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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ Do not enter social security numbers on this form as it may be made public
▶ Information about Form 990 and its instructions is at www.IRS.gov/form990

OMB No 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 01-01-2014 , and ending 12-31-2014

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

C Name of organization
ST JOSEPH REGIONAL HEALTH CENTER

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
2801 FRANCISCAN DRIVE

City or town, state or province, country, and ZIP or foreign postal code
BRYAN, TX 778022544

D Employer identification number
74-1282696

E Telephone number
(979) 776-3777

G Gross receipts $ 374,679,866

F Name and address of principal officer
JAMES SCHUESSLER
2801 FRANCISCAN DRIVE
BRYAN,TX 778022544

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

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

H(c) Group exemption number ▶ 0928

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

J Website: ▶ WWW ST-JOSEPH ORG

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

L Year of formation 1936

M State of legal domicile TX

Part I Summary

1 Briefly describe the organization's mission or most significant activities
IN THE FRANCISCAN TRADITION, OUT OF REVERENCE FOR THE DIGNITY OF EVERY PERSON, OUR MISSION IS TO PROVIDE EXCELLENT HEALTH CARE AND PROMOTE WELLNESS THROUGHOUT THE BRAZOS VALLEY

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

Activities & Governance

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	14
5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)	**5**	3,333
6	Total number of volunteers (estimate if necessary)	**6**	919
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	27,180
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	25,760

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,051,439	8,567,169
9	Program service revenue (Part VIII, line 2g)	319,273,595	343,751,951
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,343,408	4,549,966
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,721,948	5,474,890
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	330,390,390	362,343,976

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	6,325,002	6,784,063
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	126,167,351	137,868,512
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	181,491,752	202,031,033
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	313,984,105	346,683,608
19	Revenue less expenses Subtract line 18 from line 12	16,406,285	15,660,368

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	447,958,336	496,140,489
21	Total liabilities (Part X, line 26)	175,072,850	166,559,280
22	Net assets or fund balances Subtract line 21 from line 20	272,885,486	329,581,209

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

****** | 2015-11-13
Signature of officer | Date

DANIEL GOGGIN CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
JEREMY S HERMAN	JEREMY S HERMAN			P00745789

Firm's name ▶ PLANTE & MORAN PLLC | Firm's EIN ▶ 38-1357951

Firm's address ▶ 1111 SUPERIOR AVENUE SUITE 1250
CLEVELAND, OH 44141 | Phone no (216) 523-1010

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

IN THE FRANCISCAN TRADITION, OUT OF REVERENCE FOR THE DIGNITY OF EVERY PERSON, OUR MISSION IS TO PROVIDE EXCELLENT HEALTH CARE AND PROMOTE WELLNESS THROUGHOUT THE BRAZOS VALLEY

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 $ 17,826,273 including grants of $ 0) (Revenue $ 22,680,091)

TRAUMA AND EMERGENCY CARE SERVICESTHE TRAUMA PROGRAM AT ST JOSEPH REGIONAL HEALTH CENTER (SJRHC) IS A STATE-DESIGNATED LEVEL II TRAUMA CENTER, THE HIGHEST LEVEL TRAUMA CENTER IN THE REGION, AND IS THE ONLY CENTER IN THE REGION STAFFED WITH BOARD CERTIFIED EMERGENCY PHYSICIANS 24 HOURS A DAY ST JOSEPH HAS ON-SITE ST JOSEPH AIR MEDICAL HELICOPTER TRANSPORT SERVICES TO MEET THE NEEDS OF OUR LARGE SERVICE AREA ST JOSEPH IS RECOGNIZED AS THE REGION'S LEADER IN EMERGENCY SERVICES, HAVING RECEIVED THE FIRST DESIGNATION AS AN ACCREDITED CHEST PAIN CENTER AND FIRST AS A PRIMARY STROKE CENTER IN THE REGION SJRHC HAS THREE EMERGENCY CENTERS THAT REGISTERED 74,813 VISITS IN 2014

4b (Code) (Expenses $ 9,560,126 including grants of $ 0) (Revenue $ 12,163,201)

