORIA COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 187,319 FOR PEORIA COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$50,712 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 17% TAZEWELL COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 135,707 FOR TAZEWELL COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$56,067 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 9.3% WOODFORD COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 39,187 FOR WOODFORD COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$66,639 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 8.1% SAINT ANTHONY MEDICAL CENTER ("SAINT ANTHONY") IS A 254 LICENSED BED ACUTE CARE HOSPITAL LOCATED ON THE NORTHEAST SIDE OF ROCKFORD, ILLINOIS IT IS THE REGION'S RESOURCE CENTER FOR EMERGENCY SERVICES SAINT ANTHONY - ROCKFORD PROVIDES PRIMARY, SECONDARY AND TERTIARY CARE, INCLUDING OPEN HEART SURGERY AND IS DESIGNATED BY THE STATE OF ILLINOIS AS A LEVEL I (HIGHEST LEVEL) TRAUMA CENTER AND A REGIONAL BURN UNIT SAINT ANTHONY COLLEGE OF NURSING IS AN INTEGRAL PART OF THE HOSPITAL IT'S A FULLY ACCREDITED COLLEGE OF NURSING GRANTING BACCALAUREATE, MASTERS AND DOCTORATE OF NURSING PRACTICE DEGREES AS NOTED IN THE CHNA, SAINT ANTHONY MEDICAL CENTER IS LOCATED IN WINNEBAGO COUNTY WINNEBAGO COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 288,542 FOR WINNEBAGO COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$47,072 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 17% OSF ST JOSEPH MEDICAL CENTER ("ST JOSEPH") IN BLOOMINGTON, ILLINOIS, AND OSF SAINT JAMES-JOHN W. ALBRECHT MEDICAL CENTER ("SAINT JAMES") IN PONTIAC, ILLINOIS ARE LOCATED APPROXIMATELY 35 MILES APART AND SERVE PARTIALLY OVERLAPPING MARKETS RESIDENTS OF PONTIAC AND ITS SURROUNDING AREAS FREQUENTLY TRAVEL TO BLOOMINGTON TO RECEIVE HEALTH CARE SERVICES ST JOSEPH IS A 137-LICENSED ACUTE CARE BED AND 12 BED SKILLED NURSING CARE HOSPITAL LOCATED ON THE EAST SIDE OF BLOOMINGTON, ILLINOIS ST JOSEPH IS A COMMUNITY-SIZED HOSPITAL THAT PROVIDES A NUMBER OF HIGH LEVEL TERTIARY SERVICES INCLUDING OPEN HEART SURGERY, ENDOVASCULAR SURGERY AND INTERVENTIONAL NEURORADIOLOGY SAINT JAMES HOSPITAL HAS 42 LICENSED ACUTE CARE BEDS, WHICH INCLUDES 33 MEDICARE APPROVED SWING BEDS THIS HOSPITAL FACILITY IS LOCATED ON THE WEST SIDE OF PONTIAC, ILLINOIS, NEAR INTERSTATE 55 AND WAS COMPLETED IN SEPTEMBER 2002 SAINT JAMES IS THE ONLY ACUTE CARE HOSPITAL LOCATED IN LIVINGSTON COUNTY, ILLINOIS THE NEAREST COMPETING HOSPITAL TO SAINT JAMES IS ADVOCATE BROMENN MEDICAL CENTER IN NORMAL, ILLINOIS, WITH 198 (STAFFED) ACUTE CARE BEDS, LOCATED APPROXIMATELY 37 MILES FROM SAINT JAMES AS NOTED IN THE CHNA, ST JOSEPH MEDICAL CENTER IS LOCATED IN MCLEAN COUNTY IN ILLINOIS MCLEAN COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2016 WAS 174,879 FOR MCLEAN COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2014 WAS \$66,355 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 14.7% SAINT JAMES HOSPITAL IS LOCATED IN LIVINGSTON COUNTY IN ILLINOIS LIVINGSTON COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 38,476 FOR LIVINGSTON COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$54,723 AND THE PERCENT OF PERSONS BELOW POVERTY</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community Information	<p>ERTY LEVEL WAS 10 9% OSF ST MARY MEDICAL CENTER ("ST MARY") IN GALESBURG, ILLINOIS, AND OSF HOLY FAMILY MEDICAL CENTER ("HOLY FAMILY") IN MONMOUTH, ILLINOIS ARE LOCATED APPROXIMATELY 19 MILES APART AND SERVE PARTIALLY OVERLAPPING MARKETS RESIDENTS OF MONMOUTH AND ITS SURROUNDING AREAS FREQUENTLY TRAVEL TO GALESBURG TO RECEIVE HEALTH CARE SERVICES THE CORPORATION HAS COMBINED MANAGEMENT AND REPORTING FOR ST MARY AND HOLY FAMILY IN ORDER TO GAIN OPERATING EFFICIENCIES AND EXECUTE THE SYSTEM'S STRATEGIC PLANS ACROSS THIS ENTIRE SERVICE AREA AS NOTED IN THE CHNA, ST MARY IS AN 81 LICENSED BED ACUTE CARE HOSPITAL LOCATED ON THE NORTHEAST SIDE OF GALESBURG, ILLINOIS IN ADDITION TO PRIMARY AND SECONDARY CARE, ST MARY HAS DESIGNATIONS FROM THE STATE OF ILLINOIS AS A LEVEL II TRAUMA CENTER, A TRAUMA NETWORK RESOURCE HOSPITAL, A LEVEL II PERINATAL CENTER AND A HEMOPHILIA EMERGENCY TREATMENT CENTER ST MARY HAS BEEN DESIGNATED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES ("CMS") AS A RURAL REFERRAL CENTER ST MARY IS QUALIFIED AS A MEDICARE DEPENDENT HOSPITAL AND THEREBY IS ENTITLED TO ADDITIONAL MEDICARE REIMBURSEMENT HOLY FAMILY IS A 23 LICENSED BED CRITICAL ACCESS HOSPITAL FACILITY LOCATED IN MONMOUTH, ILLINOIS ALL OF ITS ACUTE BEDS ARE ALSO MEDICARE APPROVED SWING BEDS AS NOTED IN THE CHNA, ST MARY MEDICAL CENTER IS LOCATED IN KNOX COUNTY IN ILLINOIS AND PRIMARILY SERVES RESIDENTS LIVING IN KNOX AND WARREN COUNTIES THE CHNA SHOWS 83% OF PATIENTS COME FROM KNOX AND WARREN COUNTIES KNOX COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 52,069 FOR KNOX COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$40,667 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 17 7% OSF HOLY FAMILY MEDICAL CENTER IS LOCATED IN WARREN COUNTY IN ILLINOIS WARREN COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 17,874 FOR WARREN COUNTY, THE MEDIAN HOUSEHOLD INCOME IN 2014 WAS \$43,536 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 15 6% OSF ST FRANCIS HOSPITAL IS A CRITICAL ACCESS HOSPITAL LOCATED ON THE WEST SIDE OF ESCANABA, MICHIGAN OSF ST FRANCIS HOSPITAL IS CURRENTLY LICENSED FOR AND OPERATES 25 INPATIENT BEDS, WHICH INCLUDES TEN MEDICARE APPROVED SWING BEDS OSF ST FRANCIS HOSPITAL IS SITUATED ON APPROXIMATELY 82 ACRES OF LAND AT THE WEST END OF THE ESCANABA CITY LIMITS AS THE ONLY HOSPITAL IN DELTA COUNTY, MICHIGAN, OSF ST FRANCIS HOSPITAL PROVIDES A RANGE OF INPATIENT AND OUTPATIENT HOSPITAL, DIAGNOSTIC, THERAPEUTIC AND ANCILLARY SERVICES AS NOTED IN THE CHNA, ST FRANCIS HOSPITAL IS LOCATED IN DELTA COUNTY IN MICHIGAN DELTA COUNTY IS A METROPOLITAN STATISTICAL AREA AND ITS POPULATION IN 2014 WAS 36,559 FOR DELTA COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$49,087 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 17 2% OSF SAINT LUKE MEDICAL CENTER ("SAINT LUKE"), FORMERLY KNOWN AS KEWANEE HOSPITAL, IS A CRITICAL ACCESS HOSPITAL LOCATED IN KEWANEE, ILLINOIS THE CORPORATION COMMENCED OPERATIONS AT SAINT LUKE ON MAY 1, 2014 SAINT LUKE IS CURRENTLY LICENSED FOR AND OPERATES 25 INPATIENT BEDS, PROVIDING BASIC, PRIMARY CARE, ANCILLARY SERVICES, CLINICS AND SPECIALTY CLINICS SAINT LUKE'S SERVICE AREAS ARE LOCATED PRIMARILY IN HENRY COUNTY BUT EXTEND INTO PORTIONS OF STARK AND BUREAU COUNTIES, APPROXIMATELY 50 MILES NORTHWEST OF PEORIA AS NOTED IN THE CHNA, OSF SAINT LUKE MEDICAL CENTER IS LOCATED IN HENRY COUNTY ITS POPULATION IN 2014 WAS 49,635 FOR HENRY COUNTY, THE MEDIAN HOUSEHOLD INCOME FROM 2009-2013 WAS \$52,940 AND THE PERCENT OF PERSONS BELOW POVERTY LEVEL WAS 14 4%</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5 Promotion of community health	<p>THE CORPORATION'S SPONSORING ORGANIZATION IS A RELIGIOUS CONGREGATION OF THE ROMAN CATHOLIC CHURCH KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS IN ACCORDANCE WITH CANON LAW OF THE ROMAN CATHOLIC CHURCH AND FEDERAL TAX LAW APPLICABLE TO SUPPORTING ORGANIZATIONS, A MAJORITY OF THE MEMBERS OF THE BOARD OF DIRECTORS OF THE CORPORATION ARE PROFESSED MEMBERS OF THE SPONSORING RELIGIOUS CONGREGATION EACH HOSPITAL OPERATED BY THE CORPORATION HAS A COMMUNITY ADVISORY BOARD CONSISTING OF MEMBERS OF THE COMMUNITY WHO ARE NOT DIRECTORS, OFFICERS, OR CONTRACTORS OF THE CORPORATION EXCEPT FOR HOSPITAL DEPARTMENTS WHICH HAVE BEEN CLOSED, OR IN WHICH CLINICAL PRIVILEGES HAVE BEEN RESTRICTED, FOR CLINICAL OR QUALITY OF CARE REASONS BY ACTIONS OF THE HOSPITAL'S MEDICAL STAFF AND THE BOARD OF DIRECTORS, THE CORPORATION EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITIES THE CORPORATION'S SURPLUS FUNDS WERE USED DURING ITS FISCAL YEAR ENDED SEPTEMBER 30, 2018 FOR IMPROVEMENTS IN PATIENT CARE, MEDICAL EDUCATION, AND RESEARCH IN THE FOLLOWING WAYS -CAPITAL EXPENDITURES OF APPROXIMATELY \$75,896,000 WERE MADE DURING THE FISCAL YEAR FOR CONSTRUCTION AND RENOVATION OF PATIENT CARE FACILITIES AND ACQUISITION OF MEDICAL EQUIPMENT AND OTHER EQUIPMENT USED IN PATIENT CARE AND RELATED SUPPORT SERVICES -THE CORPORATION INCURRED NET COSTS (EXPENSES MINUS REVENUES) OF APPROXIMATELY \$44,190,333 DURING THE FISCAL YEAR FOR ACCREDITED PHYSICIAN RESIDENCY PROGRAMS AND NET COSTS OF APPROXIMATELY \$5,422,271 FOR UNDERGRADUATE AND GRADUATE NURSING EDUCATION PROGRAMS AND OTHER MEDICAL EDUCATION PROGRAMS SEE SCHEDULE O, FORM 990, PART III, LINE 4D FOR A DESCRIPTION OF SUCH PROGRAMS -THE CORPORATION INCURRED NET COSTS (EXPENSES MINUS REVENUES) OF APPROXIMATELY \$1,110,475 DURING THE FISCAL YEAR FOR CLINICAL RESEARCH PROGRAMS AND ACTIVITIES ALL OF THE CORPORATION'S HOSPITALS MEET THE REQUIREMENTS OF REVENUE RULING 69-545 BY -OPERATING EMERGENCY DEPARTMENTS WHICH ARE STAFFED 24 HOURS PER DAY BY QUALIFIED PHYSICIANS AND OTHER MEDICAL PERSONNEL AND WHICH ARE OPEN TO ALL PERSONS WITHOUT REGARD TO ABILITY TO PAY -HAVING MEDICAL STAFFS WHICH ARE OPEN TO ALL QUALIFIED PHYSICIANS, MID-LEVEL PROVIDERS, PODIATRISTS, AND DENTISTS IN THE COMMUNITY (EXCEPT WHERE RESTRICTED IN RARE CASES FOR CLINICAL QUALITY REASONS BY ACTION OF THE MEDICAL STAFF AND THE BOARD OF DIRECTORS) -ACCEPTING MEDICARE, MEDICAID AND OTHER GOVERNMENT PROGRAM PATIENTS -ACCEPTING ALL PATIENTS, INCLUDING UNINSURED PATIENTS, WITHOUT REGARD TO THEIR ABILITY TO PAY -USING SURPLUS FUNDS TO IMPROVE THEIR FACILITIES, EQUIPMENT, PATIENT CARE, MEDICAL TRAINING, EDUCATION, AND RESEARCH AS DESCRIBED ABOVE SEE SCHEDULE H, PART VI, LINE 4 COMMUNITY INFORMATION FOR A SUMMARY OF SERVICES EACH OSF HOSPITAL PROVIDES OSF HEALTHCARE SYSTEM IS CHARGED WITH PROMOTING COMMUNITY HEALTH THE OSF CENTER FOR HEALTH IN STREATOR IS BEING TRANSFORMED INTO A HUB THAT NOT ONLY TAKES CARE OF THE PHYSICAL HEALTH OF INDIVIDUALS, BUT ENDEAVORS TO POSITIVELY SHAPE THE ENVIRONMENT, SOCIAL AND ECONOMIC STATUS AND LIFESTYLE CHOICES OF THE ENTIRE COMMUNITY THE ORGANIZATION IS ENLISTING A VARIETY OF COMMUNITY-BASED ORGANIZATIONS TO CO-LOCATE WITHIN THE CENTER FOR HEALTH, MAKING THE FACILITY A CONVENIENT SPACE FOR HEALTH AND WELLNESS NEEDS OSF IS UTILIZING SOFTWARE DEVELOPED BY PIECE TECHNOLOGIES, A PART OF THE OSF VENTURES PORTFOLIO, TO BRIDGE THE INFORMATION GAP THAT IS TYPICALLY PREVALENT AMONG SOCIAL SERVICE ORGANIZATIONS AND HEALTH CARE PROVIDERS COMMUNITY-BASED GROUPS AND OSF WILL HAVE THE ABILITY TO BETTER COMMUNICATE ABOUT PATIENTS' WELL-BEING AND INTERVENE SOONER IN THEIR HEALTH CARE OSF PARTNERS WITH INCUBATORS, ACCELERATORS, CORPORATIONS AND UNIVERSITIES OUTSIDE OF THE MINISTRY TO DISCOVER TECHNOLOGY, PRODUCTS AND SERVICES WE CAN FURTHER DEVELOP TO MEET OUR NEEDS, TEST, PILOT AND/OR IMPLEMENT THROUGHOUT THE HEALTH CARE SYSTEM ONE OF THESE PARTNERSHIPS INCLUDES PATIENT WISDOM PATIENT WISDOM IS A DIGITAL PLATFORM THAT COLLECTS AND SHARES PATIENT STORIES TO IMPROVE HEALTH AND THE EXPERIENCE OF CARE FOR THE PHYSICIAN/PATIENT RELATIONSHIP OSF IS FOCUSING EFFORTS AND RESOURCES FOR ADDITIONAL INNOVATION PROJECTS IN THE FOLLOWING AREAS "ADVANCING SIMULATION, "MORE FOR THOSE WITH LESS", "RADICAL ACCESS TO CARE AND AGING IN PLACE" MORE ON THIS CAN BE FOUND HERE HTTPS //WWW.OSFHEALTHCARE.ORG/INNOVATION/ OSF HAS CREATED A BEHAVIORAL HEALTH UNIT AT THE SYSTEM LEVEL TO HELP CLOSE GAPS WITH BEHAVIORAL HEALTH NEEDS THROUGH THE COMMUNITIES WE SERVE OSF NOW OFFERS ON CALL 24/7 ONLINE ACCESS TO MEDICAL CARE VIA SMART PHONE, TABLET OR COMPUTER THE ABOVE ARE JUST A FEW EXAMPLES OF HOW OSF HEALTHCARE SYSTEM IS PROMOTING COMMUNITY HEALTH</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 Affiliated health care system	<p>THE CORPORATION IS PART OF AN AFFILIATED HEALTH CARE SYSTEM (THE "OSF SYSTEM") WHICH PROVIDES INTEGRATED HEALTH CARE SERVICES THROUGHOUT CENTRAL ILLINOIS, PARTS OF NORTHERN ILLINOIS, AND PARTS OF THE UPPER PENINSULA OF MICHIGAN. THE OSF SYSTEM INCLUDES THE OTHER CORPORATIONS LISTED BELOW, ALL OF WHICH ARE CONTROLLED, DIRECTLY OR INDIRECTLY, BY THE SISTERS OF THE THIRD ORDER OF SAINT FRANCIS (THE "CONGREGATION"). ALL AFFILIATED CORPORATIONS (WHETHER TAXABLE OR EXEMPT) APPLY AND FOLLOW THE CHARITY CARE POLICIES OF THE CORPORATION AND ARE OPERATED IN FURTHERANCE OF THE MISSION OF THE CONGREGATION TO PROVIDE COMPREHENSIVE, INTEGRATED, QUALITY CARE, INCLUDING PREVENTIVE, PRIMARY, ACUTE, CONTINUOUS AND REHABILITATIVE HEALTH SERVICES TO THE COMMUNITIES SERVED BY THE CORPORATION AND THE OSF SYSTEM. SPECIAL EMPHASIS IS PLACED ON MEETING THE PHYSICAL, SPIRITUAL, EMOTIONAL, AND SOCIAL NEEDS OF EVERYONE WHO IS CARED FOR IN THE OSF SYSTEM REGARDLESS OF RACE, COLOR, RELIGION AND ABILITY TO PAY. THE AFFILIATED CORPORATIONS ARE:</p> <ul style="list-style-type: none"> -THE SISTERS OF THE THIRD ORDER OF SAINT FRANCIS, WHICH HOLDS THE ASSETS OF THE RELIGIOUS CONGREGATION AND DIRECTS ALL OTHER CORPORATIONS IN THE AFFILIATED HEALTH CARE SYSTEM THROUGH BOARD REPRESENTATION AND THE EXERCISE OF RESERVED POWERS -OSF SAINT FRANCIS, INC., AN ILLINOIS BUSINESS CORPORATION, INCORPORATED DECEMBER 23, 1986, WHICH OPERATES FOR-PROFIT BUSINESSES IN SUPPORT OF OSF HEALTHCARE SYSTEM -OSF SAINT FRANCIS, INC. IS THE SOLE SHAREHOLDER OF OSF DESIGN GROUP, INC. AND OSF ASSURANCE COMPANY AND IS THE SOLE MEMBER OF OSF AVIATION, LLC, OSF FINANCE COMPANY, LLC, STATE AND ROXBURY, LLC, AND 124 ADAMS PROPERTY MANAGEMENT, LLC -OSF AVIATION, LLC, WHICH IS AN FAA PART CERTIFIED CARRIER PROVIDING EMS HELICOPTER SERVICES THROUGHOUT CENTRAL ILLINOIS AND PARTS OF NORTHERN ILLINOIS -OSF LIFELINE AMBULANCE, LLC, WHICH PROVIDES GROUND AMBULANCE TRANSPORTATION SERVICES IN PARTS OF NORTHERN ILLINOIS -OSF HEALTHCARE FOUNDATION, AN ILLINOIS NOT-FOR-PROFIT CORPORATION, INCORPORATED JULY 7, 1989, WHICH CONDUCTS FUNDRAISING AND ANY OTHER ACTIVITIES FOR THE BENEFIT OF OSF HEALTHCARE SYSTEM AND IN SUPPORT OF THE MISSION OF THE SISTERS OF THE THIRD ORDER OF SAINT FRANCIS -OSF ASSURANCE COMPANY, A VERMONT GENERAL CORPORATION, INCORPORATED DECEMBER 8, 2004, ORGANIZED FOR THE PURPOSE OF WRITING INSURANCE AND REINSURANCE AS A CAPTIVE INSURANCE COMPANY -OSF SAINT FRANCIS, INC. IS THE SOLE MEMBER OF THIS CORPORATION -OSF FINANCE COMPANY, LLC, AN ILLINOIS LIMITED LIABILITY COMPANY, ORGANIZED ON NOVEMBER 19, 2007, ORGANIZED TO ISSUE ADJUSTABLE RATE TAXABLE SECURITIES, WHOSE PROCEEDS WILL BE LOANED TO OSF SAINT FRANCIS, INC. FOR VARIOUS PROJECTS -OSF SAINT FRANCIS, INC. IS THE SOLE MEMBER OF THIS CORPORATION -ILLINOIS PATHOLOGIST SERVICES, LLC, AN ILLINOIS LIMITED LIABILITY COMPANY, ORGANIZED ON JULY 9, 2009, TO PROVIDE PROFESSIONAL PATHOLOGY SERVICES IN THE ROCKFORD, ILLINOIS, AREA -OSF DESIGN GROUP, INC., AN ILLINOIS BUSINESS CORPORATION, INCORPORATED MAY 20, 2004, WHICH PROVIDES PROFESSIONAL ARCHITECTURAL SERVICES AS A REGISTERED PROFESSIONAL DESIGN FIRM TO OSF HEALTHCARE SYSTEM AND OTHER OSF CORPORATIONS -OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER, AN ILLINOIS NOT-FOR-PROFIT CORPORATION (FORMERLY NAMED COMMUNITY HOSPITAL OF OTTAWA), INCORPORATED ON DECEMBER 7, 1964 -OSF HEALTHCARE SYSTEM BECAME THE SOLE MEMBER OF THIS CORPORATION ON APRIL 30, 2012, AND THE HOSPITAL WAS RENAMED AS D/B/A OSF SAINT ELIZABETH MEDICAL CENTER -OSF MULTI-SPECIALTY GROUP, AN ILLINOIS NOT-FOR-PROFIT CORPORATION, CREATED ON SEPTEMBER 8, 2011, EMPLOYS PRIMARY CARE AND SPECIALTY PHYSICIANS, MID-LEVEL PROVIDERS, NURSES, AND SUPPORT PERSONNEL TO PROVIDE PROFESSIONAL HEALTH CARE SERVICES -POINTCORE, LLC, A DELAWARE LIMITED LIABILITY COMPANY, FOUNDED ON MARCH 19, 2014, WHICH WILL IMPROVE THE QUALITY OF HEALTHCARE BY POOLING THE RESOURCES OF ITS MEMBERS TO PROVIDE SERVICES TO ITS MEMBERS AND THIRD PARTIES -SAINT ANTHONY'S, LLC, A DELAWARE LIMITED LIABILITY COMPANY, CREATED ON APRIL 17, 2000 THE CORPORATION, WITH ITS PRINCIPAL OFFICE IN ALTON, ILLINOIS, OPERATES EXCLUSIVELY FOR CHARITABLE, EDUCATIONAL AND SCIENTIFIC PURPOSES, SPECIFICALLY, TO OWN, OPERATE OR MAINTAIN THE AFFAIRS OF INSTITUTIONS THAT FOSTER LOW INCOME HOUSING, PROVIDE AND IMPROVE HEALTH SERVICES, PROMOTE PHYSICIAN AND MENTAL WELL-BEING AND INDEPENDENCE AND MOBILIZE COMMUNITY SUPPORT AND RESOURCES TO SERVE SAID HEALTH AND HOUSING NEEDS -OSF HEALTHCARE SYSTEM BECAME THE SOLE MEMBER OF THIS CORPORATION ON NOVEMBER 1, 2014 -NDC CORPORATE EQUITY FUND IV, L.P. WAS THE PARTY INVOLVED WITH SAINT ANTHONY'S, LLC IN THE SAINT CLARE'S VILLA, LIMITED PARTNERSHIP IN ALTON, ILLINOIS ON JANUARY 1, 2017, SAINT ANTHONY'S, LLC BECAME THE SOLE MEMBER OF SAINT CLARE'S VILLA WHEN IT ACCEPTED THE ASSIGNMENT OF NDC'S SHARES ON DECEMBER 31, 2016 -SAINT CLARE'S VILLA, LIMITED PARTNERSHIP, AN ILLINOIS LIMITED PARTNERSHIP, CREATED ON APRIL 17, 2000, BETWEEN SAINT ANTHONY'S, LLC AND NDC CORPORATE EQUITY

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 Affiliated health care system	<p>Y FUND IV, L P SAINT CLARE'S VILLA OPERATES A 64 BED LOW INCOME ASSISTED LIVING FACILITY FOR THE ELDERLY AT 915 EAST FIFTH STREET IN ALTON, ILLINOIS SAINT ANTHONY'S, LLC BECAME THE SOLE MEMBER OF SAINT CLARE'S VILLA ON JANUARY 1, 2017 -MENDOTA COMMUNITY HOSPITAL, AN ILLINOIS NOT-FOR-PROFIT CORPORATION, CREATED ON MARCH 24, 1944, WITH THE NAME MENDOTA HOSPITAL FOUNDATION THE NAME OF THE CORPORATION WAS CHANGED TO MENDOTA COMMUNITY HOSPITAL ON JUNE 16, 1967 OSF HEALTHCARE SYSTEM BECAME THE SOLE MEMBER OF THIS CORPORATION ON APRIL 1, 2015, AND THE HOSPITAL WAS RENAMED AS D/B/A OSF SAINT PAUL MEDICAL CENTER -STATE AND ROXBURY, LLC, AN ILLINOIS LIMITED LIABILITY COMPANY, ESTABLISHED ON JANUARY 10, 2008, WAS ORGANIZED TO ACQUIRE AND OPERATE THE REAL ESTATE AT 5668 EAST STATE STREET, ROCKFORD, ILLINOIS STATE AND ROXBURY, LLC WAS INITIALLY OWNED BY SAINT ANTHONY MEDICAL CENTER (51%) AND BRENT B JOHNSON (49%) EFFECTIVE FEBRUARY 1, 2016, SAINT ANTHONY MEDICAL CENTER PURCHASED THE 49% OWNERSHIP OF BRENT B JOHNSON OSF SAINT FRANCIS, INC SUBSEQUENTLY PURCHASED 100% OWNERSHIP OF STATE AND ROXBURY, LLC FROM SAINT ANTHONY MEDICAL CENTER AND BECAME THE SOLE MEMBER STATE AND ROXBURY, LLC IS A MEMBER MANAGED COMPANY -OSF COLLEGE OF HEALTH SCIENCES, AN ILLINOIS NOT-FOR-PROFIT CORPORATION, CREATED ON NOVEMBER 7, 2016, HAS OVERSIGHT OVER ONE OR MORE EDUCATIONAL INSTITUTIONS FOR THE TRAINING OF INDIVIDUALS FOR THE PURPOSE OF IMPROVING OR DEVELOPING THEIR CAPABILITIES AND INSTRUCTION OF THE PUBLIC ON SUBJECTS USEFUL TO INDIVIDUALS AND BENEFICIAL TO THE COMMUNITY INCLUDING AND WITHOUT LIMITATION ONE OR MORE COLLEGES OF NURSING INITIAL DIVISIONS INCLUDE D/B/A SAINT ANTHONY COLLEGE OF NURSING, ROCKFORD, ILLINOIS, AND D/B/A SAINT FRANCIS MEDICAL CENTER COLLEGE OF NURSING, PEORIA, ILLINOIS -124 ADAMS PROPERTY MANAGEMENT, LLC, AN ILLINOIS LIMITED LIABILITY COMPANY, ORGANIZED ON DECEMBER 11, 2017, OPERATES TO MANAGE 124 ADAMS PROPERTY HOLDINGS, LLC OSF SAINT FRANCIS, INC IS THE SOLE MEMBER OF THIS CORPORATION</p>

990 Schedule H, Supplemental Information

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

Schedule H (Form 990) 2017

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
EIN: 37-0813229
Name: OSF Healthcare System

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 11		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	SAINT FRANCIS MEDICAL CENTER 530 NE GLEN OAK AVENUE PEORIA, IL 61637 https://www.osfhealthcare.org/saint-francis/ IL0002394	X	X	X	X		X	X	X		
2	SAINT ANTHONY MEDICAL CENTER 5666 EAST STATE STREET ROCKFORD, IL 61108 https://www.osfhealthcare.org/saint-anthony/ IL0002253	X	X		X		X	X			
3	OSF HEART OF MARY MEDICAL CENTER 1400 W PARK STREET URBANA, IL 61801 https://www.osfhealthcare.org/heart-of-mary/ IL0006080	X	X		X			X			
4	OSF SACRED HEART MEDICAL CENTER 812 N LOGAN AVENUE DANVILLE, IL 61832 https://www.osfhealthcare.org/sacred-heart/ IL0006072	X	X					X			
5	ST JOSEPH MEDICAL CENTER 2200 EAST WASHINGTON STREET BLOOMINGTON, IL 61701 https://www.osfhealthcare.org/st-joseph/ IL0002535	X	X					X			

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

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 11											
Name, address, primary website address, and state license number											
6	OSF SAINT ANTHONY'S HEALTH CENTER 1 ST ANTHONYS WAY ALTON, IL 62002 https://www.osfhealthcare.org/saint-anthonys/ IL0005942	X	X					X			
7	ST MARY MEDICAL CENTER 3333 NORTH SEMINARY STREET GALESBURG, IL 61401 https://www.osfhealthcare.org/st-mary/ IL0002675	X	X					X			
8	SAINT JAMES HOSPITAL 2500 W REYNOLDS STREET PONTIAC, MI 48176 https://www.osfhealthcare.org/saint-james/ IL0005264	X	X					X			
9	ST FRANCIS HOSPITAL 3401 LUDINGTON STREET ESCANABA, MI 49829 https://www.osfhealthcare.org/st-francis/ MI1060000051	X	X			X		X			
10	OSF SAINT LUKE MEDICAL CENTER 1051 W SOUTH STREET KEWANEE, IL 61443 https://www.osfhealthcare.org/saint-luke/ IL0005926	X	X			X		X			

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

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 11											
Name, address, primary website address, and state license number											
11	OSF HOLY FAMILY MEDICAL CENTER 1000 W HARLEM AVENUE MONMOUTH, IL 61462 https://www.osfhealthcare.org/holy-family/ IL0005439	X	X			X		X			

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA. See CHNA for further information.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER FOR THE 2016 CHNA, OSF HEALTHCARE CENTER d/b/a OSF FRANCIS MEDICAL CENTER SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) ADMINISTRATORS FROM THE PEORIA, WOODFORD AND TAZEWELL COUNTY HEALTH DEPARTMENTS 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WAS RECEIVED FROM A COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE TRI-COUNTY COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS, HEALTH CARE PROVIDERS INCLUDING KINDRED HOSPITAL, ADVOCATE EUREKA HOSPITAL, HOPEDALE MEDICAL COMPLEX, PEKIN HOSPITAL, THE CHIEF MEDICAL OFFICER OF A FEDERALLY QUALIFIED HEALTH CENTER AND EPIDEMIOLOGISTS WORKING WITH THE PEORIA AND TAZEWELL COUNTY HEALTH DEPARTMENTS, HEART OF ILLINOIS UNITED WAY, HEARTLAND COMMUNITY HEALTH CLINIC AND BRADLEY UNIVERSITY MEMBERS OF THE COLLABORATIVE TEAM BY NAME, AFFILIATIONS, TITLE AND EXPERTISE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER THE TRI-COUNTY CHNA FOR PEORIA, WOODFORD AND TAZEWELL COUNTIES WAS COMPLETED AS A COLLABORATIVE UNDERTAKING BY SAINT FRANCIS MEDICAL CENTER AND UNITYPOINT HEALTH-METHODIST/PROCTOR SUPPORTED BY KINDRED HOSPITAL, ADVOCATE EUREKA HOSPITAL, HOPEDALE MEDICAL CENTER AND PEKIN HOSPITAL THE CHNA THAT WAS CONDUCTED IN 2016 WAS APPROVED AND ADOPTED BY THE OSF BOARD OF DIRECTORS ON JULY 25, 2016 THE NEXT TRI-COUNTY CHNA HAS BEEN DEVELOPED AND WILL BE APPROVED AND MADE WIDELY AVAILABLE TO THE PUBLIC PRIOR TO OUR FISCAL YEAR END 2019

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER THE TRI-COUNTY CHNA FOR PEORIA, WOODFORD AND TAZEWELL COUNTIES WAS COMPLETED AS A COLLABORATIVE UNDERTAKING SUPPORTED BY THE FOLLOWING ORGANIZATIONS OTHER THAN HOSPITALS PEORIA CITY/COUNTY HEALTH DEPARTMENT, TAZEWELL COUNTY HEALTH DEPARTMENT, WOODFORD COUNTY HEALTH DEPARTMENT, HEART OF ILLINOIS UNITED WAY, HEARTLAND COMMUNITY HEALTH CLINIC AND BRADLEY UNIVERSITY

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>Facility , 1 - SAINT FRANCIS MEDICAL CENTER OSF SAINT FRANCIS MEDICAL CENTER COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE TRI COUNTY CHNA (PEORIA, WOODFORD AND PEORIA COUNTIES) WAS DONE AS A COLLABORATIVE UNDERTAKING TO HIGHLIGHT THE HEALTH NEEDS AND WELL BEING OF RESIDENTS IN THE COUNTY AREA THE COLLABORATIVE TEAM IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY HEALTHY BEHAVIORS AND BEHAVIORAL HEALTH HEALTHY BEHAVIORS IS DEFINED AS ACTIVE LIVING AND HEALTHY EATING AND THEIR IMPACT ON OBESITY BEHAVIORAL HEALTH ADDRESSES MENTAL HEALTH AND SUBSTANCE ABUSE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE HOSPITAL DEVELOPED AN IMPLEMENTATION STRATEGY DESCRIBING THE ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS BOTH PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED BOTH PRIORITY HEALTH NEEDS IS PROVIDED BELOW HEALTHY BEHAVIORS - ACTIVE LIVING, HEALTHY EATING AND OBESITY GOALS INCREASE PERCENTAGE OF ADULTS CONSUMING THREE OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY, INCREASE THE PERCENTAGE OF INDIVIDUALS EXERCISING WITHIN THE LAST WEEK, MONITOR SLEEP HYGIENE, NUTRITION, EXERCISE, HEALTHY WEIGHT, SAFETY, SPIRITUALITY, AND AVOIDANCE OF SUBSTANCE USE THE 2016 GOALS IDENTIFIED FOR HEALTHY BEHAVIORS WERE ACHIEVED * THE PERCENTAGE OF ADULTS CONSUMING THREE OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY INCREASED BY 5% FROM 2016 TO 2019 * THE PERCENTAGE OF INDIVIDUALS EXERCISING IN THE LAST WEEK INCREASED FROM 2016 TO 2019 THE NUMBER OF RESPONDENTS INDICATING THEY EXERCISED ONE OR MORE TIMES IN THE LAST WEEK INCREASED BY 11% * SLEEP HYGIENE, NUTRITION, EXERCISE, HEALTHY WEIGHT, SAFETY, SPIRITUALITY AND AVOIDANCE OF SUBSTANCE ABUSE WAS MONITORED THROUGH STRATEGIC INITIATIVES OF THE FAITH COMMUNITY NURSING PROGRAM (FCN), CARE-A-VAN AND OTHER PROGRAMING THE FOLLOWING ACTIVITIES AND INITIATIVES HELPED TO SUPPORT THE GOALS FOR HEALTHY BEHAVIORS FROM 2016 TO 2018 OSF'S FCN PROGRAM OFFERS A UNIQUE PARTNERSHIP BETWEEN TWO HEALING ENTITIES, OUR HOSPITALS AND THE FAITH COMMUNITY THE FOCUS OF THE PROGRAM IS ON PREVENTATIVE HEALTHCARE AND INDIVIDUALS ARE HELPED TO LEAD HEALTHIER LIVES THROUGH EDUCATION, SCREENING AND REFERRALS TO COMMUNITY RESOURCES THE FCNS ALSO STAFF THE OSF CARE-A-VAN, WHICH IS A MOBILE HEALTH CENTER THAT CONNECTS RESIDENTS WITH SCREENINGS, IMMUNIZATION, EDUCATION, HEALTH RISK ASSESSMENTS, SIGNING UP F</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>OR HEALTHCARE COVERAGE, EXPLORING ADVANCED CARE PLANNING AND MORE STRATEGIC INITIATIVES OF THE FCN PROGRAM AND CARE-A-VAN WERE EXECUTED AND BASELINE UTILIZATION TO PROVIDE HEALTHY BEHAVIORS EDUCATION TO NEIGHBORHOODS AND SCHOOLS WITH THE GREATEST PERCENTAGE OF POVERTY WAS ESTABLISHED SINCE ESTABLISHED IN 2016, THE CARE-A-VAN HAS SERVED THE FOLLOWING COMMUNITY MEMBERS * 426 IN FY16, * 538 IN FY17, * 929 IN FY18 CONTINUED CONNECTIONS WITH VOLUNTEER NURSES AND FAITH-BASED ORGANIZATIONS HELPED THE FCN PROGRAM TO EXPAND COMMUNITY OUTREACH FCN PARTNERSHIPS AND OUTREACH INCLUDED * 20 FAITH-BASED ORGANIZATIONS AND 27 NURSES IN FY16 * 29 FAITH-BASED ORGANIZATIONS, 22 NURSES AND 23,000 OUTREACH CONTACTS IN FY17 * 27 FAITH-BASED ORGANIZATIONS, 21 NURSES AND 28,000 OUTREACH CONTACTS IN FY18 ADDITIONAL COMMUNITY OUTREACH ACTIVITIES FOR THE CARE-A-VAN AND FCNS INCLUDED, BUT WERE NOT LIMITED TO, EDUCATION AT * THE RIVERFRONT MARKET, * SENIOR AND CAREGIVER EXPO, * WALK WITH THE CARE-A-VAN EVENT, * HY-VEE HEART HEALTHY EVENT ADDITIONAL SERVICES WERE PROVIDED IN CONJUNCTION WITH OUR PARTNER ORGANIZATIONS, SUCH AS SOPHIA'S KITCHEN, SOUTHSIDE MISSION, CATHOLIC CHARITIES, NEIGHBORHOOD HOUSE, FRIENDSHIP HOUSE, SALVATION ARMY, DREAM CENTER AND OTHERS PROVIDED NUTRITION AND EXERCISE EDUCATION AIMED AT HEALTHY BEHAVIORS AND A BASELINE RELATING TO PARTICIPATION RATES WAS ESTABLISHED NUTRITION AND EXERCISE ACTIVITIES AND INITIATIVES FROM 2016 TO 2018 ARE AS FOLLOWS, BUT ARE NOT LIMITED TO * ANNUAL OSF WOMEN'S LIFESTYLE SHOW, WHICH HAD 3,000 ATTENDEES IN 2016, 3,250 IN 2017 AND 3,000 IN 2018 * OVER 1200 CHILDREN PARTICIPATED IN NATIONAL WALK TO SCHOOL DAY * ASTHMA AND HEALTH SCREENINGS WERE PROVIDED AND HYGIENE KITS DISTRIBUTED DURING BASKETBALL CAMPS FOR UNDERPRIVILEGED YOUTH * 100+ NUTRITION EDUCATION EVENTS AND COOKING DEMONSTRATIONS, REACHING OVER 10,000 INDIVIDUALS, WHICH INCLUDED COOKING CLASS IN PARTNERSHIPS WITH THE PEORIA RIVERPLEX, RIVERPLEX HEART HEALTHY MONTH FAIR, UFS STROKE FAIR, CITY OF EAST PEORIA SMART SNACKING FAIR AND MORE * MEDICAL NUTRITION THERAPY WAS PROVIDED BY A DIETITIAN TO 66 PATIENTS AT HEARTLAND HEALTH SERVICES * DIETETIC INTERNS WORKED WITH CHILDREN TO MAKE HEALTHY FAMILY-FRIENDLY SNACKS AND A CAMPAIGN WAS CREATED TO SHARE THIS WORK ON SOCIAL MEDIA THE CAMPAIGN WAS VIEWED 1,847 TIMES * OSF CHILDREN'S ADVOCACY ATTENDED 80 OTHER EVENTS TO PROMOTE NUTRITION AND EXERCISE AND INTERACTED WITH OVER 11,000 COMMUNITY MEMBERS * OVER 2,500 FITNESS TRACKERS WERE DISTRIBUTED TO CHILDREN * BACK TO SCHOOL AND HEALTHY LIVES 4 KIDS EVENTS SERVING THOUSANDS OF CHILDREN * OSF HEALTHCARE CHILDREN'S HOSPITAL OF ILLINOIS AND KOHL'S CARES HOLD HEALTHY LIVES 4 KIDS DAYS THESE EVENTS WERE PACKED WITH INTERACTIVE GAMES AND ACTIVITIES THAT FAMILIES ENJOYED WHICH PROMOTED HEALTH AND WELLNESS IN CHILDREN EACH CHILD RECEIVED A VARIETY OF GIVEAWAYS RELATED TO WELLNESS AT THE EVENTS * SPONSORED POSTS PROMOTING HEALTHY LIVES 4 KIDS EVENTS IN PEORIA AND TAZE</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>WELL COUNTY WHICH WERE VIEWED 75,308 TIMES VIA FACEBOOK AND INSTAGRAM * PEORIA FARM TO TABLE FOOD SAMPLES WERE GIVEN TO OVER 250 COMMUNITY MEMBERS MEDIA AND SOCIAL MEDIA INTERACTION WAS USED TO HELP OSF IMPROVE COMMUNICATION AND EDUCATION OF HEALTHY BEHAVIORS BETWEEN 2016 AND 2018 * APPROXIMATELY 40 HEALTHY RECIPES WERE SHARED VIA OSF SOCIAL MEDIA * OVER 50 ARTICLES FROM OSF DIETITIANS WERE POSTED ON THE PEORIA JOURNAL STAR FIT FOR LIFE BLOG * OSF DIETITIANS APPEARED OVER 100 TIMES ON LOCAL TELEVISION AND RADIO OSF4LIFE, OSF'S WORKSITE WELLNESS PROGRAM, WAS ROLLED OUT IN MAY, 2016 THROUGH THIS PROGRAM A BASELINE FOR OSF EMPLOYEES ENGAGED WELLNESS WAS ESTABLISHED PARTICIPATION CONTINUES TO INCREASE, WITH THE FOLLOWING NUMBER OF EMPLOYEES (MISSION PARTNERS) ENROLLED IN THE PROGRAM EACH YEAR * 405 IN FY16 * 1,349 IN FY17 * 2,083 IN FY18 IN ADDITION TO WORKING WITH OSF MISSION PARTNERS, OSF4LIFE'S TEAM PARTICIPATED IN 12 COMMUNITY OUTREACH EVENTS SPONSORED BY LOCAL BUSINESSES AND PROVIDED HEALTHY BEHAVIORS EDUCATION AND PRESENTATIONS FOR EMPLOYERS THE WHOLESOME FOOD FUND (WFF) IS A PARTNERSHIP FORMED IN 2010 BETWEEN OSF SAINT FRANCIS MEDICAL CENTER, THE PEORIA RIVERFRONT MARKET, AND COMMUNITY FOUNDATION OF CENTRAL IL WFF ALLOWS PEOPLE TO DOUBLE THEIR DOLLARS TO PURCHASE FRESH, LOCALLY GROWN PRODUCE AT THE MARKET, BENEFITTING LOCAL FARMERS, RESIDENTS AND THE ENVIRONMENT DIETITIANS PROVIDED EDUCATION ON NUTRITION AND FOOD PREP TO WFF CUSTOMERS THE GARDEN OF HOPE, A COMMUNITY GARDEN, IS A COLLABORATIVE EFFORT BETWEEN ST ANN'S CATHOLIC CHURCH, OSF SAINT FRANCIS MEDICAL CENTER AND OTHER COMMUNITY PARTNERS LOCATED ON THE CITY OF PEORIA'S SOUTH SIDE, THE COMMUNITY GARDEN SERVES A DUAL PURPOSE OF GROWING NUTRITIOUS FOODS FOR PEOPLE IN NEED WHILE ALSO IMPROVING AND BEAUTIFYING THE COMMUNITY THE GARDEN ALSO SERVES AS A HOST TO COMMUNITY EVENTS AND NUTRITION EDUCATION IN 2018, 1300+ PLANTS AND OVER 350 CUPS OF PRODUCE WERE HARVESTED AND DISTRIBUTED TO THE COMMUNITY MENTAL HEALTH GOALS IMPROVE MENTAL HEALTH WITHIN THE TRI-COUNTY POPULATIONS, INCREASE THE PERCENTAGE OF ADULTS WHO SELF-REPORTED GOOD OR BETTER MENTAL HEALTH FROM 72% TO 75% WITH A STRETCH GOAL OF 80% (HP2020 HEALTH RELATED QUALITY OF LIFE/WELL-BEING OBJECTIVE 1.2), DECREASE THE PERCENTAGE OF PEOPLE WITH POOR HEALTH DAYS, CURRENT IS 35%, INCREASE SCREENING AND INTERVENTION IN MENTAL HEALTH ISSUES INCLUDING DEPRESSION AND (SAFE HOME) ABUSE MENTAL HEALTH'S MEASUREMENT AND IMPACT OSF SAINT FRANCIS MEDICAL CENTER INCREASED SCREENINGS AND INTERVENTIONS FOR MENTAL HEALTH CONCERNS, INCLUDING DEPRESSION AND (SAFE HOME) ABUSE</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE IN ADDITION, ENROLLMENT IN ANY ONE OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ESTABLISHES ELIGIBILITY FOR PRESUMPTIVE CHARITY WIC, SNAP, LIHEAP, IL FREE LUNCH AND BREAKFAST PROGRAM, RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES, OR ENROLLMENT IN AN ORGANIZED COMMUNITY BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - Saint Francis Medical Center THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - SAINT FRANCIS MEDICAL CENTER A PLAIN LANGUAGE SUMMARY THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA. See CHNA for further information.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - SAINT ANTHONY MEDICAL CENTER FOR THE 2016 CHNA, OSF HEALTHCARE CENTER d/b/a OSF SAINT ANTHONY MEDICAL CENTER SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) PUBLIC HEALTH ADMINISTRATORS FROM THE WINNEBAGO COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM A COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS, INCLUDING THE CEO OF YWCA ROCKFORD, EXECUTIVE DIRECTOR & GENERAL COUNSEL OF NORTHWESTERN IL AREA AGENCY ON AGING, VP OF YWCA LA VOZ LATINA, PRESIDENT OF GOODWILL INDUSTRIES OF NORTHERN IL WISCONSIN STATELINE AREA AND BOARD OF DIRECTOR FOR ROCKFORD SCHOOL DISTRICT 205, AND HEALTH CARE PROVIDERS INCLUDING THE CHIEF MEDICAL OFFICER AND CHIEF SURGICAL OFFICER OF THE FACILITY, AND THE FOUNDER OF PHYSICIANS' IMMEDIATE CARE MEMBERS OF THE COLLABORATIVE TEAM BY NAME, AFFILIATIONS, TITLE AND EXPERTISE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA

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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Facility , 1 - SAINT ANTHONY MEDICAL CENTER OSF SAINT ANTHONY MEDICAL CENTER COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(r)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE WINNEBAGO COUNTY CHNA WAS DONE AS A COLLABORATIVE UNDERTAKING TO HIGHLIGHT THE HEALTH NEEDS AND WELL BEING OF RESIDENTS IN THE WINNEBAGO COUNTY AREA THE COLLABORATIVE COMMUNITY PARTNERS IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY ACCESS TO HEALTH SERVICES, MENTAL HEALTH AND OBESITY IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE HOSPITAL DEVELOPED AN IMPLEMENTATION STRATEGY DESCRIBING THE ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS ALL THREE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW FY2016 - 2018 Access to Health Services Goal *Facilitate access to appropriate medical services for residents of Winnebago County Access to Health Services Measurement and Key Accomplishments (1) Tracking of thirty day all-cause readmission rate for patients discharged to a skilled nursing facility -Created metrics to improve readmission rates of patients discharged to a skilled nursing facility Achieved improvements in metrics making ongoing target 8% (2) Tracked ratio of campus prompt care visits to Emergency Department at levels one, two and three -The prompt care opened April of 2018 The current ratio is 61.2% (3) Tracked percentage of new primary care patient appointments made within seven days -Percentage ranged from 40-50% OSF Healing Pathways Cancer Resource Center had unique clients accessing free services in all years with at least 12 new clients per quarter (4) Tracked number of unique primary care patients -Patient number increased each year with over 250,000 through the three years (5) Tracked the growth rate of the OSF On-Call virtual Emergency Department/Prompt Care visits -Served over 3500 annually in the OSF on-call Partnered to provide the Parish Nursing Program for community engagement -Three parish nurses serve approximately 1540 clients in our community each year All services are provided free of charge and include home, hospital, nursing home visits, office visits, education events, blood pressure screenings and providing over 70 participants with free skin checks annually and referrals to specialists for suspicious lesions -Advanced Care Planning has been involved in the Annual Center for Cancer Care Skin Checks that were</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>e held FY2016 - 2018 Mental Health Goal *To improve the mental health of individuals living within Winnebago County Mental Health Measurement and Key Accomplishments (1) Tracked readmission rate of patients with a mental health ICD-10 dx codes -Readmission rates of patients with a mental health diagnosis average 10% (2) Tracked percentage of completed annual depression screens performed at primary care office -Active participation in system-wide Behavioral Health initiative, the goal of which is the development of the OSF future state behavioral health delivery network that takes into account the needs of the community we serve and the community resources that are already in place Performed a continuum of care functional assessment of mental health screening at all access points Evaluated and enhanced primary pediatric anxiety and depression screening tools and interventions throughout the pediatric service line Target of 80% has been made each year (3) Tracked growth rate of the On Call virtual Emergency Department and Prompt Care Visits -Have been able to serve over 10,000 patients (4) Tracked the number of Social Service placements facilitated through Rosecrance, the local Mental Health provider -Exceeded targets by incorporating mental health screening tools into disease specific support groups (5) Ratio of participants in Post-Partum Clinics to deliveries, including screenings were tracked -Target of 90% was met each year Cancer Care provided over 70 participants with free skin checks each year and referrals to specialists for suspicious lesions See the Parish Nursing Program for additional detail FY2016 - 2018 Obesity Goal *To provide opportunities in order to combat adult and childhood obesity Obesity Measurement and Key Accomplishments (1) Tracked number of residents receiving nutritional consults by a licensed provider -Educated over 3,000 community members on nutritional consults in three years (2) Tracked number of participants accessing basic health screening tests at community events -Educated over 1,200, exceeding targets (3) Increased collaboration with community partners -Partnered with local Plant-a-Row for collection of excess fresh produce from local gardens Total collection was approximately 4000lbs of fresh produce Increased our participation each year (4) Tracked participants who met or exceeded national criteria each quarter in a 3-4 Week Weight Loss programs -Decision Free Diet program had 89% meet their goal (Gold standard 86% National average 59%) -Healthy Solutions program had 63% meet their goal (Gold standard 77% National average 58%) -Phase 2 program had 67% met their goal (Gold standard 82% National average 62%) Participated in Health fairs and events A pre and post survey was completed After receiving educational information and answering all the questions, over 50% of those individuals stated that they would change their diet and/or activity and would contact their Primary Care Phys</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	ician to determine their eligibility for FIT testing

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT ANTHONY MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT ANTHONY MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE IN ADDITION, ENROLLMENT IN ANY ONE OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ESTABLISHES ELIGIBILITY FOR PRESUMPTIVE CHARITY WIC, SNAP, LIHEAP, IL FREE LUNCH AND BREAKFAST PROGRAM, RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES, OR ENROLLMENT IN AN ORGANIZED COMMUNITY BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - SAINT ANTHONY MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - SAINT ANTHONY MEDICAL CENTER A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 2	The Organization executed an Asset Purchase Agreement dated September 11, 2017 with Presence Health Network, Presence Central and Suburban Hospitals Network and Presence Healthcare Services d/b/a Presence Medical Group ("Presence Entities") Under the transaction that closed on February 1, 2018, the Presence Entities sold to the Organization the facilities, furniture, furnishings, equipment and supplies used in and related to the operation of two hospitals and Presence physician practice sites, and the Organization commenced operating the hospitals on February 1, 2018 The hospitals acquired were Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, and Presence Covenant Medical Center in Champaign County, Illinois, and now known as OSF Heart of Mary Medical Center Effective February 1, 2018, the hospitals adopted and implemented the Organization's Financial Assistance Policy, Fair Billing - Collection Policy, and EMTALA Policy Pursuant to Â§1 501(r)-3(d), the Organization will satisfy the requirements of Â§501(r)-3 governing Community Health Needs Assessments with respect to the hospitals by September 30, 2020, which is the last day of the Organization's second taxable year beginning after the date on which the hospital facilities were acquired The Organization will adopt implementation strategies related to the Community Health Needs Assessments on or before February 15, 2021

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3 Facility , 1	Facility , 1 - OSF HEART OF MARY MEDICAL CENTER THE ORGANIZATION COMMENCED OPERATING THE HOSPITAL ON FEBRUARY 1, 2018 PURSUANT TO Â§1 501(R)-3(D), THE ORGANIZATION WILL SATISFY THE REQUIREMENTS OF Â§501(R)-3 GOVERNING COMMUNITY HEALTH NEEDS ASSESSMENTS WITH RESPECT TO THE HOSPITAL BY SEPTEMBER 30, 2020, WHICH IS THE LAST DAY OF THE ORGANIZATION'S SECOND TAXABLE YEAR BEGINNING AFTER THE DATE ON WHICH THE HOSPITAL FACILITY WAS ACQUIRED THE ORGANIZATION WILL ADOPT IMPLEMENTATION STRATEGIES RELATED TO THIS COMMUNITY HEALTH NEEDS ASSESSMENT ON OR BEFORE FEBRUARY 15, 2021

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - OSF HEART OF MARY MEDICAL CENTER THE ORGANIZATION COMMENCED OPERATING THE HOSPITAL ON FEBRUARY 1, 2018 THE ORGANIZATION WILL SATISFY THE REQUIREMENTS GOVERNING COMMUNITY HEALTH NEEDS ASSESSMENTS BY SEPTEMBER 30, 2020 A COPY OF THE CHNA REPORT FOR THE CHNA CONDUCTED IN 2018 BY PRESENCE COVENANT MEDICAL CENTER IN CHAMPAIGN COUNTY, ILLINOIS, AND NOW KNOWN AS OSF HEART OF MARY MEDICAL CENTER, IS PUBLISHED ON THE HOSPITAL FACILITY'S WEBSITE HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/ The CHNA Report for the CHNA conducted in 2018 reports input was obtained from surveys including surveys completed by hand at the public health district and at various local community organizations, surveys completed by 89 Community Agency Representatives, and surveys completed by county residents The 89 Community Agency Representatives represented more than 55 different agencies

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - OSF HEART OF MARY MEDICAL CENTER PRESENCE COVENANT MEDICAL CENTER IN CHAMPAIGN COUNTY, ILLINOIS, AND NOW KNOWN AS OSF HEART OF MARY MEDICAL CENTER, PARTNERED WITH CARLE FOUNDATION HOSPITAL TO CONDUCT AND DOCUMENT ITS COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - OSF HEART OF MARY MEDICAL CENTER PRESENCE COVENANT MEDICAL CENTER IN CHAMPAIGN COUNTY, ILLINOIS, AND NOW KNOWN AS OSF HEART OF MARY MEDICAL CENTER, PARTNERED WITH THE CHAMPAIGN-URBANA PUBLIC HEALTH DISTRICT AND UNITED WAY OF CHAMPAIGN COUNTY TO CONDUCT AND DOCUMENT ITS COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - OSF HEART OF MARY MEDICAL CENTER THE ORGANIZATION COMMENCED OPERATING THE HOSPITAL ON FEBRUARY 1, 2018 THE ORGANIZATION WILL ADOPT IMPLEMENTATION STRATEGIES ON OR BEFORE FEBRUARY 15, 2021 RELATED TO THE COMMUNITY HEALTH NEEDS ASSESSMENT TO BE CONDUCTED ON OR BEFORE SEPTEMBER 30, 2020 A COPY OF THE COMMUNITY HEALTH PLAN PREPARED IN 2018 BY PRESENCE COVENANT MEDICAL CENTER IN CHAMPAIGN COUNTY, ILLINOIS, AND NOW KNOWN AS OSF HEART OF MARY MEDICAL CENTER, IS PUBLISHED ON THE HOSPITAL FACILITY'S WEBSITE HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF Heart of Mary Medical Center Catastrophic Financial Assistance is available when charges exceed 25% of annual Family Income The amount billed is adjusted to 25% of Family Income when OSF determines this adjustment is the most generous assistance

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF Heart of Mary Medical Center Presumptive Financial Assistance is available and provides for a discount of 100% of billed charges for medically necessary services provided to a patient with no insurance benefits, when the patient establishes financial need at time of registration by satisfying one of the following categories of Presumptive Eligibility Criteria Homelessness, Deceased with no Estate, Mental Incapacitation with no one to act on the patient's behalf, and current Medicaid eligibility, but not on date of service or for non-covered service In addition, enrollment in any one of the following programs with criteria at or below 200% of the Federal Poverty Income Guidelines establishes eligibility for presumptive Charity WIC, SNAP, LIHEAP, IL Free Lunch and Breakfast Program, receipt of Grant Assistance for medical services, or enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criterion for membership

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - OSF Heart of Mary Medical Center The Financial Assistance Policy directs patients to staff in the Patient Financial Services and Admitting Areas at OSF Hospitals for assistance in obtaining answers to questions regarding the Policy

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - OSF Heart of Mary Medical Center A Plain Language Summary of the FAP is offered to patients as part of the intake or discharge process, information about financial assistance and the application process is included on or with the OSF Patient Billing Statement, and OSF provides copies of the Plain Language Summary and the FAP Application Form to referring staff physicians

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 2	The Organization executed an Asset Purchase Agreement dated September 11, 2017 with Presence Health Network, Presence Central and Suburban Hospitals Network and Presence Healthcare Services d/b/a Presence Medical Group ("Presence Entities") Under the transaction that closed on February 1, 2018, the Presence Entities sold to the Organization the facilities, furniture, furnishings, equipment and supplies used in and related to the operation of two hospitals and Presence physician practice sites, and the Organization commenced operating the hospitals on February 1, 2018 The hospitals acquired were Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, and Presence Covenant Medical Center in Champaign County, Illinois, and now known as OSF Heart of Mary Medical Center Effective February 1, 2018, the hospitals adopted and implemented the Organization's Financial Assistance Policy, Fair Billing - Collection Policy, and EMTALA Policy Pursuant to Â§1 501(r)-3(d), the Organization will satisfy the requirements of Â§501(r)-3 governing Community Health Needs Assessments with respect to the hospitals by September 30, 2020, which is the last day of the Organization's second taxable year beginning after the date on which the hospital facilities were acquired The Organization will adopt implementation strategies related to the Community Health Needs Assessments on or before February 15, 2021

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center The Organization commenced operating the Hospital on February 1, 2018 Pursuant to Â§1 501(r)-3(d), the Organization will satisfy the requirements of Â§501 (r)-3 governing Community Health Needs Assessments with respect to the Hospital by September 30, 2020, which is the last day of the Organization's second taxable year beginning after the date on which the Hospital facility was acquired The Organization will adopt implementation strategies related to this Community Health Needs Assessment on or before February 15, 2021 The CHNA Report for the CHNA conducted in 2017 reports input was obtained from surveys developed for completion on-line and by hand and distributed with the assistance of the UIC School of Nursing to ensure the survey sample represented all of the communities within Vermilion County including rural, urban, villages and cities In addition, 50 individuals representing a variety of agencies and organizations served on a Community Advisory Committee providing input from the community

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center The Organization commenced operating the Hospital on February 1, 2018 The Organization will satisfy the requirements governing Community Health Needs Assessments by September 30, 2020 A copy of the CHNA Report for the CHNA conducted in 2017 by Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, is published on the Hospital facility's website HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/ The CHNA Report for the CHNA conducted in 2017 reports input was obtained from surveys developed for completion on-line and by hand and distributed with the assistance of the UIC School of Nursing to ensure the survey sample represented all of the communities within Vermilion County including rural, urban, villages and cities In addition, 50 individuals representing a variety of agencies and organizations served on a Community Advisory Committee providing input from the community

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, partnered with Carle Hoopeson Regional Health Center to conduct and document its Community Health Needs Assessment

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, partnered with the Vermilion County Health Department and the United Way of Danville Area to conduct and document its Community Health Needs Assessment

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center The Organization commenced operating the Hospital on February 1, 2018 The Organization will adopt implementation strategies on or before February 15, 2021 related to the Community Health Needs Assessment to be conducted on or before September 30, 2020 A copy of the Community Health Plan prepared in 2017 by Presence United Samaritans Medical Center in Vermillion County, Illinois, and now known as OSF Sacred Heart Medical Center, is published on the Hospital facility's website HTTPS //WWW OSFHEALTHCARE ORG/ABOUT/COMMUNITY-HEALTH/

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center Catastrophic Financial Assistance is available when charges exceed 25% of annual Family Income The amount billed is adjusted to 25% of Family Income when OSF determines this adjustment is the most generous assistance

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center Presumptive Financial Assistance is available and provides for a discount of 100% of billed charges for medically necessary services provided to a patient with no insurance benefits, when the patient establishes financial need at time of registration by satisfying one of the following categories of Presumptive Eligibility Criteria Homelessness, Deceased with no Estate, Mental Incapacitation with no one to act on the patient's behalf, and current Medicaid eligibility, but not on date of service or for non-covered service In addition, enrollment in any one of the following programs with criteria at or below 200% of the Federal Poverty Income Guidelines establishes eligibility for presumptive Charity WIC, SNAP, LIHEAP, IL Free Lunch and Breakfast Program, receipt of Grant Assistance for medical services, or enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criterion for membership

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center The Financial Assistance Policy directs patients to staff in the Patient Financial Services and Admitting Areas at OSF Hospitals for assistance in obtaining answers to questions regarding the Policy

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - OSF Sacred Heart Medical Center A Plain Language Summary of the FAP is offered to patients as part of the intake or discharge process, information about financial assistance and the application process is included on or with the OSF Patient Billing Statement, and OSF provides copies of the Plain Language Summary and the FAP Application Form to referring staff physicians

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER OSF HEALTHCARE CENTER d/b/a ST JOSEPH MEDICAL CENTER, ADVOCATE BROMENN MEDICAL CENTER, THE McLEAN COUNTY HEALTH DEPARTMENT, AND UNITED WAY OF McLEAN COUNTY, WITH THE GUIDANCE OF THE McLEAN COUNTY COMMUNITY HEALTH COUNCIL, COLLABORATED TOGETHER FOR THE FIRST TIME TO CONDUCT THE 2016 McLEAN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF THE McLEAN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN THE PURPOSE OF THE McLEAN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN IS TO IMPROVE THE HEALTH OF McLEAN COUNTY RESIDENTS BY DEVELOPING AND MAINTAINING PARTNERSHIPS TO IMPLEMENT INTERVENTIONS, ENCOURAGE HEALTH AND HEALTHCARE ACCESS AWARENESS, AND PROMOTE HEALTHY LIFESTYLE CHOICES THAT CAN IMPROVE HEALTH AND REDUCE THE RISK OF DEATH AND DISABILITY FOR THE 2016 CHNA, THE COLLABORATIVE SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) McLEAN COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT SOCIAL SERVICE ORGANIZATIONS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED THROUGH THE FORMATION OF THE McLEAN COUNTY COMMUNITY HEALTH COUNSEL THIS COLLABORATIVE TEAM WAS CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE McLEAN COUNTY COMMUNITY HEALTH COUNSEL INCLUDED 7 REPRESENTATIVES FROM THE McLEAN COUNTY HEALTH DEPARTMENT, CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING UNITED WAY OF McLEAN COUNTY, ECONOMIC DEVELOPMENT COUNSEL, MARCFIRST SPICE SERVING DEVELOPMENTAL DISABILITIES/EARLY CHILDHOOD, AND THE McLEAN COUNTY CENTER FOR HUMAN SERVICES, LOCAL GOVERNMENT OFFICIALS, REPRESENTATIVES FROM McLEAN COUNTY AND BLOOMINGTON SCHOOL DISTRICTS AS WELL AS A REPRESENTATIVE FROM THE REGIONAL OFFICE OF EDUCATION AND FROM THE IL STATE UNIVERSITY SCHOOL OF SOCIAL WORK, AND HEALTH CARE PROVIDERS INCLUDING A COMMUNITY HEALTH CARE CLINIC, IMMANUEL HEALTH CENTER AND A FEDERALLY QUALIFIED HEALTH CENTER MEMBERS OF THE McLEAN COUNTY COMMUNITY HEALTH COUNCIL IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED ON PAGES 7 AND 8 OF THE 2016 CHNA

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6a Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER THE CHNA THAT WAS CONDUCTED IN 2016 WAS APPROVED AND ADOPTED BY THE OSF BOARD OF DIRECTORS ON JULY 25, 2016 THE MCLEAN COUNTY CHNA WAS A COLLABORATIVE UNDERTAKING BY ST JOSEPH MEDICAL CENTER AND BROMENN MEDICAL CENTER

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 6b Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER THE MCLEAN COUNTY CHNA WAS A COLLABORATIVE UNDERTAKING CONDUCTED WITH ORGANIZATIONS OTHER THAN HOSPITALS MCLEAN COUNTY HEALTH DEPARTMENT AND THE UNITED WAY OF MCLEAN COUNTY

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>Facility , 1 - ST JOSEPH MEDICAL CENTER OSF ST JOSEPH MEDICAL CENTER ("SJMC") COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY ACCESS TO APPROPRIATE HEALTH CARE FOR THE UNDERSERVED AND AREAS OF HIGH SOCIOECONOMIC NEED, BEHAVIORAL HEALTH (INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE) AND OBESITY IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED A JOINT IMPLEMENTATION STRATEGY, WHICH DESCRIBES THE ACTIONS SJMC INTENDS TO TAKE TO ADDRESS THE THREE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW ACCESS TO APPROPRIATE HEALTHCARE FOR THE UNDERSERVED AND AREAS OF HIGH SOCIOECONOMIC NEED GOAL *BY 2020, DECREASE BARRIERS TO UTILIZING PRIMARY CARE IN 61701 IN ORDER TO REDUCE USE OF HOSPITAL EMERGENCY DEPARTMENTS (ER) FOR NON-EMERGENCY CONDITIONS MEASUREMENT AND PROGRESS FOR FY 2018 (1) NUMBER OF LOCATIONS WHERE FLYERS REGARDING THE APPROPRIATE USE OF THE EMERGENCY ROOM ARE DISTRIBUTED AND/OR THE IMPORTANCE OF HAVING A MEDICAL HOME -PROGRESS TWENTY-SEVEN LOCATIONS OFFER INFORMATION REGARDING WHEN TO USE AN URGENT CARE VS AN ER, INCLUDING FOUR OSF PROMPT CARE SITES INFORMATION ALSO DISTRIBUTED THROUGH OSF DIRECT MAIL CAMPAIGNS TO LOCAL RESIDENTS (2) ESTABLISH A BASELINE FOR THE NUMBER OF ORGANIZATIONS RECEIVING PATIENT-CENTERED MEDICAL HOME (PCMH) RECOGNITION -PROGRESS FOUR ORGANIZATIONS WITH 11 SITES IN MCLEAN COUNTY HAVE PCMH DESIGNATION, INCLUDING EIGHT OSF MEDICAL GROUP SITES (3) ESTABLISH A BASELINE FOR THE # OF LOW ACUITY VISITS TO SJMC'S EMERGENCY DEPARTMENT BY PATIENTS WITH MEDICAID OR SELF-PAY AS PAYER -PROGRESS BASELINE ESTABLISHED WITH OVER 2,500 VISITS AT THE MEDICAL CENTER (4) EXPLORE UTILIZING COMMUNITY HEALTH WORKERS IN MCLEAN COUNTY -PROGRESS COORDINATED APPROPRIATE ACCESS TO COMPREHENSIVE CARE (CAATCH) PILOT AT COMMUNITY HEALTH CARE CLINIC TWO HUNDRED AND SIXTY-FIVE REFERRALS WERE MADE FROM SJMC TO ESTABLISH PATIENTS WITH PRIMARY CARE PROVIDERS -OSF HEALTHCARE MEDICAL GROUP CONTINUES AN INTEGRATED CARE MODEL IN ALL LOCAL PRIMARY CARE OFFICES TO IMPROVE ACCESS TO CARE THIS IS ACCOMPLISHED THROUGH TEAM-BASED CARE, IN WHICH PHYSICIANS, ADVANCED CARE PROVIDERS, NURSES, BEHAVIORAL HEALTH SPECIALISTS, DIETICIANS, PHARMACISTS AND SOCIAL WORKERS CO</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>ORDINATE PROVIDING THE MOST APPROPRIATE LEVEL OF CARE FOR PATIENTS -SJMC EMPLOYS AN ED N A VIGATOR WHO ASSISTS PATIENTS WITH REFERRALS TO PRIMARY CARE PROVIDERS AND OTHER SERVICES I N THE COMMUNITY OSF MEDICAL GROUP OPENED A NEW PRIMARY CARE SITE WITH URGENT CARE ACCESS IN NORTH NORMAL, NEAR RAAB ROAD, GIVING NEW MEDICAL ACCESS TO THOSE IN THAT AREA BEHAVIOR AL HEALTH GOAL *BY 2020, REDUCE BEHAVIORAL HEALTH STIGMA TO INCREASE EARLIER ACCESS TO CA RE MEASUREMENT AND PROGRESS (1) NUMBER OF MENTAL HEALTH FIRST AID COURSES SPONSORED BY SJ MC -PROGRESS SJMC HOSTED THREE COURSES PER YEAR FOR COMMUNITY MEMBERS AND FOUR COURSES F OR EMPLOYEES (2)NUMBER OF MCLEAN COUNTY COMMUNITY MEMBERS TRAINED IN MENTAL HEALTH FIRST AID PER YEAR -PROGRESS APPROXIMATELY 80 COMMUNITY MEMBERS TRAINED AT EVENTS HOSTED AT SJM C PER YEAR (3) # OF CAMPAIGN MESSAGES, AND TYPES, AIMED AT REDUCING BEHAVIORAL HEALTH STI GMA - - PROGRESS CAMPAIGN SUBCOMMITTEE BEGAN MEETING IN 9/17 TO EXPLORE OFFERING A COLLAB ORATIVE BEHAVIORAL HEALTH CAMPAIGN SJMC REPRESENTATIVES ARE PART OF THE PLANNING DISCUSSI ON SINCE INCEPTION, OVER 41,000 PEOPLE HAVE ACCESSED THIS DATA -RELATED ACCOMPLISHMENTS THERE WERE OVER 3,500 PARTICIPANTS AT SJMC COMMUNITY PRESENTATIONS RELATED TO STRESS MANA GEMENT THE MCLEAN COUNTY BOARD HOSTED A COMMUNITY BEHAVIORAL HEALTH FORUM ON MAY 18, 2017 APPROXIMATELY 100 INDIVIDUALS WERE IN ATTENDANCE AND PRESENTATIONS ON A VARIETY OF BEHAV IORAL HEALTH ISSUES WERE HELD TWO SJMC LEADERS ASSISTED WITH THE PLANNING AND ORGANIZING OF THE EVENT CHESTNUT HEALTH SYSTEMS IN PARTNERSHIP WITH ADVOCATE BROMENN MEDICAL CENTER, THE MCLEAN COUNTY HEALTH DEPARTMENT AND SJMC WAS AWARDED A GRANT BY THE ILLINOIS DIVISION OF MENTAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO HOST A TWO-DAY ADVERSE CHILD DHOOD EXPERIENCES (ACES) MASTER TRAINING FOR 25 INDIVIDUALS THE TRAINING COURSE WAS HELD ON OCTOBER 12TH AND 13TH WITH INSTRUCTORS FROM THE FOLLOWING ORGANIZATIONS IN MCLEAN COUNT Y ADVOCATE BROMENN MEDICAL CENTER, BABY FOLD, CENTER FOR YOUTH AND FAMILY SOLUTIONS, CHES TNUT HEALTH SYSTEMS, DISTRICT 87, HOME SWEET HOME MINISTRIES, MCLEAN COUNTY COURT SERVICES , MCLEAN COUNTY HEALTH DEPARTMENT, PATH, PROJECT OZ, REGIONAL OFFICE OF EDUCATION #17, AND OSF HEALTHCARE CHESTNUT HEALTH SYSTEMS IN PARTNERSHIP WITH ADVOCATE BROMENN MEDICAL CENT ER, THE MCLEAN COUNTY HEALTH DEPARTMENT AND SJMC WAS AWARDED THE SUBSTANCE ABUSE AND MENTA L HEALTH SERVICES ADMINISTRATION (SAMHSA) TECHNICAL ASSISTANCE AWARD IN DECEMBER 2017 FROM THE NATIONAL CENTER ON TRAUMA-INFORMED CARE -OSF HEALTHCARE IMPLEMENTED SILVERCLOUD, A SECURE, IMMEDIATE ACCESS TO ON-LINE SUPPORTED COGNITIVE BEHAVIORAL THERAPY PROGRAMS FOR THE COMMUNITY SILVERCLOUD FOCUSES ON IMPROVING DEPRESSION AND ANXIETY LEVELS AMONG ADULT IND IVIDUALS -SJMC WAS GRANTED FUNDS FOR BEHAVIORAL HEALTH INITIATIVES TO TRAIN OSF EMPLOYEES TO BETTER IMPACT PATIENTS WHO STRUGGLE WITH A MENTAL HEALTH DIAGNOSES FUNDING WENT TO TH E CENTER FOR HUMAN SERVICES FO</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>R EDUCATION, TOOLS AND RESOURCES TO PROVIDE THE TRAINING OBESITY GOAL *BY 2020, PURSUE POLICY, SYSTEM AND ENVIRONMENTAL CHANGES TO MAINTAIN OR INCREASE THE PERCENTAGE OF PEOPLE LIVING AT A HEALTHY BODY WEIGHT IN MCLEAN COUNTY MEASUREMENT AND PROGRESS (1) ESTABLISH A BASELINE FOR THE # OF FREE PROGRAMS/EVENTS PROMOTING PHYSICAL ACTIVITY IN THE COMMUNITY BY THE MCLEAN COUNTY WELLNESS COALITION (MCWC) -PROGRESS OVER 70 EVENTS (2) ESTABLISH A BASELINE FOR THE # OF COMMUNITY MEMBERS PARTICIPATING IN FREE PROGRAMS/EVENTS PROMOTING PHYSICAL ACTIVITY IN THE COMMUNITY BY THE MCWC -PROGRESS 17,000 MEMBERS THIS INCLUDED OVER 4,000 PARTICIPANTS AT SJMC COMMUNITY PRESENTATIONS RELATED TO PHYSICAL ACTIVITY (3) ESTABLISH A BASELINE FOR THE # OF PROGRAMS PROMOTING PHYSICAL ACTIVITY IN THE WORKPLACE BY THE MCWC -PROGRESS 92 PROGRAMS (4) ESTABLISH A BASELINE FOR THE NUMBER OF EMPLOYEES PARTICIPATING IN PROGRAMS PROMOTING PHYSICAL ACTIVITY IN THE WORKPLACE BY THE MCWC -PROGRESS 11,858 EMPLOYEES (5) WALK SCORES (BASELINE BLOOMINGTON - 35, NORMAL - 36, WALKSCORE COM, 2016) -PROGRESS BLOOMINGTON - 35, NORMAL - 38 (6) COORDINATE FOOD ACCESS SUMMIT IN 2017 PROGRESS FY2017 COMPLETED MARCH 2017 SJMC STAFF PLAYED A ROLE IN PLANNING AND ORGANIZING THE EVENT OVER 80 ATTENDED (7)NUMBER OF POUNDS OF PRODUCE DISTRIBUTED AT VEGGIE OASIS -PROGRESS OVER 15,000 POUNDS DISTRIBUTED IN THREE YEARS (8) NUMBER OF EVENTS WHERE HEALTHY VEGETABLE RECIPES ARE PROVIDED (BASELINE 6 EVENTS, MCWC, 2016) -PROGRESS 30 EVENTS -OSF HEALTHCARE SJMC SPONSORED PROJECT FIT AMERICA (\$20,000 GRANT) TO HEYWORTH HIGH SCHOOL - IMPLEMENTED FALL 2017 PROJECT FIT AMERICA ENHANCES PHYSICAL EDUCATION THROUGH CURRICULUM, INDOOR AND OUTDOOR FITNESS EQUIPMENT -HOME SWEET HOME MINISTRIES AND THE COMMUNITY HEALTH CARE CLINIC LAUNCHED A FOOD FARMACY PILOT PROGRAM IN AUGUST 2017 THE PROGRAM PROVIDES PATIENTS AT THE CLINIC WHO HAVE DIABETES OR HEART DISEASE A PRESCRIPTION PASS, WHICH CAN BE USED TO OBTAIN FREE PRODUCE THROUGH 12 VISITS TO THE BREAD FOR LIFE FOOD CO-OP IN 2017, 19 INDIVIDUALS PARTICIPATED, 61 SHOPPING TRIPS WERE TAKEN, AND FAR MORE FRESH PRODUCE AND HEALTHY ITEMS ARE BEING TAKEN THAN BEFORE THE FOOD FARMACY PROGRAM WAS INITIATED IN 2018, SJMC STAFF ASSISTED WITH PROVIDING HEALTHY FOOD RECIPES FOR THE PARTICIPANTS IN THE PROGRAM -SJMC DEVELOPED A PROGRAM CALLED SMART MEALS IN WHICH INGREDIENTS, RECIPES AND EDUCATION MATERIALS ARE GIVEN TO THE COMMUNITY SJMC DEVELOPED THE RECIPES, BOUGHT THE FOOD, BAGGED THE FOOD, AND PROMOTED THE SERVICE TO THE COMMUNITY APPROXIMATELY 1000 PEOPLE RECEIVED A SMARTMEALS FOR FREE IN 2018 -THE CENTER FOR HEALTHY LIFESTYLES AT SJMC PARTNERED WITH THE BOYS AND GIRLS CLUB TO OFFER A NUTRITION PROGRAM FOR THE 5TH GRADE MEMBERS TO HELP EDUCATE AND BRING AWARENESS (THROUGH TASTE-TESTING NEW FOODS, UNDERSTANDING IMPORTANCE OF EATING THESE FOODS, AND SIMPLE WAYS TO PREPARE THEM) THIS 6-WEEK PROGRAM WAS HELD IN THE SUMMER OF 2018</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE IN ADDITION, ENROLLMENT IN ANY ONE OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ESTABLISHES ELIGIBILITY FOR PRESUMPTIVE CHARITY WIC, SNAP, LIHEAP, IL FREE LUNCH AND BREAKFAST PROGRAM, RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES, OR ENROLLMENT IN AN ORGANIZED COMMUNITY BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - ST JOSEPH MEDICAL CENTER A PLAIN LANGAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER OSF HEALTHCARE CENTER d/b/a SAINT ANTHONY'S HEALTH CENTER FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 MADISON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) THE HEALTH PROMOTION MANAGER AT MADISON COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH TO ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING PRESIDENT OF THE RIVER BEND GROWTH ASSOCIATION, WHICH IS THE CHAMBER OF COMMERCE AND ECONOMIC DEVELOPMENT AGENCY IN MADISON COUNTY, ASSOCIATE EXECUTIVE DIRECTOR OF SENIOR SERVICES PLUS, INC , DIRECTOR OF OASIS WOMEN'S CENTER AND CERTIFIED DOMESTIC VIOLENCE PROFESSIONAL, EXECUTIVE DIRECTOR OF BOYS & GIRLS CLUB OF ALTON AND ASSISTANT FOOTBALL COACH AT ALTON HIGH SCHOOL, VP FOR THE COMMUNITY BEHAVIORAL HEALTHCARE ASSOCIATION OF IL, DIRECTOR FOR IL REGION FOR UNITED WAY OF GREATER ST LOUIS, ASSISTANT SUPERINTENDENT OF THE ALTON SCHOOL DISTRICT, AND HEALTH CARE EDUCATORS AND PROVIDERS INCLUDING AN ADULT NURSE PRACTITIONER AND DIRECTOR OF NURSING EDUCATION AT LEWIS AND CLARK COMMUNITY COLLEGE, REGISTERED DIETICIAN, INTERIM CHIEF NURSING OFFICER FOR THE FACILITY, PHYSICIAN ASSISTANT WHO IS A PROVIDER AT A NON-PROFIT MEDICAL MISSIONARY GROUP, AND A BOARD CERTIFIED FAMILY PRACTICE PHYSICIAN MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER OSF SAINT ANTHONY'S HEALTH CENTER ("SAHC ") COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY OBESITY, AND BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE/TOBACCO USE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPLEMENTATION STRATEGY THAT DESCRIBES THE ACTIONS SAHC INTENDS TO TAKE TO ADDRESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW</p> <p>OBESITY GOAL *INCREASE AWARENESS OF NUTRITION AND FITNESS RESOURCES FOR PROVIDERS AND COMMUNITY MEASUREMENT AND PROGRESS (1) ESTABLISH A BASELINE FOR THE NUMBER OF PROGRAMS/EVENTS PROMOTING PHYSICAL ACTIVITY OFFERED BY OSF SAINT ANTHONY'S HEALTH CENTER -PROGRESS EDUCATIONAL EVENTS WITH PHYSICAL AND OCCUPATIONAL THERAPISTS WERE HELD AT COMMUNITY SITES, INCLUDING A SPRING HEALTH FAIR AT SENIOR SERVICES PLUS, UNITED METHODIST VILLAGE, RETIRED NURSES GROUP, AND GIRLS NIGHT OUT FOR BREAST HEALTH FIT & FLEXIBLE 6-WEEK PHYSICAL FITNESS PROGRAM OFFERED THROUGHOUT THE YEARS INCLUDING SPRING AND FALL HEALTH FAIR AT SENIOR SERVICES PLUS, ARGOSY EMPLOYEE HEALTH FAIR AND RADIO BROADCAST ON HEART HEALTH AND NUTRITION (2) DEVELOP A PROCESS TO INTRODUCE NUTRITIONAL EDUCATION/INFORMATION IN OSF SAINT ANTHONY'S PRIMARY CARE OFFICE -PROGRESS CLINICIANS DOWN LOADED NUTRITIONAL GUIDANCE FOR PATIENTS, AS WELL AS DIRECTED PATIENTS TO OSF HEALTHCARE'S HEALTH AND WELLNESS RESOURCES UP-TO-DATE DIET EDUCATION ON NORMAL AND DISEASE CONDITIONS CAN BE DOWNLOADED OR PRINTED DIETITIANS PROVIDED DIET EDUCATION TO PATIENTS PER CLINICAL CARE PROCESSES AND STAFF WHEN REQUESTED PROVIDED A LEADER FOR THE MADISON COUNTY PARTNERSHIP COMMUNITY HEALTH-OBESITY REDUCTION COMMITTEE, WORKING TO COLLABORATE EFFORTS OF ORGANIZATIONS TO PROMOTE HEALTHY ENVIRONMENTS AND LIFESTYLES THE PROJECT DEVELOPED HEALTHY EATING SIGNAGE FOR THE COMMUNITY (3) CONTINUALLY ADD COMMUNITY RESOURCE INFORMATION TO THE OSF SAINT ANTHONY'S WEBSITE -PROGRESS UPDATES HAVE BEEN MADE TO THE WEBSITE ON NUTRITION RECIPES WITH A SEARCH TOOL AND ADDED NUTRITIONAL VALUES AND VIDEOS FOR INSTRUCTION (4) UTILIZE HEART CHECK STATION TO PROMOTE NUTRITIONAL AND FITNESS INFORMATION -PROGRESS HEART HEALTH NUTRITION AND FITNESS</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>MATERIALS HAVE BEEN UPDATED AND PLACED AT THE HEART CHECK STATION IN 2017 (5) HOST A FOOD DRIVE -PROGRESS HOLIDAY FOOD DRIVE CHALLENGE HAS BEEN HELD TO BENEFIT THE CRISIS FOOD PANTRY INCLUDING DEPARTMENT LEVEL FOOD DRIVES THROUGHOUT THE YEAR (6) WORKFORCE WELLNESS PLAN -PROGRESS AN OSF 4LIFE WELLNESS PROGRAM WAS ROLLED OUT TO EMPLOYEES ACTIVITIES ARE ONGOING THROUGH THE OSF SYSTEM DIETITIANS HELP TO PROVIDE HEALTH COACHES ON THE OSF4LIFE PORTAL AND COMMUNICATE WITH ENROLLED PARTICIPANTS (7) NUMBER OF EVENTS AND PEOPLE AT OSF SAINT ANTHONY'S NUTRITION/EXERCISE EVENTS AND/OR OUTREACH PARTNERSHIPS IN THE COMMUNITY -PROGRESS SERVED OVER 600 COMMUNITY MEMBERS ON EDUCATION FOR NUTRITION AND FITNESS, SERVED OVER 350 WITH A FIT AND FLEXIBLE PROGRAM, EDUCATED 200 AT SENIOR SERVICES PLUS, PROVIDED EDUCATION TO 36 AT AN EMPLOYEE EVENT, EDUCATION PROVIDED TO 150 AT GIRLS NIGHT OUT, EDUCATED APPROX 270 AT THE FALL HEALTH FAIR AND PARTNERED WITH UNITED METHODIST VILLAGE TO EDUCATE 50 RESIDENTS (8) NUMBER OF PATIENTS RECEIVING NUTRITION EDUCATION AND INFORMATION - PROGRESS APPROXIMATELY 600 PRIMARY CARE PATIENTS WITH OSF MEDICAL GROUP WERE GIVEN REFERRALS FOR NUTRITION EDUCATION / INFORMATION (9) NUMBER OF VISITS TO WEBSITE, SOCIAL MEDIA AND HEART CHECK STATION RE NUTRITION AND FITNESS MESSAGING -PROGRESS Over 9,000 VISITS WERE MADE TO THE HEART CHECK STATION, (9B) Over 1,000 VIDEO VIEWS ON FACEBOOK FOR HEALTHY HOLIDAY EATING WITH DIETITIAN ABLE TO REACH OVER 1,000 ON SOCIAL MEDIA FOR POSTS ON HEALTHY FOOD CHOICES AND NUTRITION (10) TRACKED NUMBER OF VISITS TO HEART CHECK STATION -PROGRESS THIS NEW METRIC PRODUCED 8,111 VISITS TO THE HEART CHECK STATION IN 2018 (11) TRACKED NUMBER OF PERSONS SERVED THROUGH FOOD DRIVES PROGRESS APPROXIMATELY 167 MEALS WERE PROVIDED BY FIVE PALLETS OF FOOD COLLECTED AT HOLIDAY FOOD DRIVE BEHAVIORAL HEALTH GOALS LINK COMMUNITY TO EXISTING RESOURCES FOR MENTAL HEALTH CARE, INCREASE AWARENESS AND ENGAGEMENT TO DECREASE SUBSTANCE ABUSE (MARIJUANA, OPIATES, ETC) AND TOBACCO USE IN MADISON COUNTY AND INCREASE REFERRALS INTO APPROPRIATE TREATMENT PROGRAMS MEASUREMENT AND PROGRESS (1) ESTABLISH A BASELINE FOR THE NUMBER OF PROGRAMS/EVENTS FOR MENTAL HEALTH OFFERED BY OSF SAINT ANTHONY'S HEALTH CENTER -PROGRESS PROVIDED FREE COMMUNITY SCREENINGS HELD FOR DEPRESSION AND ANXIETY THAT INCLUDED TARGETED DISTRIBUTION OF MENTAL HEALTH MATERIALS, PROVIDED A SPEAKER TO CARING CIRCLE WOMEN'S GROUP ON HANDLING STRESS, PROVIDED ADDITIONAL SPEAKERS TO A STROKE SUPPORT GROUP, PRESENTED AT A CHURCH BANQUET ON HEALTHY COMMUNICATION, IN ADDITION TO PRESENTING AT UNITED METHODIST VILLAGE ON DEMENTIA, APPROXIMATELY SIX MENTAL HEALTH PROGRAMS OR EVENTS OCCURRED EACH YEAR REACHING 230 COMMUNITY MEMBERS PER YEAR, (2) ESTABLISH A BASELINE FOR THE NUMBER OF PROGRAMS/EVENTS FOR SUBSTANCE ABUSE OFFERED BY OSF SAINT ANTHONY'S HEALTH CENTER -PROGRESS PROVIDED SITTER COVERAGE AND DESIGNATED SPECIFIC FULL TIME EMPLOYEES TO ENSURE THE</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>SAFETY OF AT-RISK PATIENTS, PROVIDED AN OPIOID EDUCATION PROGRAM FOR CAREGIVERS ON USING BEHAVIORAL HEALTH FOR MANAGEMENT OF CHRONIC PAIN, PRESENTED TO COPE PLASTICS ON OPIOID ADDICTION, PARTICIPATED ON THE RADIO WBGZ ON ALCOHOL ADDICTION, APPROXIMATELY THREE PRESENTATIONS FOR SUBSTANCE ABUSE WERE COMPLETED EACH YEAR, REACHING ABOUT 115 PER SESSION (3) ESTABLISH A BASELINE FOR THE # PROGRAMS/EVENTS FOR TOBACCO USE OFFERED BY OSF SAINT ANTHONY'S HEALTH CENTER -PROGRESS AN AMERICAN CANCER SOCIETY FRESHSTART SMOKING CESSATION WAS HELD IN THE 4TH QUARTER OF 2018, A LUNCH AND LEARN WAS OFFERED TO THE COMMUNITY REGARDING THE HEALTH EFFECTS OF SMOKING AS RELATED TO CANCER, SMOKING CESSATION MATERIALS WERE DISTRIBUTED AT VARIOUS HEALTH FAIRS FOR UNITED METHODIST VILLAGE, APPROXIMATELY FIVE PROGRAMS OR EVENTS FOR TOBACCO USE PER YEAR WERE CONDUCTED, REACHING ABOUT 600 EACH YEAR (4) DEVELOPMENTAL HEALTH, SUBSTANCE ABUSE, TOBACCO USE MESSAGING AIMED AT REDUCING STIGMA/ABUSE/USE, DISTRIBUTING THROUGH SOCIAL MEDIA -PROGRESS DISTRIBUTED MATERIALS THROUGH SOCIAL MEDIA OR THROUGH COMMUNITY RESOURCE INFORMATION ON THE OSF SAINT ANTHONY'S WEBSITE, SOCIAL MEDIA MESSAGES FOR MENTAL HEALTH, SUBSTANCE ABUSE, AND ALCOHOL AWARENESS WERE DEVELOPED IN COLLABORATION WITH BEHAVIORAL HEALTH AND ONCOLOGY NURSES/SMOKING CESSATION FACILITATORS, NEW BLOG POSTS POSTED ON WEBSITE TO ADDRESS ANXIETY, STRESS, SUICIDE STIGMA, SEASONAL AND WORKPLACE OVEREATING, SMOKING CESSATION, SEDENTARY LIFESTYLES, REDUCING SUGAR INTAKE, YOUTH VAPING , NUTRITIONAL MANDATES, EXERCISE, AND WEIGHT LOSS (5) ADDED COMMUNITY RESOURCE INFORMATION TO THE OSF SAINT ANTHONY'S WEBSITE -PROGRESS COLLABORATED WITH BEHAVIORAL HEALTH MANAGER TO UPDATE EXISTING WEB PAGE IDENTIFYING COUNSELING SERVICES OFFERED (6) ESTABLISH A BASELINE FOR NUMBER OF PATIENTS SEEN THROUGH THE ED WITH BEHAVIORAL HEALTH DIAGNOSES -PROGRESS ED PATIENTS NOW TRANSFERRED TO OSF BEHAVIORAL HEALTH NAVIGATOR FOR FOLLOW UP A FORM WAS CREATED TO FACILITATE THE TRANSFER BETWEEN SERVICES (7) NUMBER OF PROGRAMS/EVENTS FOR MENTAL HEALTH OFFERED BY OSF SAINT ANTHONY'S HEALTH CENTER -PROGRESS IN 2018, 2696 VIEWS FOR SOCIAL MEDIA POSTS ON MENTAL HEALTH, SUBSTANCE ABUSE, AND TOBACCO USE OCCURRED IN 2018, 2315 VIEWS FOR SOCIAL MEDIA MESSAGING ON SILVERCLOUD, A FREE MENTAL HEALTH SERVICES 94 VIEWS ON SOCIAL MEDIA FOR BLOG POSTS ON MENTAL HEALTH 679 OR 96.86% OF PATIENTS SEEN IN THE ED WITH BEHAVIORAL HEALTH PROBLEMS, RECEIVED AN INTERVENTION BASED ON THEIR RESPONSES TO A RISK OF SUICIDE QUESTIONNAIRE (RSQ) IN ADDITION, FOUR ONCOLOGY CLINICIANS RECEIVED THEIR TRAINING FOR AMERICAN CANCER SOCIETY FRESHSTART SMOKING CESSATION CLASSES FOLLOWING THE FINAL CLASS, COMMUNICATION WITH A LOCAL</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE IN ADDITION, ENROLLMENT IN ANY ONE OF THE FOLLOWING PROGRAMS WITH CRITERIA AT OR BELOW 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ESTABLISHES ELIGIBILITY FOR PRESUMPTIVE CHARITY WIC, SNAP, LIHEAP, IL FREE LUNCH AND BREAKFAST PROGRAM, RECEIPT OF GRANT ASSISTANCE FOR MEDICAL SERVICES, OR ENROLLMENT IN AN ORGANIZED COMMUNITY BASED PROGRAM PROVIDING ACCESS TO MEDICAL CARE THAT ASSESSES AND DOCUMENTS LIMITED LOW INCOME FINANCIAL STATUS AS CRITERION FOR MEMBERSHIP

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - OSF SAINT ANTHONY'S HEALTH CENTER A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - ST MARY MEDICAL CENTER OSF HEALTHCARE CENTER d/b/a ST MARY MEDICAL CENTER FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 KNOX COUNTY AND WARREN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) THE PUBLIC HEALTH ADMINISTRATOR AS WELL AS THE DIVISION DIRECTOR OF HEALTH PROTECTION FROM THE KNOX COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED TO ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED 2 REPRESENTATIVES FROM THE KNOX COUNTY HEALTH DEPARTMENT, CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING THE EXECUTIVE DIRECTOR OF THE GALESBURG COMMUNITY FOUNDATION, THE EXECUTIVE DIRECTOR OF THE UNITED WAY OF KNOX COUNTY AND CHAIR OF THE EMERGENCY FOOD AND SHELTER PROGRAM, AND THE CEO OF THE KNOX COUNTY YMCA, AND HEALTH CARE PROVIDERS INCLUDING THE PRESIDENT AND THE CHIEF NURSING OFFICER OF THE HOSPITAL FACILITY AS WELL AS A LICENSED CLINICAL PROFESSIONAL COUNSELOR MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA

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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Facility , 1 - ST MARY MEDICAL CENTER OSF ST MARY MEDICAL CENTER ("SMMC") COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY OBESITY, MENTAL HEALTH, AND ACCESS TO HEALTH CARE IN RESPONSE TO THESE THREE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPLEMENTATION STRATEGY THAT DESCRIBES THE ACTIONS SMMC INTENDS TO TAKE TO ADDRESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW</p> <p>OBESITY GOALS *INCREASE THE PERCEPTION THAT OVERWEIGHT AND OBESITY ARE SIGNIFICANT PUBLIC HEALTH RISKS, INCREASE THE PROPORTION OF PERSONS WHO KNOW THE HEALTH RISKS AND DISEASES ASSOCIATED WITH OVERWEIGHT AND OBESITY, INCREASE THE PROPORTION OF PERSONS WHO KNOW THE ENVIRONMENTAL SOCIOECONOMIC AND FACTORS THAT CONTRIBUTE TO OBESITY, INCREASE THE PROPORTION OF ADULTS WHO KNOW THEIR OWN WEIGHT STATUS AND THEIR CHILDREN'S WEIGHT STATUS AND, IMPROVE LIFELONG HEALTHY EATING AND PHYSICAL ACTIVITY MEASUREMENT AND PROGRESS (1) INCREASE PARTICIPATION ADDITION OF ONE SCHOOL EACH YEAR TO HOST A HEALTHY EATING AND EXERCISE EDUCATIONAL EVENT -PROGRESS ATTENDED KNOXVILLE HIGH SCHOOL ANNUALLY TO EDUCATE STUDENTS ON HEALTHY EATING AND DRINKING CHOICES APPROXIMATELY 500 STUDENTS WERE GIVEN THIS EDUCATION IN ALL YEARS COLLABORATED WITH SILAS-WILLARD ELEMENTARY SCHOOL IN THE WALKING SCHOOL BUS PROGRAM 10-15 CHILDREN PARTICIPATED IN THE 2 DAYS PER SCHOOL YEAR ANNUALLY (2) INCREASED PARTICIPATION OF THE PERCENTAGE OF COMMUNITY MEMBER'S THAT ATTEND THE COMMIT TO FIT CHALLENGE ANNUALLY -PROGRESS COLLABORATED WITH THE YMCA TO BE ABLE TO PROVIDE EDUCATION TO OVER 400 PARTICIPANTS IN THE PAST THREE YEARS (3) INCREASED AWARENESS IN HEALTHY BEHAVIOR EDUCATION OR DEMONSTRATIONS AT COMMUNITY EVENTS -DIETICIAN PROVIDED ONE ON ONE DIABETES EDUCATION THROUGHOUT THE YEARS BASED ON PHYSICIAN REFERRALS -PARTICIPATED AT WOMEN'S HEART FAIRS ANNUALLY REGARDING HEALTHY BEHAVIORS, SERVING OVER 300 PARTICIPANTS -PARTICIPATED IN HEALTHY LIVES 4 KIDS EVENTS HOSTED AT KNOX COLLEGE SERVING OVER 100 PARTICIPANTS -PARTICIPATED EACH YEAR IN YMCA HEALTHY KIDS DAY, SERVING 50 PARTICIPANTS ANNUALLY -COLLABORATED WITH KLEINE PEDIATRIC WELLNESS AT CEDAR CREEK HOUSING AUTHORITY TO PROVIDE EDUCATION TO CHILDREN AND PARENTS REGARDING HEALTHY</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>BEHAVIORS INCLUDING FOOD, EXERCISE, AND ACTIVITIES -ANNUAL GARDEN CONTINUES ON THE SAINT MARY MEDICAL CENTER PROPERTY -DIETICIAN PUBLISHED MONTHLY ARTICLE REGARDING HEALTHY BEHAVIORS IN LOCAL NEWSPAPER PUBLICATION -EMPLOYEES COLLABORATED TO CREATE FOOD DRIVES WITH KNOX COUNTY COUNCIL FOR HUMAN SERVICES DONATED OVER 300 LBS EACH YEAR OF FOOD FOR LOCAL FOOD PANTRIES (4) INCREASED PARTICIPATION IN THE CLINTON HEALTH MATTERS INITIATIVE (CHMI) WORKGROUP -COLLABORATED WITH CHMI AND RIVERBED FOOD BANK TO BRING A DISTRIBUTION CENTER TO KNOX COUNTY ACCESS TO HEALTH SERVICES GOALS IMPROVE ACCESS TO COMPREHENSIVE QUALITY HEALTH CARE SERVICES, INCREASE THE NUMBER OF PRACTICING PHYSICIANS AND ADVANCED PRACTICE PROVIDERS, REDUCE THE PORTION OF PEOPLE WHO ARE UNABLE TO OBTAIN OR DELAY IN OBTAINING NECESSARY MEDICAL CARE, DENTAL CARE, PRESCRIPTION MEDICATIONS OR MENTAL HEALTH CARE, REDUCE THE PROPORTION OF HOSPITAL EMERGENCY DEPARTMENT VISITS IN WHICH THE WAIT TIME TO SEE AN EMERGENCY DEPARTMENT CLINICIAN EXCEEDS THE RECOMMENDED TIMEFRAME, IMPROVE THE COMMUNITY'S UNDERSTANDING OF THE SERVICES AVAILABLE, MODERNIZING SURGERY PROJECT FOR ACCESS, PROVIDE CENTRALIZED LOCATION FOR OUTPATIENT SERVICES TO PROVIDE ACCESS AND, AMBULATORY CLINIC REMODEL TO INCREASE THE NUMBER OF EXAMS ROOMS MEASUREMENT AND PROGRESS (1) INCREASED ACCESS IN PROVIDING CPR TRAINING TO ORGANIZATIONS IN THE WORKPLACE -CPR CLASSES WERE GIVEN AT FIRE DEPARTMENTS AND HIGH SCHOOLS THROUGHOUT THE YEARS (2) INCREASED ACCESS TO PROVIDE BLOOD PRESSURE SCREENINGS WITHIN THE COMMUNITY -BLOOD PRESSURE SCREENINGS WERE CONDUCTED AT NUMEROUS HOUSING AUTHORITIES, FOOD PANTRIES, CHURCHES, AND AVAILABLE WEEKLY AT THE MEDICAL CENTER (3) INCREASED ACCESS IN PROVIDING FLU SHOTS TO THE COMMUNITY IN ORDER TO DECREASE FLU HOSPITALIZATIONS AND SEVERITY OF FLU SYMPTOMS -FLU SHOTS WERE NOT ONLY GIVEN TO 100'S OF OUR EMPLOYEES BUT ALSO GIVEN OUT AT WELLS PET FOODS, AND AREA GRADE SCHOOLS ANNUALLY (4) PROVIDED ACCESS TO STUDENTS WHO WERE UNABLE TO ATTEND OR SCHEDULE THEIR SCHOOL PHYSICALS -HIGH SCHOOL PHYSICALS WERE PROVIDED AT GALESBURG HIGH SCHOOL ANNUALLY (5) INCREASED ACCESS IN PROVIDING INTERPRETER SERVICES BY BREAKING DOWN LANGUAGE BARRIERS AND COMMUNICATE WITH NON-ENGLISH SPEAKING PATIENTS -PROVIDED EFFECTIVE, ACCURATE, AND TIMELY COMMUNICATION SERVICES FOR PATIENTS, COMPANIONS, AND/OR PATIENT REPRESENTATIVES THESE SERVICES INCLUDED VISUAL, SPEECH IMPAIRMENTS, INABILITY TO WRITE, AND/OR HEARING IMPAIRMENTS 24 HOURS A DAY, 7 DAYS A WEEK (6) INCREASED ACCESS IN PROVIDING EDUCATION ON OSF MY CHART FOR TEST RESULTS, COMMUNICATION WITH DOCTORS, AND SCHEDULING APPOINTMENTS -KIOSKS HAVE BEEN AVAILABLE AT OSF GALESBURG CLINIC AND OSF MEDICAL GROUP WITH ASSISTANCE TO SIGN-UP FOR OSF MY CHART PROVIDING EDUCATION TO PATIENTS IN ORDER TO MANAGE THEIR OWN HEALTH (7) PARTICIPATED IN LOCAL UNMET NEEDS COMMITTEE COLLABORATED WITH ORGANIZATIONS SUCH AS, BUT NOT LIMITED TO, CHURCHES, UNITED WAY, SALVATION ARM</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Y, ETC -OSF REPRESENTATION ON ALL LOCAL AREA COMMITTEES IN ORDER TO PROVIDE RESOURCE OR ACCESS WHERE APPLICABLE MENTAL HEALTH GOALS STRIVE TO ASSURE THAT PATIENTS RECEIVE SERVICES THAT ARE INDIVIDUALIZED, SAFE AND REHABILITATIVE IN NATURE, TO PROVIDE SUPPORT TO AND ENHANCE COMMUNITY ALCOHOL, TOBACCO AND OTHER DRUG ABUSE PREVENTION EFFORTS, THEREBY ENHANCING OVERALL HEALTH OF THE COMMUNITY AND, ASSIST FAMILIES IN GAINING ACCESS TO COMMUNITY RESOURCES MEASUREMENT AND PROGRESS (1) INCREASED AWARENESS WITH THE RESOURCE LINK CARE COORDINATOR TO MEET WITH ALL NEW PROVIDERS, SCHOOLS, AND OTHER SOCIAL SERVICES ABOUT SERVICES THIS AWARENESS HAS BEEN DONE IN SEVERAL WAYS INCLUDING -PARTICIPATION IN THE BLUE RIBBON TASK FORCE ANNUALLY (CHILD ABUSE AWARENESS/PREVENTION) -EACH MONDAY OF APRIL 2018, 100 TO 200 BLUE PINWHEELS WERE PUT IN THE GROUND AT 3 DIFFERENT SITES IN GALESBURG TO HELP RAISE AWARENESS -MET WITH DISTRICT SUPERINTENDENT OF SCHOOLS TO DISCUSS WAYS THE CHILDREN'S HOSPITAL AND THE RESOURCE LINK DEPARTMENT CAN SUPPORT OUR SCHOOL DISTRICT -A PRIMARY CARE BEHAVIORAL HEALTH PROVIDER POSITION WAS FILLED AT THE OSF MEDICAL GROUP -COORDINATED WITH KNOX/WARREN/HENDERSON COUNTIES SYSTEM OF CARE DEVELOPMENT CONSISTING OF COMMUNITY AGENCIES TO HELP YOUTH RECEIVE CARE THEY NEED IN AREAS SUCH AS COUNSELING, PSYCHIATRY, SUBSTANCE ABUSE, DOMESTIC ABUSE, FOOD INSECURITY, ETC -RESOURCE LINK EDUCATION WAS GIVEN TO SAFE HARBOR, ADMINISTRATIVE TEAM FOR DISTRICT 205, HENRY/STARK COUNTY SPECIAL EDUCATION DEPT , Y MCA SOLUTIONS PROGRAM STAFF, KNOX COMMUNITY HEALTH CENTER, BIG BROTHER BIG SISTER PROGRAM, REGIONAL OFFICE OF EDUCATION, PARENTS AS TEACHERS PROGRAM STAFF, EDUCATION IN THE SCHOOLS , DISTRICT 205 STAFF (354 PEOPLE), JACOBSON DISTRICT 205 SCHOOLS, EDUCATION STAFF AND -REGIONAL SUPERINTENDENT OF SCHOOLS -A BEHAVIORAL HEALTH NAVIGATOR WAS HIRED AND THEY PROVIDED EDUCATION TO RESOURCE LINK ADVISORY GROUP, KNOX COUNTY HUMAN SERVICE COUNCIL, HENRY COUNTY MENTAL HEALTH ALLIANCE, KEWANEE, OSF MEDICAL GROUP PROVIDER MEETING, GALESBURG, KNOX COMMUNITY HEALTH CENTER, BRIDGEWAY, WIRC VICTIMS ADVOCATE, WARREN COUNTY HUMAN SERVICE COUNCIL MEETING -MARKETING AND DISTRIBUTION OF THE RESOURCE LINK AND THE 211 UNITED WAY PROGRAM HANDS AROUND THE COURTHOUSE EVENT AT THE KNOX COUNTY COURTHOUSE, LOCAL AGENCIES DEVELOPED THE UNMET NEEDS COMMITTEE TO IDENTIFY BARRIERS FOR FAMILIES STRUGGLING WITH VARIOUS HEALTH AND FINANCIAL ISSUES, 297 REFERRALS FOR PSYCHIATRIC CARE (242 ATTENDED APPOINTMENT), CO-SPONSORED THE FREE MOVIE NIGHT, MULTIPLE OSF REPRESENTATIVES PRESENT AT LOCAL COMMUNITY EVENTS</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST MARY MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST MARY MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - ST MARY MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - ST MARY MEDICAL CENTER A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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
<p>Schedule H, Part V, Section B, Line 5 Facility , 1</p>	<p>Facility , 1 - SAINT JAMES HOSPITAL OSF HEALTHCARE CENTER d/b/a SAINT JAMES HOSPITAL - JOHN W ALBRECHT MEDICAL CENTER ("SJH") FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 LIVINGSTON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) THE DIRECTOR OF THE LIVINGSTON COUNTY HEALTH DEPARTMENT AND THE DIRECTOR OF HEALTH EDUCATION & MARKETING FOR THE LIVINGSTON COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT ALL ORGANIZATIONS THAT SPECIFICALLY TARGET LOW-INCOME RESIDENTS SUCH AS FOOD PANTRIES 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING THE EXECUTIVE DIRECTOR OF THE INSTITUTE FOR HUMAN RESOURCES AND DIRECTORS SITTING ON THE FOLLOWING BOARDS STATEWIDE COMMUNITY BEHAVIORAL HEALTH ASSOCIATION, LIVINGSTON COUNTY HOUSING, LIVINGSTON COUNTY UNITED WAY, AND THE EXECUTIVE BOARD OF THE LIVINGSTON COUNTY CHILDREN'S NETWORK, AND HEALTH CARE EDUCATORS AND PROVIDERS INCLUDING THE FACILITY'S VP OF PATIENT CARE SERVICES - CHIEF NURSING OFFICER, EDUCATION MANAGER, AND THE MANAGER OF ITS EMERGENCY DEPARTMENT, REGISTERED NURSES, A CERTIFIED HEALTH EDUCATION SPECIALIST, AND A LICENSED CLINICAL SOCIAL WORKER MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Facility , 1 - SAINT JAMES HOSPITAL SJH COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY HEALTHY BEHAVIORS DEFINED AS ACTIVE LIVING AND HEALTHY EATING AND THEIR IMPACT ON OBESITY, AND BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPLEMENTATION STRATEGY THAT DESCRIBES THE ACTIONS SJH INTENDS TO TAKE TO ADDRESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW HEALTHY BEHAVIORS AND OBESITY GOAL *INCREASED AWARENESS AND ENGAGEMENT IN REDUCING OBESITY AND PROMOTING HEALTHY BEHAVIORS IN ORDER TO IMPROVE LIVINGSTON COUNTY RESIDENTS' OVERALL HEALTH MEASUREMENT AND PROGRESS (1) INCREASED PARTICIPATION ADDITION OF ONE NEW AREA SCHOOL PARTICIPATION IN A HEALTHY BEHAVIORS -PROGRESS PARTNERED WITH LOCAL SCHOOLS TO EDUCATE THEM ON HEALTHY BEHAVIORS, DENTAL HYGIENE AND PHYSICAL ACTIVITY THROUGH VARIOUS PROGRAMS THROUGHOUT THE THREE YEARS THESE PROGRAMS HELPED OVER 150 CHILDREN IN ADDITION, PARTNERSHIP WITH THE BOYS AND GIRLS CLUBS IN ALL LIVINGSTON COUNTY LOCATIONS HAS BEEN INCREASED TO PROVIDE ADDITIONAL RESOURCES INCREASED PARTICIPATION IN THE 4-H FAIR HAS GIVEN KNOWLEDGE TO OVER 180 CHILDREN ALONG WITH 60 PARTICIPANTS WHO BUILT A FITNESS TRACKER AT A 4-H SCIENCE EVENT TO HELP WITH THE BENEFITS OF EXERCISE AND HEALTHY BEHAVIORS (2) INCREASED PARTICIPATION PERCENTAGE OF MISSION PARTNER (EMPLOYEE) PARTICIPATION IN THE OSF 4LIFE PROGRAM -PROGRESS THROUGH THIS EXPANDED PARTICIPATION, OSF EMPLOYEES NOT ONLY JOINED THE PROGRAM AND GAINED KNOWLEDGE ABOUT HEALTHY BEHAVIORS BUT ALSO PARTICIPATED IN ANNUAL RUNS SUCH AS "RUN FOR RESPECT" THROUGH PONTIAC HIGH SCHOOL AND COMMUNITY WALKS SUCH AS "AMERICAN HEART WALK" (3) INCREASED AWARENESS HEALTHY BEHAVIOR EDUCATION AND/OR DEMONSTRATIONS AT LEAST 6 COMMUNITY EVENTS ANNUALLY -PROGRESS DIABETES SUPPORT GROUP MEETINGS HELD MONTHLY AVERAGING 10-15 PARTICIPANTS PER MEETING, PRE-DIABETES CLASSES HELD THROUGHOUT THE YEARS, THESE INCLUDED 5 - 10 PARTICIPANTS PER SESSION, LAUNCHING OF A NEW DIABETES PREVENTION PROGRAM THIS IS AN ANNUAL PROGRAM TO MONITOR AND HELP PATIENTS AVOID GETTING DIABETES THE FIRST SESSION WAS HELD, AND 24 PARTICIPANTS WERE ABLE TO TAKE</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>E ADVANTAGE OF THIS NEW ANNUAL PROGRAM, A SAINT JAMES HOSPITAL DIETITIAN HAS PROVIDED NUTRITION EDUCATION SESSIONS TO VARIOUS COMMUNITY GROUPS THROUGHOUT THE THREE YEARS WITH AVERAGE OF 75-150 PARTICIPANTS PER YEAR, A PROGRAM ENTITLED "LIFE AFTER LOSS" HELD GROUP SESSIONS 2 TIMES PER MONTH WITH 3-10 PARTICIPANTS AT EACH SESSION ANNUALLY, SEVERAL "WE LIVE" EVENTS HELPING APPROXIMATELY 150 PER EVENT THE EVENT HAS HELPED WOMAN DISCUSS MAINTAINING HEALTH HABITS DURING THE HOLIDAYS IN ADDITION, THIS PROGRAM HAS HEART HEALTH SCREENINGS, EATING HEALTHY FUN FOOD AND EDUCATION ON DANCE EXERCISES, PROVIDED SCREENINGS TO AG HEALTH AND A SAFETY FAIR THESE INCLUDED WELLNESS CHECKS AND SAFETY INFORMATION TO AG COMMUNITY APPROXIMATELY 145 PARTICIPANTS ANNUALLY, ON THE SAINT JAMES CAMPUS, IN COLLABORATION WITH UNITED WAY, ESTABLISHED AND COORDINATED THE GROWING WELL GARDEN WITH A HARVEST OF APPROXIMATELY 2,400 LBS OF PRODUCE DISTRIBUTED TO AREA FOOD PANTRIES, FALL OF 2018, A GROWING WELLS ORCHARD WAS PLANTED, COLLECTION DRIVES INCLUDING FOOD AND HYGIENE PRODUCTS HAVE BEEN ONGOING, DONATING ITEMS TO LOCAL FOOD PANTRIES AND COMMUNITY AGENCIES BEHAVIORAL HEALTH GOAL *INCREASE AWARENESS OF AND ACCESS TO BEHAVIORAL HEALTH (BOTH MENTAL HEALTH AND SUBSTANCE ABUSE) SERVICES FOR LIVINGSTON COUNTY RESIDENTS INCREASED AWARENESS AND ENGAGEMENT TO DECREASE INSTANCES OF RISKY BEHAVIOR AND SUBSTANCE ABUSE TO PROTECT THE HEALTH, SAFETY, AND QUALITY OF LIFE FOR ALL IN LIVINGSTON COUNTY, ESPECIALLY CHILDREN MEASUREMENT AND PROGRESS (1) ADDITION OF ONE OFFSITE LOCATION FOR IHR COUNSELING SERVICES -PROGRESS ADDED PONTIAC SAINT JAMES CAMPUS LOCATION FOR CO-LOCATION OF IHR COUNSELOR (2) INCREASED ACCESS 10% INCREASE IN PATIENT REFERRALS FROM OSF TO BEHAVIORAL HEALTHCARE PROVIDERS -PROGRESS PARTICIPATION ON THE OSF PEDIATRIC COUNCIL, INCLUDING COLLABORATION WITH LIVINGSTON COUNTY CHILDREN'S NETWORK (LCCN), ON AREA GRADE SCHOOL AGE STUDENT GROWTH AND DEVELOPMENT PROGRAMS WORK CLOSELY WITH NEW OSFMSG BEHAVIORAL HEALTH COORDINATOR FOR ADULT RESOURCES AND PLACEMENTS COUNSELORS WERE ADDED TO CHENOA AND THE REYNOLDS STREET CAMPUS LOCATIONS, PARTICIPATED IN THE OSF PEDIATRICS COUNCIL, INCLUDING COLLABORATION WITH LIVINGSTON COUNTY CHILDREN'S NETWORK (LCCN), GIVES US THE ABILITY TO ASSIST WITH LOCAL AREA GRADE SCHOOL STUDENT GROWTH AND DEVELOPMENTAL PROGRAMS IN ADDITION, WORKED CLOSELY WITH THE NEW BEHAVIORAL HEALTH COORDINATOR FOR ADULT RESOURCES AND PLACEMENTS (3) INCREASED AWARENESS PARTICIPATION BY OSF MISSION PARTNERS AND OTHER COMMUNITY CAREGIVERS IN ONE TO TWO BEHAVIORAL HEALTH EDUCATION PROGRAMS ANNUALLY -PROGRESS HELD MENTAL HEALTH TRAINING COURSES FOR OSF AND COMMUNITY EMERGENCY MEDICAL SERVICE PROVIDERS, EDUCATION PROVIDED BY HOSPITAL EXECUTIVES ON OPIOID CRISIS AND HOW OSF IS WORKING WITH PONTIAC AND LIVINGSTON COUNTY TO INCREASE AWARENESS, EDUCATION PROVIDED TO 110 PROVIDERS ON THE SILVER CLOUD MOBILE APP AND THE SERVICES AVAILABLE TO COMMUNITY MEMBERS, DEVELO</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	PED PROCESSES AND PROCEDURES TO REDUCE THE USE OF OPIOIDS AND ASSURE ALL PATIENTS HAVE A CURRENT MEDICATION MANAGEMENT AGREEMENT SINCE THESE AGREEMENTS HAVE BEGUN SAINT JAMES HOSP ITAL HAS SEEN A SIGNIFICANTLY LOWER OPIOID PRESCRIPTION USAGE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT JAMES HOSPITAL CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - SAINT JAMES HOSPITAL PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - SAINT JAMES HOSPITAL THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - SAINT JAMES HOSPITAL A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA. See CHNA for further information.

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>Facility , 1 - ST FRANCIS HOSPITAL OSF HEALTHCARE CENTER d/b/a ST FRANCIS HOSPITAL FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 DELTA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) THE HEALTH OFFICER FOR THE PUBLIC HEALTH DELTA & MENOMINEE COUNTIES 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH TO ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING MENOMINEE, DELTA AND SCHOOLCRAFT COMMUNITY ACTION AGENCY AND HUMAN RESOURCES AUTHORITY, EXECUTIVE DIRECTOR OF THE TRI-COUNTY SAFE HARBOR, INC SERVING VICTIMS OF DOMESTIC VIOLENCE, EXECUTIVE DIRECTOR OF UNITED WAY DELTA COUNTY, COMMUNITY PLANNER FOR CENTRAL UPPER PENINSULA PLANNING AND DEVELOPMENT REGIONAL COMMISSION, TWO REPRESENTATIVES FROM YMCA DELTA CENTER, AND THE EXECUTIVE DIRECTOR OF CATHOLIC SOCIAL SERVICES OF THE UPPER PENINSULA, AS WELL AS HEALTH CARE EDUCATORS AND PROVIDERS INCLUDING THE FACILITY'S LEAD SOCIAL WORKER/CASE MANAGER, CHIEF NURSING OFFICER, A REGISTERED DIETICIAN/CERTIFIED DIABETIC EDUCATOR AND ITS PATIENT SAFETY OFFICER/RISK MANAGER, A PHYSICIAN BOARD CERTIFIED IN FAMILY MEDICINE, A HEALTH OCCUPATION INSTRUCTOR IN THE DELTA-SCHOOLCRAFT INTERMEDIATE SCHOOL DISTRICT, AND A NURSING HOME ADMINISTRATOR MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Facility , 1 - ST FRANCIS HOSPITAL ST FRANCIS HOSPITAL COMPLETED A COMMUNITY HEALTH NEED S ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 201 9 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNI TY HEALTH NEEDS AS A PRIORITY HEALTHY BEHAVIOR DEFINED AS ACTIVE LIVING, HEALTHY EATING A ND THEIR IMPACT ON OBESITY, AND BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE AB USE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPL EMENTATION STRATEGY THAT DESCRIBES THE ACTIONS ST FRANCIS HOSPITAL INTENDS TO TAKE TO ADDR ESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE H EALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRE SS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AN D MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW H EALTHY BEHAVIORS GOAL *ENCOURAGE HEALTHY BEHAVIORS AMONG THE CITIZENS OF DELTA COUNTY TO MANAGE AND PREVENT THE ONSET OF OBESITY WITH A GOAL OF REDUCING OBESITY AMONG CHILDREN AGE S 10-17 AND ADULTS MEASUREMENT AND PROGRESS (1)TRACK NUMBER OF SCHOOLS WHO PARTICIPATE I N "FUEL UP" PROGRAMS -PROGRESS PROGRAM HAS FIVE SCHOOLS PARTICIPATING IN FUEL UP THIS P ROGRAM OFFERS HEALTHY BEHAVIORS TO DELTA COUNTY CHILDREN (2)TRACK NUTRITIONAL COUNSELING SESSIONS -PROGRESS PROVIDED OVER 350 PATIENTS WITH NUTRITIONAL CONSULTS (3) TRACK NUMBER OF NUTRITIONAL CLASSES -PROGRESS HOSTED OVER 22 SESSIONS PER YEAR OF AN INTENSE DIABETE S, PREVENTION PROGRAM SERVING THREE PARTICIPANTS PER SESSION (4) TRACK SPONSORSHIP OF COMM UNITY ACTIVITIES THAT SUPPORT ACTIVE LIFESTYLES -PROGRESS PARTICIPATED IN OVER 20 HEALTH FAIRS ANNUALLY THESE INCLUDED GLUCOSE, CHOLESTEROL AND BLOOD PRESSURE SCREENINGS, PROVID ED PHYSICIAN SPEAKERS FOR THREE YMCA, ASK AN EXPERT SERIES PROVIDED ADMINISTRATIVE AND MA TERIAL SUPPORT TO FIRST AID STATIONS AT THE UPPER PENINSULA STATE FAIR AND SYMETRA PROFESS IONAL GOLF TOURNAMENTS, IN ADDITION, SPONSORED 17 YEARLY ACTIVITIES INCLUDING DELTA COUNT Y SUICIDE PREVENTION TASK FORCE - END THE SILENCE WALK/RUN TO NAME A FEW BEHAVIORAL HEALTH GOAL *IMPROVE ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN DELTA COUNTY MEASU REMENT AND PROGRESS (1) TRACK FUNDS PROVIDED TO PATHWAYS/CSS TO MAINTAIN MENTAL HEALTH SE RVICES -PROGRESS PROVIDED \$3000 PER MONTH (2)COMPLETE BUSINESS CASE FOR PROVISION OF MEN TAL HEALTH SERVICES WITHIN THE OSF MULTISPECIALTY GROUP IN DELTA COUNTY -PROGRESS MENTAL HEALTH SERVICES WITHIN THE MULTI-SPECIALTY GROUP ACHIEVED WITH SUPPORT OF THE OSF PHYSICI AN ENTERPRISE SERVICES HIRED</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>AN APP WHO IS DUAL BOARD CERTIFIED IN FAMILY MEDICINE AND PSYCHIATRY HIRED AN LMSW WHO IS NOW EMBEDDED IN THE PRIMARY CARE PRACTICES THAT WILL PROVIDE BRIEF THERAPEUTIC INTERVENTIONS THIS LMSW PROVIDES DIAGNOSIS AND TREATMENT FOR BEHAVIORAL HEALTH CONDITIONS AND WORKS WITH PATIENTS ON BEHAVIORAL CHANGE SUCH AS SMOKING CESSATION, WEIGHT LOSS, ETC (3) ESTABLISHED SUBSTANCE AGREEMENTS WITH PATIENTS IDENTIFIED AS CHRONIC OPIOID USERS WHO HAVE OBTAINED PRESCRIPTIONS FROM MULTIPLE PROVIDERS (3 OR MORE PROVIDERS) IN ONE YEAR - -PROGRESS ESTABLISHED A SUBSTANCE AGREEMENT WITH PATIENTS WHO IDENTIFIED AS CHRONIC OPIOID USERS (SEE ABOVE) COMPLETED OVER 1600 SUBSTANCE AGREEMENTS IN ADDITION, RECENT CHANGES IN MICHIGAN PRESCRIBING LAWS WILL ASSIST IN EFFORT TO REDUCE OPIOID USE DISORDERS (4) PARTNER WITH LOCAL PUBLIC SAFETY DEPARTMENT TO PLAN SEMI-ANNUAL OPIOID RECOVERY AND MEDICATION TAKE BACK EVENTS -PROGRESS PARTICIPATED IN TWO STATEWIDE DRUG RECOVERY PROGRAMS THROUGH MICHIGAN OPEN (5) CONTINUE ACTIVE PARTICIPATION IN DRUG ABUSE PREVENTION TASK FORCE -PROGRESS ACTIVE PARTICIPATION IN DRUG ABUSE PREVENTION TASK FORCE KEPT ANNUALLY, WITH SAVE COUNCIL AND COMMUNITIES THAT CARE COUNCIL (6) TRACK NUMBER OF "LIFE RIDES" PROVIDED ON NEW YEAR'S EVE -PROGRESS THE PROGRAM OFFERS A RIDE TO DELTA COUNTY RESIDENTS ON NEW YEAR'S EVE THESE "LIFERIDES" PROVIDED ANNUALLY HAVE HELPED OVER 1500 COMMUNITY MEMBERS STAY SAFE IN THE past three years</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST FRANCIS HOSPITAL CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - ST FRANCIS HOSPITAL PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - ST FRANCIS HOSPITAL THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - ST FRANCIS HOSPITAL A PLAIN LANGUAGE SUMMERY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	<p>Facility , 1 - OSF SAINT LUKE MEDICAL CENTER OSF HEALTHCARE CENTER d/b/a SAINT LUKE MEDICAL CENTER ("SLMC") FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 HENRY COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) ADMINISTRATOR OF THE HENRY AND STARK COUNTY HEALTH DEPARTMENTS 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE ENTIRE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, REPRESENTATIVES FROM NONPROFIT AND COMMUNITY-BASED ORGANIZATIONS INCLUDING THE EXECUTIVE DIRECTOR OF THE YMCA OF KEWANEE, VP OF BEHAVIORAL HEALTH SERVICES FOR BRIDGEWAY, INC , AND DIRECTORS SITTING ON THE FOLLOWING BOARDS KEWANEE SCHOOLS FOUNDATION, KEWANEE KIWANIS CLUB, CHAIR OF THE ABILITIES PLUS PREVENTION INITIATIVE ADVISORY BOARD, HOUSING AUTHORITY OF HENRY COUNTY, AND THE KEWANEE ECONOMIC DEVELOPMENT CORPORATION, HEALTH CARE EDUCATORS AND PROVIDERS INCLUDING THE FACILITY'S DIRECTOR OF REHABILITATION SERVICES AND VP-CHIEF NURSING OFFICER, A COMMUNITY AND ECONOMIC DEVELOPMENT EDUCATOR FOR THE UNIVERSITY OF IL EXTENSION, AND A LICENSED CLINICAL PROFESSIONAL COUNSELOR AND NATIONALLY CERTIFIED MENTAL HEALTH FIRST AID USA INSTRUCTOR, SUPERINTENDENT OF THE KEWANEE COMMUNITY UNIT SCHOOL DISTRICT 229, AND A RETIRED EDUCATOR WITH 34 YEARS EXPERIENCE AS A TEACHER, COACH AND PRINCIPAL MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>Facility , 1 - OSF SAINT LUKE MEDICAL CENTER SLMC COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY HEALTHY BEHAVIORS DEFINED AS ACTIVE LIVING AND HEALTHY EATING AND THEIR IMPACT ON OBESITY, AND BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPLEMENTATION STRATEGY THAT DESCRIBES THE ACTIONS SLMC INTENDS TO TAKE TO ADDRESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW HEALTHY BEHAVIORS AND OBESITY GOALS IMPROVE LIFELONG HEALTHY EATING AND PHYSICAL ACTIVITY IN YOUTH, INCREASE THE PERCEPTION THAT OVERWEIGHT AND OBESITY ARE SIGNIFICANT PUBLIC HEALTH RISKS, AND INCREASE THE NUMBER OF YOUTH RECEIVING FLU SHOTS MEASUREMENT AND PROGRESS (1) TRACK NUMBER OF IMMUNIZATIONS GIVEN AT LOCAL SCHOOLS -PROGRESS A TEAM OF CAREGIVERS ATTENDED THE LOCAL SCHOOL ENROLLMENTS TO EDUCATE AND OBTAIN AUTHORIZATIONS FOR FLU IMMUNIZATIONS, ADMINISTERED OVER 3,000 FREE FLU IMMUNIZATIONS TO SCHOOL AGED-CHILDREN AND THEIR TEACHERS (2) MEASURE AND TRACK THE IMPACT ON SCHOOL ABSENCES DUE TO THE IMMUNIZATIONS -PROGRESS ADMINISTERED FREE FLU IMMUNIZATIONS TO SCHOOL AGED CHILDREN AND THEIR TEACHERS, CURRENTLY EVALUATING RESULTS TO IMPROVE PROGRAM (3) TRACK NUMBER OF PARTICIPANTS IN THE WELLNESS EDGE FOR KIDS -PROGRESS A TEAM OF HEALTHCARE PROVIDERS SPENT TIME AT THE HOUSING AUTHORITY FOR THE WELLNESS EDGE SUMMER PROGRAM PROVIDING EDUCATION ON HEALTHY BEHAVIORS APPROXIMATELY 150 HIGH RISK YOUTH PARTICIPANTS IN ALL YEARS (4) TRACK NUMBER OF EDUCATIONAL AND LOCAL SPONSORSHIPS SUPPORTING PHYSICAL ACTIVITY AND HEALTHY EATING -PROGRESS ATHLETIC TRAINING SERVICES WERE PROVIDED FOR SCHOOL ACTIVITIES TO GIVE EDUCATION AND ENSURE SAFETY OF STUDENT ATHLETES , HOSTED A 5K RUN/WALK WITH APPROXIMATELY 370 PARTICIPANTS, HOSTED A COMMUNITY EVENT CALLED "MUMS THE WORD" WITH A CARE PROVIDER SHARING PREVENTATIVE CARE EDUCATIONAL MATERIAL EDUCATED 100 COMMUNITY PARTICIPANTS, SAINT LUKE MEDICAL CENTER CHAIRED THE PREVENTATIVE INITIATIVE ADVISORY GROUP MADE UP OF A COMMUNITY COLLABORATIVE SEVERAL AT-RISK CHILDREN FROM AREA FAMILIES PARTICIPATED IN THE PROGRAM, PROVIDED PARKINSON'S DISEASE EDUCATION, WEEKLY SUPPORT GROUP AND EXERCISE, AND</p>

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 11 Facility , 1	<p>CHAired the preventative initiative advisory made up of a community collaborative (5) of FER community lunch and learns at least twice a year -PROGRESS Hosted multiple lunch & learn community events such as "Love Your Heart" (6) Provide nutrition and concussion education for student athletes at least once per year -PROGRESS Concussion management seminar 20 community coaches, school nurses & administrators, healthcare providers and parents, reaching a broader group of youth participating in community activities behavioral health goals *STRIVE to assure that patients receive services that are individualized, safe and rehabilitative in nature, to provide support to and enhance community alcohol, tobacco and other drug abuse prevention efforts, thereby enhancing overall health of the community, assist families in gaining access to community resources measurement and progress (1) Track counselor visits in OSF Medical Group-Kewanee providing early intervention depression screening and support -PROGRESS Recruitment of behavioral health counselor, addition of psychiatry e-consults for ambulatory primary care providers, added classes on management of aggressive behavior education for mission partners in high risk areas (2) Provide 24 hour sitter coverage -PROGRESS Provided sitter coverage and designated specific full time employees to ensure the safety of at risk patients (3) Increase community engagement (attendance) at monthly survivors of suicide support group meetings -PROGRESS Active members of the Henry County Mental Health Alliance, with the chairperson being an OSF SLMC mission partner, provided meeting room for the monthly survivors of suicide loss support group, collaborated with the Henry County Mental Health Alliance for planning a community education day, sponsored the 2017 Henry County Mental Health Alliance Mental Health Walk, approximately 350 community members attended and supported the 2018 Mental Health Conference organized by Henry County, sponsored the 2018 Henry County Mental Health Alliance Mental Health Walk - approximately 300 community members attended (4) Reduce behavioral health related emergency department visits impacted by preventive care and educational resources -PROGRESS Hosted "Suicide Talk Workshop via partnership with the Henry County Mental Health Alliance, 40 community members in attendance, support community Parkinson's Disease Awareness Walk and support group (5) Provide behavioral health and/or substance abuse education at least once per year for mission partners and medical group providers -PROGRESS Development of a drug take back program, drug and alcohol task force community collaborative participated in a hospital-wide skills lab, with the behavioral health navigator providing information on suicide prevention and awareness</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF SAINT LUKE MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF SAINT LUKE MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - OSF SAINT LUKE MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - OSF SAINT LUKE MEDICAL CENTER A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 3E	The significant health needs were prioritized as significant health needs of the community and identified through the CHNA See CHNA for further information

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 5 Facility , 1	Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER OSF HEALTHCARE CENTER d/b/a HOLY FAMILY MEDICAL CENTER ("HFMC") FORMED A COLLABORATIVE TEAM OF COMMUNITY PARTNERS TO CONDUCT ITS 2016 WARREN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT THIS EFFORT LED TO THE DEVELOPMENT OF AN IMPLEMENTATION STRATEGY DESIGNED TO IMPROVE THE HEALTH OF THE AREA'S RESIDENTS BY DEVELOPING AND IMPLEMENTING INTERVENTIONS TO ADDRESS SIGNIFICANT PRIORITY HEALTH NEEDS FOR THE 2016 CHNA, THE COLLABORATIVE TEAM SOLICITED AND TOOK INTO ACCOUNT INPUT FROM THE FOLLOWING SOURCES 1) DIRECTOR AT THE HENDERSON COUNTY HEALTH DEPARTMENT 2) PRIMARY DATA WAS COLLECTED FROM THE AT-RISK AND ECONOMICALLY DISADVANTAGED POPULATION BY COLLECTING A STRATIFIED SAMPLE OF SURVEYS DISTRIBUTED IN ENGLISH AND SPANISH AT ALL HOMELESS SHELTERS, FOOD PANTRIES AND SOUP KITCHENS 3) THE 2013 CHNA WAS MADE WIDELY AVAILABLE TO THE COMMUNITY AND FEEDBACK RECEIVED FROM COMMUNITY SERVICE ORGANIZATIONS WAS TAKEN INTO ACCOUNT 4) ADDITIONAL SOURCES OF INPUT WERE RECEIVED FROM THE COLLABORATIVE TEAM CREATED TO ENGAGE THE COMMUNITY IN CONDUCTING THE 2016 CHNA AND TO IMPROVE POPULATION HEALTH THE COLLABORATIVE TEAM INCLUDED CONSUMER ADVOCATES, THE FACILITY'S COORDINATOR OF DIABETES SERVICES AND DIABETIC EDUCATOR WHO IS A CERTIFIED EXERCISE SPECIALIST IN CARDIAC PULMONARY REHAB AND CERTIFIED DIABETIC EDUCATOR, AND ITS PRESIDENT WHO IS A MEMBER OF THE AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES AND THE IL CRITICAL ACCESS HOSPITAL NETWORK, AN IEPA CERTIFIED WATER OPERATOR, AND AN MS RN WHO HAS SERVED AS CHIEF NURSING OFFICER AT TWO CRITICAL ACCESS HOSPITALS MEMBERS OF THE COLLABORATIVE TEAM IDENTIFIED BY NAME, AFFILIATION, AND ROLE ARE LISTED IN APPENDIX 1 TO THE 2016 CHNA

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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER HFMC COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING FISCAL YEAR 2016 AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(c)(3) THE FINAL CHNA FOR THE HOSPITAL WAS APPROVED AND ADOPTED BY THE SYSTEM'S BOARD OF DIRECTORS ON JULY 25, 2016 THIS CHNA IS EFFECTIVE FOR FISCAL YEARS 2017, 2018 AND 2019 THE COLLABORATIVE TEAM CONDUCTING THE CHNA IDENTIFIED THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS AS A PRIORITY HEALTH BEHAVIORS DEFINED AS ACTIVE LIVING AND HEALTHY EATING, USE OF EMERGENCY DEPARTMENT AS A PRIMARY SOURCE OF MEDICAL CARE, AND HEART DISEASE IN RESPONSE TO THESE PRIORITY HEALTH NEEDS, THE COLLABORATIVE TEAM DEVELOPED AN IMPLEMENTATION STRATEGY THAT DESCRIBES THE ACTIONS HFMC INTENDS TO TAKE TO ADDRESS THE PRIORITY HEALTH NEEDS, THE RESOURCES THE HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEEDS, AND ANY PLANNED COLLABORATIONS WITH OTHER HOSPITALS OR ORGANIZATIONS TO ADDRESS THE HEALTH NEEDS THE HOSPITAL REVIEWS ITS IMPLEMENTATION STRATEGY AT LEAST ANNUALLY AND MAKES REVISIONS AS NEEDED TO MAXIMIZE THE IMPACT ON IDENTIFIED PRIORITY HEALTH NEEDS A SUMMARY OF HOW THE HOSPITAL HAS ADDRESSED THESE PRIORITY HEALTH NEEDS IS PROVIDED BELOW HEALTHY BEHAVIORS GOAL *PROVIDE EDUCATIONAL OPPORTUNITIES WITHIN THE COMMUNITY TO INSTILL THE IMPORTANCE OF HEALTH AND WELLNESS MEASUREMENT AND PROGRESS (1) PROVIDE HEALTHY WEIGHT, HEALTHY YOU -PROGRESS DEVELOPED PHASE II OF HEALTHY WEIGHT, HEALTHY YOU AND OFFERED 20 CLASSES THROUGHOUT EACH YEAR (2) OFFER HEALTH AND WELLNESS EDUCATION AT MONMOUTH COLLEGE -PROGRESS PARTICIPATED IN 2 HEALTH FAIRS WITHIN THE COUNTY (3) PARTICIPATE IN TWO AREA HEALTH FAIRS IN 2017 & 2018 -PROGRESS ANNUALLY JOINED AT LEAST TWO HEALTH FAIRS WITHIN THE COMMUNITY (4) OFFER KIDS' SAFETY DAY -PROGRESS OFFERED KIDS' SAFETY DAY TO OVER 250 PARTICIPATES ANNUALLY (5) OFFER A1C SCREENINGS AT 4 LOCAL EVENTS -PROGRESS INCREASED PARTICIPATION BY ADDING SCREENINGS AT HEALTH FAIRS (6) DEVELOP AND IMPLEMENT HEALTHY WEIGHT HEALTHY PROGRAMS -PROGRESS OFFERED LUNCH AND EARNS ON VARIOUS TOPICS TO THE COMMUNITY 4 TIMES ANNUALLY (7) OFFER TWO PODIATRY SCREENINGS -PROGRESS OFFERED TWO PODIATRY SCREENINGS ANNUALLY (8) OFFER TWO DERMATOLOGY SCREENINGS -PROGRESS OFFERED TWO DERMATOLOGY SCREENINGS ANNUALLY (9) PROVIDE EDUCATION IN AREA SCHOOLS FOUR TIMES IN THE FISCAL YEAR -PROGRESS PRESENTATIONS ON HAND HYGIENE WERE OFFERED AT SEVERAL AREA SCHOOLS FOR YOUNG CHILDREN (10) PROVIDE A MEN'S HEALTH EVENT, PROVIDE A WOMEN'S HEALTH EVENT -PROGRESS PROVIDED A MEN'S HEALTH EVENT THAT INCLUDED BLOOD SCREENINGS PROVIDED WOMEN'S HEALTH EVENT INCLUDING A HEART HEALTHY TALK BY AN OSF CARDIOLOGIST IN 2017 & 2018 USE OF THE EMERGENCY DEPARTMENT AS A PRIMARY SOURCE OF MEDICAL CARE GOAL *PROVIDE CARE TO PATIENTS IN THE APPROPRIATE LOCATION, DECREASE NON- EMERGENT CARE IN THE EMERGENCY DEPARTMENT MEASUREMENT AND PROGRESS (1)MONMOUTH COLLEGE EDUCATION ON OSF ON-CALL,</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
<p>Schedule H, Part V, Section B, Line 11 Facility , 1</p>	<p>OFFER 2 PROGRAMS PER YEAR -PROGRESS OFFERED EDUCATION AT MONMOUTH COLLEGE ON OSF ON-CAL L DURING FRESHMAN ORIENTATION AND FAMILY WEEKEND IN 2017 & 2018 (2) WORK GROUP IN THE EME RGENCY DEPARTMENT WILL IDENTIFY THE TOP 20 ED USERS IN FY16 AND DROP THEIR ED USAGE BY 10% -PROGRESS ASSEMBLED AN EMERGENCY DEPARTMENT UTILIZATION TEAM IDENTIFIED "TOP 25 USERS" AND WORKED WITH CASE MANAGEMENT TO DECREASE THE UTILIZATION OF THOSE PATIENTS RESULTING I N A DECREASE OF 58% IN THE NUMBER OF VISITS FOR THOSE 25 PATIENTS (3) EDUCATION THROUGH T HE WARREN COUNTY HOUSING AUTHORITY WILL BE OFFERED AT LEAST ONCE ANNUALLY -PROGRESS EDUC ATED RESIDENTS OF THE WARREN COUNTY HOUSING AUTHORITY ON THE PROPER LEVEL OF CARE TO SEEK FOR COMMON AILMENTS (4) COMPLEX CASE MANAGEMENT WILL CONTACT 50 WARREN COUNTY RESIDENTS A NNUALLY -PROGRESS COMPLEX CASE MANAGEMENT CONTACTED 50 OR MORE WARREN COUNTY RESIDENTS A NNUALLY (5) DISTRIBUTE 1500 CARDS IN THE COMMUNITY DESCRIBING THE PROPER CARE TO SEEK FOR COMMON HEALTH ISSUES -PROGRESS SENT OUT APPROXIMATELY 1500 CARDS REGARDING THE PROPER P OINT OF CARE TO COMMUNITY MEMBERS ANUALLY HEART DISEASE GOAL *CREATE AN AWARENESS OF CARD IAC RELATED HEALTH ISSUES WITHIN THE COMMUNITY MEASUREMENT AND PROGRESS (1)PROVIDE BLOOD PRESSURE SCREENINGS TO THE COMMUNITY -PROGRESS OFFERED AT LEAST THREE BLOOD PRESSURE SC REENINGS TO THE COMMUNITY ANNUALLY (2) OFFER 2 PULSE OX AND HEART RATE SCREENINGS -PROGR ESS OFFERED TWO PULSE OX AND HEART RATE SCREENINGS TO COMMUNITY ANNUALLY (3) OFFER A "BR EATHING EASY" PRESENTATION TO THE COMMUNITY -PROGRESS THE DIRECTOR OF RESPIRATORY THERAP Y CONDUCTED A BREATHING AND RESPIRATION PRESENTATION DURING THE LUNCH AND LEARNS (4) OFFE R CARDIOLOGIST-LED EDUCATION TO THE COMMUNITY TWICE WITHIN THE FISCAL YEAR -PROGRESS OFF ERED CARDIOLOGIST EDUCATION TO THE COMMUNITY TWO TIMES ANNUALLY, ONE DURING THE WOMEN'S HE ALTH EVENT, WHICH ALSO FOCUSED ON WOMEN'S HEART HEALTH (6) DEVELOPED AND PROMOTED HEART H EALTHY COOKING PROGRAM -PROGRESS DEVELOPED A HEART HEALTHY COOKING PROGRAM ATTENDED BY S IX MEMBERS OF THE COMMUNITY IN 2017 & 2018</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE WHEN CHARGES EXCEED 25% OF ANNUAL FAMILY INCOME THE AMOUNT BILLED IS ADJUSTED TO 25% OF FAMILY INCOME WHEN OSF DETERMINES THIS ADJUSTMENT IS THE MOST GENEROUS ASSISTANCE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 13 Facility , 1	Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER PRESUMPTIVE FINANCIAL ASSISTANCE IS AVAILABLE AND PROVIDES FOR A DISCOUNT OF 100% OF BILLED CHARGES FOR MEDICALLY NECESSARY SERVICES PROVIDED TO A PATIENT WITH NO INSURANCE BENEFITS, WHEN THE PATIENT ESTABLISHES FINANCIAL NEED AT TIME OF REGISTRATION BY SATISFYING ONE OF THE FOLLOWING CATEGORIES OF PRESUMPTIVE ELIGIBILITY CRITERIA HOMELESSNESS, DECEASED WITH NO ESTATE, MENTAL INCAPACITATION WITH NO ONE TO ACT ON THE PATIENT'S BEHALF, AND CURRENT MEDICAID ELIGIBILITY, BUT NOT ON DATE OF SERVICE OR FOR NON-COVERED SERVICE

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 15 Facility , 1	Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY DIRECTS PATIENTS TO STAFF IN THE PATIENT FINANCIAL SERVICES AND ADMITTING AREAS AT OSF HOSPITALS FOR ASSISTANCE IN OBTAINING ANSWERS TO QUESTIONS REGARDING THE POLICY

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16 Facility , 1	Facility , 1 - OSF HOLY FAMILY MEDICAL CENTER A PLAIN LANGUAGE SUMMARY OF THE FAP IS OFFERED TO PATIENTS AS PART OF THE INTAKE OR DISCHARGE PROCESS, INFORMATION ABOUT FINANCIAL ASSISTANCE AND THE APPLICATION PROCESS IS INCLUDED ON OR WITH THE OSF PATIENT BILLING STATEMENT, AND OSF PROVIDES COPIES OF THE PLAIN LANGUAGE SUMMARY AND THE FAP APPLICATION FORM TO REFERRING STAFF PHYSICIANS

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

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

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

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

Name and address	Type of Facility (describe)
1 CENTER FOR HEALTH AT FT JESSE 2200 FT JESSE ROAD NORMAL, IL 61761	PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, INDUSTRIAL REHAB
1 OSF ST JOSEPH MEDICAL CENTER - COLLEGE 1701 EAST COLLEGE AVENUE BLOOMINGTON, IL 61704	AUDIOLOGY
2 OSF CENTER FOR REHABILITATION & Occupational Health - Dwight 105 JOHN STREET DWIGHT, IL 60420	PHYSICAL THERAPY
3 OSF CENTER FOR REHABILITATION & Occupational Health - Fairbury 106 SOUTH FIRST STREET FAIRBURY, IL 61739	PHYSICAL THERAPY, OCCUPATIONAL THERAPY
4 OSF CENTER FOR REHABILITATION & Occupational Health - Pontiac 608 NORTH LADD STREET PONTIAC, IL 61764	PHYSICAL THERAPY
5 OSF SAINT JAMES SLEEP LABORATORY 702 RITTENHOUSE DRIVE PONTIAC, IL 61764	POLYSYMNOGRAPHY CLINIC
6 OSF ST FRANCIS HOSPITAL AND MEDICAL GROUP - Powers Clinic (RHC) N 15995 MAIN ST POWERS, MI 49870	DIAGNOSTIC RADIOLOGY
7 OSF ST FRANCIS HOSPITAL MEDICAL GROUP - Escanaba (RHC) 3409 LUDINGTON ST ESCANABA, MI 49829	DIAGNOSTIC RADIOLOGY
8 OSF ST FRANCIS HOSPITAL MEDICAL GROUP - Gladstone (RHC) 128 MICHIGAN GLADSTONE, MI 49837	DIAGNOSTIC RADIOLOGY
9 ST FRANCIS HOSPITAL - REHAB SERVICES 704 SUPERIOR AVE GLADSTONE, MI 49837	PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY
10 OSF SAINT CLARE'S HOSPITAL 915 EAST FIFTH STREET ALTON, IL 62002	SKILLED NURSING
11 OSF SAINT ANTHONY'S CANCER CENTER 815 EAST FIFTH STREET ALTON, IL 62002	MEDICAL ONCOLOGY
12 OSF HOLY FAMILY CLINIC 1000 WEST HARLEM AVE MONMOUTH, IL 61462	CARDIOLOGY, GENERAL, NERU, PEDIATRIC, PODIATRY SLEEP CENTER
13 OSF SAINT ANTHONY MEDICAL CENTER - BELVIDERE 1954 GATEWAY CENTER DR BELVIDERE, IL 61008	LABORATORY SERVICES
14 OSF SAINT ANTHONY MEDICAL CENTER - BELVIDERE REHAB 1916 GATEWAY CENTER DR BELVIDERE, IL 61008	PHYSICAL THERAPY, OCCUPATIONAL THERAPY

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

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

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

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

Name and address	Type of Facility (describe)
16 OSF CENTER FOR HEALTH AT ROCK CUT CROSSING 9951 ROCK CUT CROSSING LOVES PARK, IL 61111	LABORATORY SERVICES
1 ROCKFORD CARDIOVASCULAR ASSOCIATES 444 ROXBURY ROAD ROCKFORD, IL 61107	CARDIAC REHAB
2 OSF Center for Health Glen Park 5114 GLEN PARK PLACE PEORIA, IL 61614	DIAGNOSTIC RADIOLOGY, LAB, OP CLINIC, ECHO, MAMMOGRAPHY, US, XRAY
3 OSF CENTER FOR HEALTH MORTON 435 MAXINE DRIVE MORTON, IL 61550	DIAGNOSTIC RADIOLOGY, LAB, EKG, OP CLINIC, CT, MRI, ECHO, MAMMOGRAPHY, US, XRAY
4 OSF Rehabilitation at Five Points 360 N WILMORE ROAD WASHINGTON, IL 61571	PEDIATRIC AND ADULT PHYSICAL THERAPY, AQUATIC THERAPY, OCCUPATIONAL THERAPY
5 OSF Wellness Services at the Riverplex 600 WATER STREET PEORIA, IL 61602	ADULT PHYSICAL THERAPY, CARDIAC REHAB, FAITH COMMUNITY NURSING, HEALTH
6 OSF OUTPATIENT SERVICES 100 NE RANDOLPH AVE PEORIA, IL 61606	PHYSICAL THERAPY, OCCUPATIONAL HEALTH, OP CLINIC
7 OSF OUTPATIENT CENTER FOR INDUSTRIAL REH 520 HIGHPOINT LANE EAST PEORIA, IL 61611	PHYSICAL THERAPY, OCCUPATIONAL THERAPY
8 OSF Rehabilitation - Glen Park 5009 GLEN PARK PLACE PEORIA, IL 61614	PHYSICAL THERAPY
9 OSF SAINT CLARE FAMILY HEALTH CENTER 10 SAINT CLARE COURT 100 WASHINGTON, IL 61571	DIAGNOSTIC RADIOLOGY, LAB, EKG, OP CLINIC, MAMMOGRAPHY, US, XRAY
10 OSF Saint Francis Radiation Oncology at Pekin Cancer Center 603 THIRTEENTH STREET PEKIN, IL 61554	Radiation Oncology
11 OSF WOMEN'S HEALTH CENTER 7800 N SOMMER SUITE 508 PEORIA, IL 61615	PHYSICAL THERAPY, BREAST FEEDING RESOURCE CENTER
12 OSF Saint Francis Medical Center - Radiation Oncology 8948 N WOOD SAGE ROAD PEORIA, IL 61615	Radiation Oncology
13 OSF SAINT ANTHONY MEDICAL CENTER - PARKVIEW 1502 PARKVIEW AVE ROCKFORD, IL 61107	PHYSICAL THERAPY, OCCUPATIONAL THERAPY
14 OSF SAINT ANTHONY MEDICAL CENTER - Center For Health on State 5666 E STATE STREET ROCKFORD, IL 61108	PHYSICAL THERAPY, OCCUPATIONAL THERAPY

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

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

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

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

Name and address	Type of Facility (describe)
31 OSF ST JOSEPH MEDICAL CENTER SLEEP LAB 2200 E WASHINGTON ST BLOOMINGTON, IL 61701	POLYSYMNOGRAPHY, NEUROLOGY
1 OSF Saint Elizabeth Medical Center Sleep Center 1601 Mercury Circle Suite 200 Ottawa, IL 61350	POLYSYMNOGRAPHY
2 Ottawa Medical Center Radiology Services 1614 East Norris Drive Ottawa, IL 61350	Diagnostic Radiology
3 OSF Healthcare Ottawa South 1640 First Avenue Ottawa, IL 61350	Occupational Health
4 OSF Center for Health - Streator 111 Spring Street Streator, IL 61364	Emergency
5 OSF Rehabilitation - Bartonville 1119 W Garfield Bartonville, IL 61607	Physical Therapy
6 OSF Rehabilitation - Chillicothe 120 N 4th St Chillicothe, IL 61523	Physical Therapy
7 OSF Rehabilitation - Metamora 709 W Mt Vernon Metamora, IL 61548	Physical Therapy
8 OSF Senior World - Morton 730 W Jefferson St Suite 200 Morton, IL 61550	Adult Day Services, Geriatric Services
9 OSF Center for Health - Pekin 3422A Court St Pekin, IL 61554	Diagnostic Radiology, Ultrasound, Laboratory Services/EKG
10 OSF Saint Francis Lab Services at Heartland at Broadway - Pekin 2709 Broadway Street Pekin, IL 61554	Laboratory Draw Station
11 OSF Healthcare Cardiovascular Institute - Pekin 610 Park Avenue Pekin, IL 61554	Nuclear and Treadmill Stress Test, Echocardiograms, Vascular Ultrasound
12 OSF Rehabilitation - Pekin 2359 Broadway St Pekin, IL 61554	Adult Physical Therapy, Pediatric Occupational Therapy, Speech Therapy
13 OSF Center for Health - Route 91 8600-8800 Rt 91 North Peoria, IL 61615	CT, Diagnostic Radiology, Lab, EKG, MRI, Pain Clinic, Mammography, PT OT, Hyperbaric Services, EKG
14 OSF HealthCare Cardiovascular Institute 5405 N Knoxville Ave PEORIA, IL 61614	Echocardiograms, Nuclear and Treadmill Stress Test, Vascular Ultrasound, Infusion Clinic, Sleep Lab

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)
46 OSF Saint Francis Outpatient Services at Illinois Medical Center Building 1001 Main St PEORIA, IL 61603	Pulmonary Rehab, Cancer Services, Physical Therapy
1 Women's Health Center 7800 N Sommer Suite 508 PEORIA, IL 61615	Breastfeeding Resource Center, Family Planning, Pelvic Floor Physical Therapy
2 OSF Rehabilitation-Gwynn and OSF Saint Francis Outpatient Diagnostics at OS F HealthCare Orthopedics 303 N William Kumpf Blvd PEORIA, IL 61605	MRI, Physical Therapy, Occupational Therapy
3 OSF Rehabilitation - Kumpf 719 N William Kumpf Blvd Suite 200 PEORIA, IL 61605	Physical Therapy
4 OSF Rehabilitation - Sheridan 6501 N Sheridan Rd PEORIA, IL 61614	Physical Therapy, Occupational Therapy, Speech Therapy, Industrial Rehab
5 OSF Senior World - Peoria 719 N William Kumpf Blvd Suite 300 PEORIA, IL 61605	Adult Day Services, Geriatric Services

**Schedule I
(Form 990)**

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the
Treasury
Internal Revenue Service

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
OSF Healthcare System

Employer identification number
37-0813229

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 ▶ 11

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

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

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) SCHOLARSHIPS	172	294,010	0	NA	NA
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
Schedule I, Part I, Line 2 Procedures for monitoring use of grant funds	GRANT RECIPIENTS WERE GIVEN GRANTS BASED ON THE NEEDS OF THE MEDICAL COMMUNITY AND THE LOCAL COMMUNITY AT LARGE LOCAL PRESIDENT'S REVIEW ASSISTANCE REQUESTS AND APPROVE BASED ON NEED IN SOME CASES, THE CORPORATION'S CEO OR CFO OR OTHER REPRESENTATIVE OF THE CORPORATION SERVES ON THE BOARD OF DIRECTORS OR ON THE FINANCE COMMITTEE OF THE GRANTEE ORGANIZATION AND RECEIVES DIRECT INFORMATION REGARDING USE OF GRANT FUNDS IN SUCH CAPACITY IN OTHER CASES, THE CORPORATION RECEIVES WRITTEN REPORTS AND/OR FINANCIAL STATEMENTS FROM THE GRANTEE ORGANIZATION WHICH INCLUDE INFORMATION REGARDING USE OF GRANT FUNDS THE COLLEGE OF NURSING IN PEORIA AND ROCKFORD ILLINOIS PROVIDE THEIR RESPECTIVE BOARDS WITH UPDATES REGARDING DISTRIBUTION OF NURSING EDUCATION SCHOLARSHIPS THE COLLEGES REQUIRE THE APPLICANTS TO SUBMIT A FINANCIAL AID APPLICATION UPON ADMITTANCE THE SCHOLARSHIP HAS ACADEMIC PERFORMANCE, FINANCIAL NEED CRITERIA, AND HAS A SELECTION COMMITTEE THAT AWARDS THE GRANTS THE COLLEGE'S MONITOR AND REVIEW THE RECIPIENTS INDIVIDUALLY ON A SEMESTER BASIS FOR SATISFACTORY ACADEMIC PROGRESS AND GOOD STANDING

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
EIN: 37-0813229
Name: OSF Healthcare System

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BLOOMINGTON YMCA 602 S Main Street Bloomington, IL 61701	37-0662603	501(C)3	0	1,960,200	Appraisal	6 acres of land	New site for YMCA
HEARTLAND COMMUNITY HEALTHCARE 1701 W Garden Street Peoria, IL 61605	37-1270794	501(C)3	625,000	0	NA	NA	SUPPORT OF CLINIC OPERATION

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 ILLINOIS 1 ILLINI DRIVE PEORIA, IL 61605	37-6000511	501(C)3	250,000	0	NA	NA	SUPPORT OF CLINIC OPERATION
BELVIDERE PARK DISTRICT 1006 W LINCOLN AV BELVIDERE, IL 61008	36-6005793	BELVIDERE PK DISTRI	80,000	0	NA	NA	SUPPORT FOR FITNESS CENTER

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
WILDLIFE PRARIE STATE PARK 3826 N TAYLOR ROAD HANNA CITY, IL 61536	20-8064678	WILDLIFE PR ST PK	50,000	0	NA	NA	SUPPORT OF ORG OPERATIONS
ST JOSEPH NURSING HOME 401 9TH ST LACON, IL 61540	36-2549037	501(C)3	44,628	0	NA	NA	SUPPORT OF CLINICAL OPERATIONS

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
ILLINOIS WESLEYAN UNIVERSITY 1312 PARK STREET BLOOMINGTON, IL 61701	37-0662594	501(C)3	25,000	0	NA	NA	SUPPORT OF ORG OPERATIONS
ROCKFORD AREA ECONOMIC DEVELOPMENT COUNCIL 100 PARK AVENUE SUITE 100 ROCKFORD, IL 61101	36-3055858	501(C)3	25,000	0	NA	NA	SUPPORT OF ORG OPERATIONS

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
GREATER LIVINGSTON COUNTY ECONOMIC DEVELOPMENT COUNCIL 210 W WATER STREET PONTIAC, IL 61794	38-2488748	501(C)3	25,000	0	NA	NA	SUPPORT OF ORG OPERATIONS
BLOOMINGTON NORMAL ECONOMIC DEVELOPMENT COUNCIL 200 W COLLEGE AVENUE NORMAL, IL 61761	37-1169886	501(C)3	21,000	0	NA	NA	SUPPORT OF ORG OPERATIONS

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
ALIGNMENT ROCKFORD 6983 815 N CHURCH ST 201 ROCKFORD, IL 61103	27-1329316	501(C)3	10,000	0	NA	NA	SUPPORT OF ORG OPERATIONS

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047
2017
Open to Public Inspection

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.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization
OSF Healthcare System

Employer identification number
37-0813229

Part I Questions Regarding Compensation

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

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
Schedule J, Part I, Line 1a Health or social club dues or initiation fees	THE CORPORATION REIMBURSES CERTAIN EXECUTIVES FOR SOCIAL CLUB DUES PAID BY SUCH EXECUTIVES. ELIGIBILITY FOR CLUB DUES REIMBURSEMENT IS DETERMINED BY THE HUMAN RESOURCES COMMITTEE OF THE BOARD OF DIRECTORS AND IS TAKEN INTO CONSIDERATION BY THE COMMITTEE IN DETERMINING FAIR MARKET COMPENSATION. SEE FORM 990 - SCHEDULE O - PART VI - LINES 15A AND 15B FOR AN EXPLANATION OF THE ROLE OF THE HUMAN RESOURCES COMMITTEE AND THE MANNER IN WHICH FAIR MARKET COMPENSATION IS DETERMINED. CLUB DUES ARE NOT ELIGIBLE FOR REIMBURSEMENT IF THE CLUB IN QUESTION DISCRIMINATES ON THE BASIS OF RACE, RELIGION, SEX, NATIONAL ORIGIN, OR OTHER PROHIBITED FACTORS. DUES REIMBURSEMENT IS TREATED AND REPORTED AS TAXABLE COMPENSATION.
Schedule J, Part I, Line 4b Supplemental nonqualified retirement plan	DURING 2017, OSF HEALTHCARE SYSTEM MAINTAINED A SUPPLEMENTAL NON-QUALIFIED DEFERRED COMPENSATION PLAN. THE FOLLOWING REPORTABLE INDIVIDUALS WERE ELIGIBLE TO PARTICIPATE IN THAT PLAN: KEVIN D. SCHOEPLIN, DANIEL E. BAKER. DURING 2017, THE FOLLOWING CONTRIBUTIONS WERE MADE BY OSF HEALTHCARE SYSTEM TO THE PLAN: KEVIN D. SCHOEPLIN - \$194,415, BAKER - \$96,937. DURING 2017, DISTRIBUTIONS WERE MADE BY OSF HEALTHCARE SYSTEM FROM THE PLAN: KEVIN D. SCHOEPLIN - \$0, DANIEL E. BAKER - \$1,646,820.

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
EIN: 37-0813229
Name: OSF Healthcare System

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 Robert C Sehring	(i)	822,949	0	26,582	42,919	25,321	917,770	0
Vice Chairperson CEO	(ii)	0	0	0	0	0	0	0
1 Kevin D Schoeplein	(i)	1,198,405	450,000	73,273	237,590	21,193	1,980,461	0
Partial Year - Vice Chairperson CEO	(ii)	0	0	0	0	0	0	0
2 Gerald J McShane MD	(i)	664,489	0	30,841	43,175	21,114	759,619	0
Board Member	(ii)	0	0	0	0	0	0	0
3 Daniel E Baker	(i)	498,211	0	1,655,921	140,112	20,418	2,314,662	43,175
Former CFO	(ii)	0	0	0	0	0	0	0
4 Kenneth J Natzke	(i)	512,459	0	16,074	30,947	16,396	575,876	0
Former CEO East Region	(ii)	0	0	0	0	0	0	0
5 Michael M Allen	(i)	558,835	0	1,589	28,482	25,172	614,079	0
CFO	(ii)	0	0	0	0	0	0	0
6 Anthony M Avellino MD	(i)	899,441	75,140	2,180	35,225	25,311	1,037,297	0
Partial Year - CEO NSSL/INI	(ii)	0	0	0	0	0	0	0
7 Kenneth E Berkovitz MD	(i)	718,287	0	3,768	23,363	18,649	764,067	0
Partial Year - CEO CVSL	(ii)	0	0	0	0	0	0	0
8 Chad E Boore	(i)	309,513	0	7,757	13,033	26,354	356,657	0
Chief Executive Officer Eastern Region	(ii)	0	0	0	0	0	0	0
9 Robert L Brandfass	(i)	509,534	0	9,887	39,200	24,840	583,462	0
SVP Chief Legal Officer	(ii)	0	0	0	0	0	0	0
10 Michelle D Conger	(i)	439,698	0	10,176	15,005	23,954	488,833	0
Chief Strategy Officer	(ii)	0	0	0	0	0	0	0
11 Roxanna Crosser	(i)	293,017	0	21,775	33,224	7,681	355,697	0
Chief Executive Officer Western Region	(ii)	0	0	0	0	0	0	0
12 Michael A Cruz MD	(i)	594,265	0	3,137	43,175	24,055	664,633	0
Chief Executive Officer Central Region	(ii)	0	0	0	0	0	0	0
13 John R Evancho	(i)	247,450	0	8,559	19,252	26,332	301,592	0
SVP Chief Compliance Officer	(ii)	0	0	0	0	0	0	0
14 Thomas G Hammerton	(i)	323,860	0	38,708	28,211	18,270	409,049	0
President OSF Healthcare Foundation Chief Development Officer	(ii)	0	0	0	0	0	0	0
15 Stephen E Hippler MD	(i)	525,836	0	15,802	43,175	24,008	608,820	0
Chief Clinical Officer	(ii)	0	0	0	0	0	0	0
16 John C Horne	(i)	336,961	0	8,181	27,779	23,888	396,808	0
SVP Chief Supply Chain Officer	(ii)	0	0	0	0	0	0	0
17 Divya-Devi Joshi	(i)	496,427	0	935	17,225	8,984	523,571	0
CEO Children SL	(ii)	0	0	0	0	0	0	0
18 James J Mormann	(i)	535,916	0	8,673	35,225	25,045	604,859	0
Chief Information Officer	(ii)	0	0	0	0	0	0	0
19 David A Schertz	(i)	567,927	0	11,767	25,175	18,551	623,420	0
Partial Year - CEO Northern Region	(ii)	0	0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees								
(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21 Dwight D Stapleton	(i)	400,865	0	114	13,250	14,273	428,502	0
Vice President Clinical Specialty Services	(ii)	0	0	0	0	0	0	0
1 Jeffrey M Tillery	(i)	500,220	0	13,182	42,797	18,509	574,708	0
SVP Chief Transformation Officer	(ii)	0	0	0	0	0	0	0
2 Lori L Wiegand	(i)	366,572	0	16,273	43,175	18,421	444,441	0
Chief Nursing Officer	(ii)	0	0	0	0	0	0	0
3 Leon A Yeh MD	(i)	519,663	4,127	47	35,225	24,746	583,809	0
VP CMO Emergency Serv	(ii)	0	0	0	0	0	0	0
4 Iftekhar U Ahmad MD	(i)	716,279	148,015	47	17,225	24,096	905,662	0
Physician	(ii)	0	0	0	0	0	0	0
5 Mete Korkmaz MD	(i)	771,363	68,586	4,779	39,200	25,204	909,132	0
Oncologist	(ii)	0	0	0	0	0	0	0
6 James L McGee MD	(i)	892,869	50,000	187	36,848	20,719	1,000,623	0
Physician	(ii)	0	0	0	0	0	0	0
7 Ekanka Mukhopadhyay MD	(i)	397,392	194,466	46	33,238	25,204	650,346	0
Physician	(ii)	0	0	0	0	0	0	0
8 Anthony C Zalduendo MD	(i)	638,451	25,000	87	43,175	22,096	728,809	0
Physician	(ii)	0	0	0	0	0	0	0

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds
 ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
 ▶ Attach to Form 990.
 ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2017
 Open to Public Inspection

Department of the Treasury
 Internal Revenue Service
 Name of the organization
 OSF Healthcare System

Employer identification number
 37-0813229

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 ILLINOIS FINANCE AUTHORITY	86-1091967	45203HVM1	08-29-2007	461,801,780	SEE PART VI	X			X		X
B ILLINOIS FINANCE AUTHORITY	86-1091967	45200FWG0	03-31-2009	249,074,230	SEE PART VI	X			X		X
C ILLINOIS FINANCE AUTHORITY	86-1091967	45200F3R8	06-29-2010	158,535,888	SEE PART VI	X			X		X
D ILLINOIS FINANCE AUTHORITY	86-1091967	45203HLH3	09-26-2012	191,360,304	SEE PART VI		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	335,000,000		41,825,000		30,775,000		10,645,000	
2 Amount of bonds legally defeased	0		83,165,000		100,710,000		0	
3 Total proceeds of issue	485,781,136		254,007,670		160,224,909		191,360,308	
4 Gross proceeds in reserve funds	0		0		0		0	
5 Capitalized interest from proceeds	17,375,881		24,929		0		0	
6 Proceeds in refunding escrows	0		0		0		0	
7 Issuance costs from proceeds	3,322,101		3,114,441		2,080,352		2,402,590	
8 Credit enhancement from proceeds	8,846,375		126,677		0		0	
9 Working capital expenditures from proceeds	0		0		0		0	
10 Capital expenditures from proceeds	289,191,716		4,908,239		42,207,813		15,813,583	
11 Other spent proceeds	167,045,063		245,833,384		115,936,744		173,144,135	
12 Other unspent proceeds	0		0		0		0	
13 Year of substantial completion	2010		2010		2010		2012	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X		X		X		X	
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		X
b Exception to rebate?		X		X		X		X
c No rebate due?	X		X		X		X	
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?	X		X			X		X
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X			X		X
b Name of provider	MERRILL LYNCH		MERRILL LYNCH					
c Term of hedge	3000 %		1000 %					
d Was the hedge superintegrated?		X		X				
e Was the hedge terminated?		X		X				

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL A	ILLINOIS FINANCE AUTHORITY - 08/29/2007 CUSIP# 452000B8E1, 45203HVM1, 45203HVN9 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2007 BONDS WHICH INCLUDED FIXED RATE BONDS, AUCTION BONDS AND VARIABLE RATE BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS TO redeem IHFA Variable Rate Demand Revenue Bonds, Series 2002 outstanding in the aggregate amount of \$73,975,000, to repay System-wide bonds \$27,984,100 in principal amount of loans, and to repay System-wide bonds approximately \$53,450,000 outstanding on draws on lines of credit, of which the proceeds of which were used to pay the costs of constructing and equipping certain facilities of the Corporation

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL B	ILLINOIS FINANCE AUTHORITY - 03/31/2009 CUSIP #45200FWG0, 45200FWE5, 45200FWF2 THE CORPORATION USED THE PROCEEDS OF THE SYSTEM-WIDE BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, TO refinance and redeem the IFA Revenue Refunding Bonds, Series 2005A in the amount of \$52,825,000, the IFA Revenue Refunding Bonds Series 2005B in the amount of \$52,550,000, the IFA Revenue Bonds, Series 2007B in the amount of \$40,000,000, the IFA Revenue Bonds, Series 2007C in the amount of \$65,000,000 and \$44,950,000 of the IFA Revenue Bonds, Series 2007D

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL C	ILLINOIS FINANCE AUTHORITY - 06/29/2010 CUSIP# 45200F3R8 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2010A BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, TO (I) REFINANCE AND REDEEM , THE ILLINOIS HEALTH FACILITY AUTHORITY VARIABLE DEMAND REVENUE BONDS, SERIES 1985B (REVOLVING FUND POOLED FINANCING PROGRAM) IN THE AMOUNT OF \$75,000,000, ILLINOIS FINANCE AUTHORITY VARIABLE RATE REVENUE BONDS, SERIES 2001 IN THE AMOUNT OF \$46,050,000, AND THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2007D IN THE AMOUNT OF \$20,050,000, (II) REIMBURSE THE CORPORATION FOR A PORTION OF THE COST OF CONSTRUCTING AND EQUIPPING THE DATA CENTER, A KEY ELEMENT IN THE IMPLEMENTATION OF THE CORPORATION'S INFORMATION MANAGEMENT STRATEGIC PLAN THAT PLAN INCLUDES, IN ADDITION TO THE DATA CENTER, REPLACEMENT OF EXISTING INFORMATION SYSTEMS WITH NEWER SYSTEMS PROVIDING FULL ELECTRONIC MEDICAL RECORD AND INTEGRATED BILLING FUNCTIONS FOR BOTH HOSPITAL AND AMBULATORY SERVICES, (III) FUND A DEBT SERVICE RESERVE FUND FOR THE SERIES 2010A BONDS, AND PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SERIES 2010A BONDS AND THE REFINANCING OF THE SERIES 1985B BONDS, THE SERIES 2001 BONDS AND THE SERIES 2007D BONDS

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL D	ILLINOIS FINANCE AUTHORITY - 09/26/2012 CUSIP #45203HLH3, 45203HLG5 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2012 BONDS TO (1) PAY OR REIMBURSE THE CORPORATION OR OTTAWA REGIONAL HOSPITAL & HEALTHCARE CENTER FOR THE COSTS OF ACQUIRING, CONSTRUCTING, RENOVATING, REMODELING AND EQUIPPING HEALTHCARE FACILITIES, (II) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2004, (III) CURRENT REFUND A PORTION OF THE ILLINOIS FINANCE AUTHORITY INSURED VARIABLE RATE DEMAND REVENUE BONDS, SERIES 2007F, (IV) CURRENTLY REFUND ALL OF THE ILLINOIS AUTHORITY VARIABLE RATE DEMAND REVENUE BONDS, SERIES 2007G, (V) ADVANCE REFUND A PORTION OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009A, (VI) CURRENTLY REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009F, (VII) REFINANCE THE PNC BANK LOAN, AND (VIII) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE BONDS AND THE REFUNDING OF THE PRIOR BONDS AND PNC BANK LOAN

Return Reference	Explanation
<p>Schedule K, Part I, Column (f) SCH K, PART I, COL E</p>	<p>ILLINOIS FINANCE AUTHORITY - 09/29/2015 CUSIP# 4520H5F5 THE CORPORATION USED THE PROCEEDS OF THE SERIES 2015A BONDS, TOGETHER WITH CERTAIN OTHER AVAILABLE FUNDS, (I) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2007A (OSF HEALTHCARE SYSTEM OUTSTANDING), (II) ADVANCE REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009A OUTSTANDING, (III) CURRENTLY REFUND ALL OF THE ILLINOIS FINANCE AUTHORITY REVENUE BONDS, SERIES 2009E CURRENTLY OUTSTANDING, (IV) PAY OR REIMBURSE THE CORPORATION FOR THE COST OF ACQUIRING, CONSTRUCTION, RENOVATION, REMODELING AND EQUIPPING, CONSTRUCTION OF AN APPROXIMATELY 150,000 SQUARE-FOOT, FOUR STORY PAVILION (THE "ROCKFORD BED PAVILION") AND THE RENOVATION AND EXPANSION OF THE COMPREHENSIVE CANCER CENTER, EACH AT OSF SAINT ANTHONY MEDICAL CENTER IN ROCKFORD, ILLINOIS THE RENOVATION OF THE FORMER NEONATAL INTENSIVE CARE UNIT AND THE OUTPATIENT NEUROSCIENCES CENTER, EACH PROJECT TO BECOME PRIVATE INPATIENT ROOMS AT OSF SAINT FRANCIS MEDICAL CENTER IN PEORIA, ILLINOIS THE CONSTRUCTION OF A NEW PEDIATRIC OPERATION ROOM SUITE AT OSF SAINT FRANCIS MEDICAL CENTER AND THE CONSTRUCTION OF SURGICAL SUITES AT OSF ST JOSEPH MEDICAL CENTER IN BLOOMINGTON, ILLINOIS, (V) PAY CERTAIN CAPITALIZED INTEREST ON THE SERIES 2015A BONDS DURING CONSTRUCTION, (VI) PAY CERTAIN SWAP TERMINATION COSTS RELATED TO THE SERIES 2015A BONDS, AND (VII) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SERIES 2015A BONDS AND THE REFINANCE OF THE PRIOR BONDS AND THE PRIOR DEBT</p>

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL F	ILLINOIS FINANCE AUTHORITY - 09/29/2016 CUSIP # 45204EMD7 THE CORPORATION WILL USE THE PROCEEDS OF THE SERIES 2016 BONDS TO (I) ADVANCE REFUND THE REFUNDED BONDS, AS HEREINAFTER DEFINED, (II) PAY THE COSTS OF TERMINATING AN INTEREST RATE AGREEMENT RELATED TO THE SERIES 2016 BONDS, AND (III) PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE ISSUANCE OF THE SERIES 2016 BONDS AND THE REFUNDING OF THE 2010A REFUNDED BONDS

Return Reference	Explanation
Schedule K, Part II 2007 Bond Re-Issuance	In 2009 , \$76,211,426 94 was transferred from the 2007 bond issue to to the 2009A-D bond issue in a refinancing for funded interest, debt service reserve and project funds All such proceeds were reflected as being expended in the 2007 BCD issue at the original amount In 2010 , \$1,798,674 21 was transferred from the 2007 bond issue to to the 2010A bond issue in a refinancing for, debt service reserve funds All such proceeds were reflected as being expended in the2007 BCD issue at the original amount Earnings on funds transferred from the 2007 bond issue to the 2009 and 2010 bond issues are reflected as total proceeds in the 2009 and 2010 bond issues, respectively, from date of transfer, as well as expended in those respective issues

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2007 Issue	Original issue price was \$461,801,780 Investment earnings were \$23,979,356 for total proceeds reported of \$485,781,136

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2009A-D	Original issue price was \$249,074,230 Investment earnings were \$4,933,440 for total proceeds reported of \$254,007,670

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2010	Original issue price was \$158,535,888 Investment earnings were \$1,689,021 for total proceeds reported of \$160,224,909

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2012	Original issue price was \$191,360,304 Investment earnings were \$4 for total proceeds reported of \$191,360,308

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2015	Original issue price was \$392,744,128 Investment earnings were \$1,899,469 for total proceeds reported of \$394,643,597

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2016	Original issue price was \$121,790,760 Investment earnings were \$33 for total proceeds reported of \$121,790,793

Return Reference	Explanation
Schedule K, Part II, Line 3 Proceeds differing from issue - 2017ABC	Original issue price was \$235,000,000 investment earnings were \$421,266 for total proceeds reported of \$235,421,266

Return Reference	Explanation
Schedule K, Part I, Column (f) SCH K, PART I, COL G	ILLINOIS FINANCE AUTHORITY - 12/20/2017 No CUSIP# - Private Placement The Corporation and the Authority are entering into this Loan Agreement in order to , among other things, obtain moneys which will be used to, together with certain other moneys to (i) pay or reimburse the Corporation or Ottawa Regional Hospital and Healthcare Center (the "User") for the costs of acquiring, construction, remodeling, renovating and equipping certain health care facilities owned by the Corporation or the User, (ii) pay for the purchase by the Corporation of certain assets, including hospital buildings, of Presence Covenant Medical Center in Urbana, Illinois and Presence United Samaritans Medical Center in Danville, Illinois (the "Presence Hospitals"), (iii) refinance certain indebtedness the proceeds of which were used to construct and equip the hospital facilities of Mendota Community Hospital (the "HUD Loan"), (iv) refund the Authority's Revenue Bond, Series 2009G (OSF Healthcare System), and (v) pay certain expenses incurred in connection with the issuance of the Series 2017A Bonds, all as permitted under the Act (collectively, the "Financing Purposes")

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN A	Issuer name ILLINOIS FINANCE AUTHORITY The calculation for computing no rebate due was performed on 08/03/2016

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN B	Issuer name ILLINOIS FINANCE AUTHORITY The calculation for computing no rebate due was performed on 05/30/2014

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN C	Issuer name ILLINOIS FINANCE AUTHORITY The calculation for computing no rebate due was performed on 07/09/2015

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN D	Issuer name ILLINOIS FINANCE AUTHORITY The calculation for computing no rebate due was performed on 03/15/2017

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds

OMB No 1545-0047

2017

Open to Public Inspection

Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI. Attach to Form 990. Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury Internal Revenue Service Name of the organization OSF Healthcare System

Employer identification number 37-0813229

Part I Bond Issues

Table with columns (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. Rows A, B, C.

Part II Proceeds

Table with columns 1-13 and sub-columns A, B, C, D. Rows 1-13 and 14-17.

Part III Private Business Use

Table with columns 1-2 and sub-columns A, B, C, D. Rows 1, 2.

Part III Private Business Use (Continued)

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

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Schedule L
(Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

▶ **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.**
 ▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization OSF Healthcare System	Employer identification number 37-0813229
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Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 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 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
(1) Jennifer Uphoff	Family Member - Jeffery M Tillery - Officer	93,632	Employment		No
(2) Matthew Sehring	Family Member - Robert Sehring - Officer	87,356	Employment		No
(3) Ryan Sehring	Family Member - Robert Sehring - Officer	69,864	Employment		No
(4) David McGrew	Family Member - Sister Diane Marie McGrew, O S F - Board Member	153,437	Employment		No
(5) Jennifer Stoller	Family Member - Lori L Wiegand - Officer	32,957	Employment		No

Part V Supplemental Information

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

Return Reference	Explanation

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No 1545-0047

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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
OSF Healthcare System

Employer identification number

37-0813229

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part I, Line 1 PART I	THE TAX LAW REQUIRES THAT EACH LEGAL ENTITY WITHIN THE OSF HEALTHCARE SYSTEM COMPLETE A SEPARATE TAX RETURN WHICH APPROPRIATELY REFLECTS THE ACTIVITIES AND FINANCIAL POSITION OF THE PARTICULAR ORGANIZATION THIS REPORTING, HOWEVER, IS NOT REFLECTIVE OF THE OSF HEALTHCARE SYSTEM AS A WHOLE PLEASE SEE THE ATTACHED AUDITED FINANCIAL STATEMENTS OF OSF HEALTHCARE SYSTEM AND SUBSIDIARIES FOR A COMPLETE OVERVIEW OF THE SYSTEM

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part III, Line 1 PART III, LINE 1, CONTINUED	OSF HEALTHCARE SYSTEM WILL PROVIDE COMPREHENSIVE, INTEGRATED, QUALITY CARE, INCLUDING PREVENTIVE, PRIMARY, ACUTE, CONTINUOUS AND REHABILITATIVE HEALTH SERVICES IN THOSE AREAS IN WHICH WE ARE NOW SERVING AND MAY SERVE IN THE FUTURE SPECIAL EMPHASIS WILL BE PLACED ON MEETING THE PHYSICAL, SPIRITUAL, EMOTIONAL, AND SOCIAL NEEDS OF EVERYONE WHO IS CARED FOR IN THE SYSTEM THE VISION WILL BE ACCOMPLISHED BY PROVIDING HIGH QUALITY AND ACCESSIBLE COMPREHENSIVE SERVICES IN AN INTEGRATED SYSTEM SERVICES WILL BE PROVIDED TO PERSONS OF ALL AGES AND SOCIAL STRATA WITH A CONCERN FOR THE DISADVANTAGED AND THE POOR OF BODY AND SPIRIT THE PHILOSOPHY AND VALUES OF THE SISTERS OF THE THIRD ORDER OF ST FRANCIS AND THE ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES WILL BE THE NORM FOR ALL SERVICES THE SYSTEM LEADERSHIP WILL NETWORK CLOSELY WITH EACH OTHER IN THEIR OWN AREA AND THROUGHOUT THE SYSTEM THEY WILL ALSO NETWORK WITH OTHER PROVIDERS WHO HAVE SIMILAR VALUES AND COMPLEMENTARY SERVICES INHERENT IN THIS DIRECTION FOR THE FUTURE IS AN EMPHASIS ON PROVIDING A CONTINUUM OF HEALTH CARE SERVICES WHILE MEETING THE SPECIFIC NEEDS OF PEOPLE SERVED HOSPITAL BASED AND FREE-STANDING PROGRAMS AND SERVICES TO MEET COMMUNITY NEEDS A COLLABORATIVE RELATIONSHIP BETWEEN THE CONGREGATION AND THE LAITY NETWORKING AMONG THE SISTERS OF THE THIRD ORDER OF ST FRANCIS MINISTRIES AND WITH OTHER PROVIDERS AND PURCHASERS A MARKET DRIVE RESPONSE TO PEOPLE'S NEEDS

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part III, Line 4d Description of other program services	(Expenses \$ 270,745,377 including grants of \$ 3,409,838)(Revenue \$ 144,386,161) Other program services beyond outpatient, inpatient and emergency department services include Home Health Services - Five Agencies located in Illinois and Michigan Hospice Services - Four programs located in Illinois and Michigan Residency Programs - OSF Healthcare System is a ffiliated with the University of Illinois and provides support for teaching of residents a nd fellowship programs College of Nursing Programs - Two of the corporations hospitals op erate accredited colleges of nursing that offer accredited baccalaureate, masters and doct oral degrees Trauma Services (Level 1) - Two hospitals in the system are designated as Le vel I Trauma (Highest Level) trauma centers and two have been designated as level II Traum a Centers EMS Flight and Ground Transportation services - The corporation provides helico pter and ground transports to patients in Northern and Central Illinois Community Clinic, Outreach and other educational programs - The corporation offers two uninsured and under insured community clinics in Bloomington and Peoria Outreach programs - The corporation p rovides outreach programs to the community with parish nursing, perinatal outreach, and a community training center All of these programs reach at risk populations to help them wi th specific and everyday healthcare needs Education - The corporation provides paramedic education, EMT education, medical tech education, radiology tech education and dietetic ed ucation programs

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 1a Delegate broad authority to a committee	BY ADOPTING CERTAIN PROVISIONS OF THE CORPORATE BYLAWS, THE BOARD OF DIRECTORS HAS DELEGATED BOARD AUTHORITY TO THE EXECUTIVE COMMITTEE OF THE BOARD THE BYLAWS PROVIDE THAT THE EXECUTIVE COMMITTEE SHALL BE AUTHORIZED TO TAKE SUCH ACTION AS MAY BE NECESSARY ON BEHALF OF THE CORPORATION DURING PERIODS WHEN THE BOARD OF DIRECTORS IS NOT IN SESSION

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 6 Classes of members or stockholders	OSF HEALTHCARE SYSTEM HAS NO CORPORATE STOCK OR STOCKHOLDERS ITS SOLE MEMBER IS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS, AN ILLINOIS NOT FOR PROFIT CORPORATION, WHICH IS CONTROLLED BY MEMBERS OF A RELIGIOUS CONGREGATION OF THE CATHOLIC CHURCH ALSO KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7a Members or stockholders electing members of governing body	THE GOVERNING BOARD OF THE SISTERS OF THE THIRD ORDER OF ST FRANCIS, AN ILLINOIS NOT FOR PROFIT CORPORATION AND THE SOLE MEMBER OF OSF HEALTHCARE SYSTEM, HOLDS RESERVED POWERS TO ELECT AND REMOVE ALL OF THE MEMBERS OF THE BOARD OF DIRECTORS OF OSF HEALTHCARE SYSTEM

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders	AS GOVERNED BY CANONICAL AND CIVIL GUIDELINES PERTAINING TO ROMAN CATHOLIC CHURCH PROPERTIES AND AS PROVIDED IN THE BYLAWS, CERTAIN TRANSACTIONS OF OSF HEALTHCARE SYSTEM MAY BE AUTHORIZED ONLY BY VOTE OF THE GOVERNING BOARD OF THE SISTERS OF THE THIRD ORDER OF ST FRANCIS, WHICH VOTE IS TO BE TAKEN ONLY AFTER CONSIDERING THE ADVICE OF THE BOARD OF DIRECTORS OF OSF HEALTHCARE SYSTEM THESE TRANSACTIONS ARE AS FOLLOWS - TO ESTABLISH THE PHILOSOPHY AND MISSION ACCORDING TO WHICH THE CORPORATION OPERATES - TO AMEND THE CORPORATION'S ARTICLES OF INCORPORATION AND BYLAWS - TO ELECT AND REMOVE WITH OR WITHOUT CAUSE THE DIRECTORS OF THE CORPORATION - TO MERGE OR DISSOLVE THE CORPORATION - TO LEASE, SELL, ENCUMBER OR OTHERWISE ALIENATE REAL PROPERTY OF THE CORPORATION - TO APPROVE ANY TRANSFER, LEASE, SALE OR ENCUMBRANCE OF PERSONAL PROPERTY OF THE CORPORATION EXCEPT IN THE ORDINARY COURSE OF BUSINESS - TO APPROVE ANY BORROWING OR DEBT FINANCING IN EXCESS OF A SPECIFIED LIMIT (CURRENTLY \$1,000,000) ESTABLISHED BY RESOLUTION OF THE MEMBER - TO APPOINT (OR APPROVE THE APPOINTMENT OF) OR REMOVE THE CORPORATION'S CHAIRPERSON, CHIEF EXECUTIVE OFFICER, PRESIDENT, REGIONAL PRESIDENT/CHIEF EXECUTIVE OFFICERS, AND THE LOCAL PRESIDENT/CHIEF EXECUTIVE OFFICER OF EACH HEALTH CARE FACILITY AND OPERATING DIVISION OWNED, OPERATED OR CONTROLLED BY THE CORPORATION - TO APPROVE STRATEGIC PLANS, MANAGEMENT OBJECTIVES AND CAPITAL AND OPERATING BUDGETS OF THE CORPORATION - TO APPROVE ANY PURCHASE OR OTHER ACQUISITION IN EXCESS OF A SPECIFIED LIMIT (CURRENTLY \$1,000,000) ESTABLISHED BY RESOLUTION OF THE MEMBER - TO REQUIRE A CERTIFIED AUDIT OF THE CORPORATION'S FINANCES AND TO APPOINT THE CERTIFIED PUBLIC ACCOUNTANT TO PERFORM THE AUDIT - TO APPROVE THE ENGAGEMENT OF ANY OUTSIDE LEGAL COUNSEL TO REPRESENT THE CORPORATION ON A REGULAR BASIS AND THE DISMISSAL OF ANY CURRENT LEGAL COUNSEL REPRESENTING THE CORPORATION ON A REGULAR BASIS - TO GIVE PRELIMINARY APPROVAL PRIOR TO THE DEVELOPMENT OF, AND TO GIVE FINAL APPROVAL PRIOR TO THE EXECUTION OF, ALL DOCUMENTS TO WHICH THE CORPORATION IS OR WILL BE A PARTY AND WHICH RELATE TO THE CREATION, FORMATION, ORGANIZATION, OR TERMINATION OF ANY OTHER LEGAL ENTITY (WHETHER A CORPORATION, LIMITED LIABILITY COMPANY, PARTNERSHIP, OR ANY OTHER ENTITY) IN WHICH THE CORPORATION WILL HAVE ANY OWNERSHIP INTEREST, MEMBERSHIP INTEREST, POWER TO ELECT OR APPOINT BOARD MEMBERS OR OFFICERS, OR ANY OTHER FORMAL PARTICIPATION ARRANGEMENT, WHETHER ACTING ALONE OR IN CONJUNCTION WITH ANY OTHER PERSON OR ENTITY

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 9 Interested person not at organization's address	BRIAN SILVERSTEIN, M D 711 APPLE TREE LANE GLENCOE, IL 60022

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 11b Review of form 990 by governing body	THE INITIAL DRAFT FORM 990 AND ALL REQUIRED SCHEDULES ARE PREPARED USING A MULTI-DISCIPLINARY PROCESS WHICH INCLUDES CORPORATE FINANCE AND ACCOUNTING, CORPORATE LEGAL, CORPORATE COMPLIANCE, AND CORPORATE MARKETING AND COMMUNICATIONS PERSONNEL WHO FOCUS INITIALLY ON SPECIFIC PORTIONS OF THE RETURN THE COMPLETED DRAFT FORM 990 AND ALL SCHEDULES ARE THEN REVIEWED BY THIS SAME MULTI-DISCIPLINARY TEAM TO ENSURE ACCURACY AND INTEGRATION OF THE INDIVIDUAL PARTS AND SCHEDULES IN ADDITION, THE INFORMATION AND SCHEDULES OF THE RETURN ARE SENT TO THE CORPORATION'S TAX CONSULTANTS, CROWE LLP, FOR REVIEW AND COMMENT CROWE LLP REVIEWS THE INFORMATION/SCHEDULES AND THEN PREPARES AND SIGNS THE FINAL RETURN COMMENTS FROM THE MULTI-DISCIPLINARY TEAM AND FROM THE AUDITORS ARE INCORPORATED INTO A PROPOSED FINAL VERSION OF FORM 990 AND ALL SCHEDULES THIS PROPOSED FINAL VERSION IS THEN SENT VIA E-MAIL TO ALL OFFICERS AND MEMBERS OF THE BOARD OF DIRECTORS FOR THEIR REVIEW PRIOR TO FILING ANY APPROPRIATE CHANGES REQUESTED BY THE OFFICERS AND DIRECTORS ARE THEN INCORPORATED INTO THE FINAL FORM 990 AND ALL SCHEDULES FOR FILING

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 12c Conflict of interest policy	DISCLOSURES BY OFFICERS, DIRECTORS AND TRUSTEES, AS WELL AS KEY EMPLOYEES AND EMPLOYEES CHARGED WITH PURCHASING, PROCUREMENT AND CONTRACTING DECISION-MAKING ARE MADE THROUGH AN ELECTRONIC REPORTING SYSTEM ON AN ANNUAL BASIS DISCLOSURES ARE RECEIVED AND REVIEWED BY THE CORPORATE COMPLIANCE DIVISION IF A POTENTIAL CONFLICT OF INTEREST IS IDENTIFIED, THEN THE DISCLOSING INDIVIDUAL IS NOTIFIED OF THE POTENTIAL CONFLICT AND MAY BE ASKED FOR ADDITIONAL INFORMATION ABOUT THE INTEREST THE CORPORATE COMPLIANCE DIVISION DETERMINES WHETHER A PLAN TO MANAGE A POSSIBLE OR ACTUAL CONFLICT OF INTEREST IS NEEDED, DISCUSSES THE MANAGEMENT PLAN WITH THE INDIVIDUAL AND MONITORS THE EMPLOYEE'S COMPLIANCE WITH THE PLAN PLANS TO MANAGE CONFLICTS ARE TRACKED THROUGH THE ELECTRONIC DISCLOSURE SYSTEM

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Process to establish compensation of top management official	THE BOARD OF DIRECTORS HAS ESTABLISHED A BOARD COMMITTEE KNOWN AS THE HUMAN RESOURCES COMMITTEE WHOSE MEMBERS ARE ALL PROFESSED MEMBERS OF THE RELIGIOUS CONGREGATION KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS WHO HAVE TAKEN A VOW OF POVERTY HENCE, THEY DO NOT PERSONALLY BENEFIT FROM DECISIONS OF THE COMMITTEE THE CHIEF EXECUTIVE OFFICER (CEO) IS NOT A MEMBER OF THE COMMITTEE THE PERFORMANCE OF THE CEO AND HIS ACHIEVEMENT OF ANNUAL GOALS IS EVALUATED EACH YEAR BY THE FULL BOARD OF DIRECTORS, AND THIS PERFORMANCE REVIEW IS PROVIDED TO THE COMMITTEE THE COMMITTEE ALSO OBTAINS COMPENSATION SURVEY DATA AND RECOMMENDATIONS FROM A NATIONALLY RECOGNIZED INDEPENDENT COMPENSATION CONSULTANT BASED ON ALL OF THESE FACTORS, THE COMMITTEE SETS THE BASE SALARY AND BENEFITS OF THE CEO AND APPROVES THE EXECUTIVE COMPENSATION PLAN APPLICABLE TO THE CEO PRIOR TO PAYMENT OF ANY BONUS OR INCENTIVE COMPENSATION, THE TOTAL COMPENSATION FOR THE CEO, INCLUDING BASE SALARY, BENEFITS, AND PROPOSED BONUS OR INCENTIVE COMPENSATION, IS AGAIN REVIEWED BY A NATIONALLY RECOGNIZED COMPENSATION CONSULTANT TO ENSURE THAT NO EXCESS BENEFIT AMOUNT IS PAID OR FURNISHED THE COMPENSATION REVIEW IS DONE ANNUALLY IN NOVEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b Process to establish compensation of other employees	THE BOARD OF DIRECTORS HAS ESTABLISHED A BOARD COMMITTEE KNOWN AS THE HUMAN RESOURCES COMMITTEE WHOSE MEMBERS ARE ALL PROFESSED MEMBERS OF THE RELIGIOUS CONGREGATION KNOWN AS THE SISTERS OF THE THIRD ORDER OF ST FRANCIS WHO HAVE TAKEN A VOW OF POVERTY HENCE, THEY DO NOT PERSONALLY BENEFIT FROM DECISIONS OF THE COMMITTEE THE COMMITTEE DETERMINES WHICH OFFICERS, KEY EMPLOYEES AND OTHER EMPLOYEES ARE ELIGIBLE TO PARTICIPATE IN THE EXECUTIVE COMPENSATION PLAN BASED ON PERFORMANCE REVIEWS BY THE SUPERVISORS OF SUCH PERSONS AND COMPENSATION SURVEY DATA AND RECOMMENDATIONS FROM A NATIONALLY KNOWN INDEPENDENT COMPENSATION CONSULTANT, THE COMMITTEE APPROVES ANY EXECUTIVE COMPENSATION PLAN APPLICABLE TO KEY EMPLOYEES AND ESTABLISHES THE BASE SALARY AND BENEFITS FOR PLAN PARTICIPANTS PRIOR TO PAYMENT OF ANY BONUS OR INCENTIVE COMPENSATION, THE TOTAL COMPENSATION FOR EACH KEY EMPLOYEE, INCLUDING BASE SALARY, BENEFITS, AND PROPOSED BONUS OR INCENTIVE COMPENSATION, IS AGAIN REVIEWED BY A NATIONALLY RECOGNIZED COMPENSATION CONSULTANT TO ENSURE THAT NO "EXCESS BENEFIT" AMOUNT IS PAID OR FURNISHED SOME KEY EMPLOYEES LISTED IN PART VII ARE PRACTICING PHYSICIANS WHO ARE LISTED AS KEY EMPLOYEES AS A RESULT OF THE COMPENSATION THEY RECEIVE AND NOT DUE TO ANY EXECUTIVE OR MANAGEMENT POSITION WHICH THEY HOLD SUCH PHYSICIANS GENERALLY ARE NOT PARTICIPANTS IN THE EXECUTIVE COMPENSATION PLAN, AND THEIR COMPENSATION, INCLUDING BASE SALARY, BENEFITS, AND ANY APPLICABLE BONUS OR INCENTIVE COMPENSATION, IS ESTABLISHED IN ACCORDANCE WITH NATIONALLY RECOGNIZED PHYSICIAN COMPENSATION SURVEYS AND IS SET FORTH IN WRITTEN EMPLOYMENT AGREEMENTS WHICH ARE APPROVED BY THE BOARD OF DIRECTORS OR ITS EXECUTIVE COMMITTEE THE COMPENSATION REVIEW IS DONE ANNUALLY IN NOVEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 19 Required documents available to the public	OSF HEALTHCARE SYSTEM MAKES ITS FORM 990, ITS FORM 990-T, AND DOCUMENTATION OF ITS EXEMPT STATUS UNDER SECTION 501(C)(3) OF THE CODE AVAILABLE FOR PUBLIC INSPECTION AND COPYING UPON REQUEST IN ACCORDANCE WITH SECTION 6104 OF THE INTERNAL REVENUE CODE NAMES AND ADDRESSES OF CONTRIBUTORS ARE NOT DISCLOSED REQUESTS MAY BE MADE IN PERSON, IN WRITING, OR BY TELEPHONE REQUESTS MADE IN PERSON ARE ACCEPTED AT THE CORPORATE OFFICE AND AT EACH HOSPITAL FACILITY OF THE CORPORATION REQUESTS MADE IN WRITING OR BY TELEPHONE TO ANY FACILITY OR LOCATION OF THE CORPORATION ARE FORWARDED TO THE CORPORATE FINANCE AND ACCOUNTING DIVISION, WHICH THEN PROVIDES COPIES OF THE REQUESTED DOCUMENTS IN THE OSF HEALTHCARE SYSTEM 37-081 3229 MANNER REQUESTED (IF SUCH DELIVERY METHOD IS AVAILABLE TO THE CORPORATION) THE CORPORATION MAKES ITS ARTICLES OF INCORPORATION, CORPORATE BYLAWS, AND CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC UPON REQUEST ALL REQUESTS ARE FORWARDED TO THE CORPORATE LEGAL DIVISION, WHICH THEN PROVIDES COPIES OF THE REQUESTED DOCUMENTS IN THE MANNER REQUESTED (IF SUCH DELIVERY METHOD IS AVAILABLE TO THE CORPORATION) IN ADDITION, THE CORPORATION'S ARTICLES OF INCORPORATION ARE PUBLICLY AVAILABLE FROM THE OFFICE OF THE ILLINOIS SECRETARY OF STATE OR FROM THE RECORDER OF DEEDS IN WOODFORD COUNTY, ILLINOIS, SITE OF THE CORPORATION'S REGISTERED OFFICE FINANCIAL STATEMENTS OF THE CORPORATION ARE PUBLICLY AVAILABLE ON THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) WEBSITE OF THE MUNICIPAL SECURITIES RULEMAKING BOARD (MSRB) AND FROM THE ILLINOIS ATTORNEY GENERAL AS PART OF THE CORPORATION'S COMMUNITY BENEFIT REPORT

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VII, Section A PART VII, SECTION A	REPORTABLE COMPENSATION IN PART VII WAS DETERMINED FROM A REVIEW OF PAYROLL QUERIES FROM THE ORGANIZATION'S AND RELATED ORGANIZATION'S PAYROLL AND GENERAL LEDGER MODULES, YEARLY PAYROLL REPORTS, AND W-2 FILINGS

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VIII, Line 11d Other Miscellaneous Revenue	Other Revenue - Total Revenue 19201801, Related or Exempt Function Revenue 19091525, Unrelated Business Revenue 92401, Revenue Excluded from Tax Under Sections 512, 513, or 514 17875,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9 Other changes in net assets or fund balances	CHANGE IN UNREALIZED MARKET VALUE OF SWAPS - 16187164, NET ASSETS RELEASED FROM RESTRICTION - -11055635, INCREASE IN PERMANENTLY RESTRICTED ASSETS - 20254691, REVERSAL OF MINIMUM PENSION LIABILITY - 96087612, SFI & SUBSIDIARY INCOME - 10248625, MINORITY INTEREST - -8305645, EQUITY TRANSFERS - -194581115, INVESTMENT RETURN - 3929704, NET SETTLEMENT OF DERIVATIVE INSTRUMENT - -5374786, LOSS ON EARLY EXTINGUISHMENT OF DEBT - -33524, ASSETS RELEASED FOR OPERATIONS - 154975, SFI EQUITY TRANSFER - 9500000, CONTRIBUTION OF EXCESS ASSETS OVER LIABILITIES - 1535490,

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2017

**Open to Public
Inspection**

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990.
- ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization
OSF Healthcare System

Employer identification number

37-0813229

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) OSF LIFELINE AMBULANCE LLC 318 ROXBURY ROAD ROCKFORD, IL 61107 20-0080542	AMBULANCE SVS	IL	-1,410,013	1,587,637	OSF
(2) POINTCORE LLC 9600 N FRANCISCAN DR PEORIA, IL 61615 46-5126926	IT SERVICES	IL	385,040	758,282	OSF
(3) SAINT ANTHONY'S LLC 915 EAST 5TH STREET ALTON, IL 62002 37-1407745	LOW INC HOUSING	IL	-391,643	3,741,045	OSF

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	
(1) CENTER FOR HEALTH AMBULATORY 8800 RTE 91 N PEORIA, IL 61615 20-5557171	SURGICAL CENTER	IL	OSF	Related	4,154,625	3,248,618		No			No	71.4 %
(2) EASTLAND MEDICAL PLAZA 1505 EASTLAND DRIVE Bloomington, IL 61701 37-1400643	SURGICAL CENTER	IL	OSF	Related	2,276,533	6,093,195		No			No	50 %
(3) FORT JESSE IMAGING CENTER LLC 2200 FT JESSE ROAD NORMAL, IL 61761 46-0515604	MEDICAL IMAGING	IL	OSF	Related	754,904	10,183		No			No	50.1 %
(4) SAINT CLARE'S VILLA 915 EAST 5TH STREET ALTON, IL 62002 37-1397289	LOW INC HOUSING	IL	OSF	Related	-391,643	3,741,045		No		Yes		100 %
(5) FOX RIVER CANCER CENTER 1211 STARFISH DRIVE OTTAWA, IL 61350 87-0805865	ONCOLOGY	IL	NA	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
(1) OSF SAINT FRANCIS INC 800 NE GLEN OAK AVE PEORIA, IL 61603 36-3484677	HLTHCARE SVCS	IL	OSF	C Corporation	10,248,625	198,245,713	100 %	Yes	
(2) ILLINOIS PATHOLOGIST SERVICES LLC 5666 EAST STATE STREET ROCKFORD, IL 61108 80-0439081	PATHOLOGY SVCS	IL	OSF	C Corporation	-608,618	697,700	100 %	Yes	
(3) LAKEVIEW MEDICAL OFFICE BUILDING 812 N LOGAN AVENUE DANVILLE, IL 61832 37-1100761	CONDOMINIUM ASSOCIATION	IL	OSF	C Corporation	1,033	85,109	66.15 %	Yes	

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

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

	Yes	No
1 During the tax year, did the 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 Yes	
b Gift, grant, or capital contribution to related organization(s)	1b Yes	
c Gift, grant, or capital contribution from related organization(s)	1c Yes	
d Loans or loan guarantees to or for related organization(s)	1d Yes	
e Loans or loan guarantees by related organization(s)	1e	No
f Dividends from related organization(s)	1f	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 Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	No
o Sharing of paid employees with related organization(s)	1o	No
p Reimbursement paid to related organization(s) for expenses	1p Yes	
q Reimbursement paid by related organization(s) for expenses	1q	No
r Other transfer of cash or property to related organization(s)	1r	No
s Other transfer of cash or property from related organization(s)	1s Yes	

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

See Additional Data Table

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

Part VII **Supplemental Information**

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

Additional Data

Software ID: 17005876
Software Version: 2017v2.2
EIN: 37-0813229
Name: OSF Healthcare System

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
800 NE GLEN OAK AVE PEORIA, IL 61603 37-1259286	PARENT/SU ORG	IL	501(c)(3)	Type I	NA		No
800 NE GLEN OAK AVE PEORIA, IL 61603 37-1259284	SUPPORT ORG	IL	501(c)(3)	Type II	NA		No
530 NE GLEN OAK AVE PEORIA, IL 61637 37-0661235	FREE CLINIC	IL	501(c)(3)	7	SIS 3RD OSF		No
1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-2604009	HOSPITAL	IL	501(c)(3)	3	OSF	Yes	
1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-4007569	SUPPORT ORG	IL	501(c)(3)	Type I	ORHHC	Yes	
1100 EAST NORRIS DRIVE OTTAWA, IL 61350 36-3854788	SUPPORT ORG	IL	501(c)(3)	Type I	ORHHC		No
800 NE GLEN OAK AVE PEORIA, IL 61603 38-3852646	HLTHCARE SVCS	IL	501(c)(3)	Type I	OSF	Yes	
800 NE GLEN OAK AVE PEORIA, IL 61603 35-2422385	HLTHCARE SVCS	IL	501(c)(3)	Type I	OSF	Yes	
800 NE GLEN OAK AVE PEORIA, IL 61603 32-0353954	HLTHCARE SVCS	IL	501(c)(3)	Type I	OSF	Yes	
800 NE GLEN OAK AVE PEORIA, IL 61603 36-4709999	HLTHCARE SVCS	IL	501(c)(3)	Type I	OSF	Yes	
1201 E 12TH STREET MENDOTA, IL 61342 36-2167785	HOSPITAL	IL	501(c)(3)	3	OSF	Yes	
PO BOX 340 ALTON, IL 62002 37-1365059	HLTHCARE SVCS	IL	501(c)(3)	10	OSF	Yes	
800 NE GLEN OAK AVE PEORIA, IL 61603 36-4868939	COLLEGE OF NURSING	IL	501(c)(3)	2	OSF	Yes	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
OSF Saint Francis Inc	A	130,418	FMV
Center for Health Ambulatory Surgery Center	A	1,013,698	FMV
Eastland Medical Plaza Surgicenter LLC	A	632,092	FMV
OSF Saint Francis Inc	A	545,743	FMV
Illinois Pathologist Services LLC	B	2,700,000	FMV
OSF Saint Francis Inc	D	6,048,996	FMV
OSF Saint Francis Inc	K	8,057,624	FMV
OSF Saint Francis Inc	L	4,378,369	FMV
Illinois Pathologist Services LLC	L	1,513,688	FMV
Ottawa Regional Hospital and Healthcare Center	L	781,690	FMV
OSF Saint Francis Inc	M	9,947,578	FMV
OSF Saint Francis Inc	P	2,753,225	FMV
Illinois Pathologist Services LLC	P	935,051	FMV
Ottawa Regional Hospital and Healthcare Center	P	4,533,508	FMV
Eastland Medical Plaza Surgicenter LLC	S	2,927,893	FMV
Fort Jesse Imaging Center LLC	S	607,733	FMV
Center for Health Ambulatory Surgery Center LLC	S	4,818,355	FMV
Illinois Pathologist Services LLC	S	1,933,510	FMV
OSF Healthcare Foundation	C	13,736,326	FMV
Fox River Cancer Center LLC	S	509,359	FMV
OSF Saint Francis Inc	S	4,856,984	FMV
Ottawa Regional Hospital and Healthcare Center	S	26,936,576	FMV