AMBULANCE SERVICES ST JOSEPH EMERGENCY MEDICAL SERVICES OPERATES A FLEET OF AMBULANCES, STAFFED BY EMERGENCY MEDICAL TECHNICIANS AND PARAMEDICS WHO RESPONDED TO 19,176 CALLS IN 2014 ST JOSEPH EMS IS A NETWORK OF AMBULANCE SERVICES THAT INCLUDE THE BRYAN-COLLEGE STATION AREA AS WELL AS BURLESON, GRIMES AND MADISON COUNTIES ALL VEHICLES ARE STAFFED WITH A MINIMUM OF 1 EMT AND 1 PARAMEDIC 6 VEHICLES ARE STAFFED 24 HOURS A DAY 7 DAYS A WEEK THE DEPARTMENT ALSO STAFFS A WHEEL CHAIR VAN THAT OPERATES ON THE WEEKDAYS

4c (Code) (Expenses $ 49,390,443 including grants of $ 0) (Revenue $ 62,838,698)

PHYSICIAN CLINICS ST JOSEPH PHYSICIANS ARE COMMITTED TO PROVIDING EXCELLENT CARE CLOSER TO HOME THIS TEAM OF PROVIDERS ARE DEDICATED TO THEIR PATIENTS AND PRIDE THEMSELVES IN THE CARE AND SERVICES THAT THEY OFFER MANY OF THE ST JOSEPH PHYSICIAN OFFICES HAVE ON-SITE DIAGNOSTIC TESTING FOR PATIENT CONVENIENCE AND PHYSICIANS CAN QUICKLY ACCESS TEST RESULTS WE ALSO OFFER EXPRESS CLINICS SO THAT WHEN YOU GET SICK AFTER HOURS, ON WEEKENDS OR HOLIDAYS, WE HAVE GOT YOU COVERED WE OFFER SAME DAY APPOINTMENTS AND ACCEPT MOST MAJOR INSURANCES THIS COMMITTED GROUP OF MEDICAL PROFESSIONALS INCLUDES FAMILY MEDICINE PHYSICIANS IN LOCATIONS ACROSS THE BRAZOS VALLEY, AS WELL AS PEDIATRIC OFFICES IN BRYAN AND COLLEGE STATION SPECIALISTS INCLUDE OBSTETRICS, ORTHOPEDICS, UROLOGY, NEUROLOGY, PAIN MANAGEMENT, NEUROSURGERY AND EAR, NOSE AND THROAT ST JOSEPH PHSYICIANS RECORDED 244,611 REGISTRATIONS IN 2014

See Additional Data

4d Other program services (Describe in Schedule O)

(Expenses $ 195,852,506 including grants of $ 6,784,063) (Revenue $ 249,180,119)

4e **Total program service expenses** ▶ 272,629,348

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	Yes	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	

Part IV Checklist of Required Schedules *(continued)*

21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	1a	627		
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	3,333		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		2b	Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .		3a	Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .		3b	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a		No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .		5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .		6a		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .		7f		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		8		
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .		9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .		9b		
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O		13a		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .		14b		

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	14		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? .	**3**			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	**4**		Yes	
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .	**5**			No
6	Did the organization have members or stockholders?	**6**		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	**8a**		Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**			No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, address, and telephone number of the person who possesses the organization's books and records

▶DANIEL GOGGIN CFO

2801 FRANCISCAN DRIVE
BRYAN,TX 778022544 (979)776-2553

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

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

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

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

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

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

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

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

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

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

1b	**Sub-Total** . . . . . ▶			
c	**Total from continuation sheets to Part VII, Section A** . . . . ▶			
d	**Total (add lines 1b and 1c)** . . . . . ▶	3,509,279	1,992,387	356,238

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶171

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
COGENT HEALTHCARE OF TX INC PO BOX 645037 CINCINNATI, OH 452645037	PROFESSIONAL / MEDICAL	3,376,384
JAMES M KIRBY & JOSEPH J FEDORCHIK 2700 E 29TH ST BRYAN, TX 77802	PROFESSIONAL / MEDICAL	1,579,801
LEGACY HEALTHCARE SERVICE 3001 SPRING FOREST ROAD RALEIGH, NC 27616	PROFESSIONAL / MEDICAL	1,420,731
CROWE HORWATH LLP PO BOX 71570 CHICAGO, IL 606941570	PROFESSIONAL / MEDICAL	1,338,868
GROUPONE HEALTHSOURCE PO BOX 1627 INDIANAPOLIS, IN 462061627	PROFESSIONAL / MEDICAL	1,217,232

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶84

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	7,375,737			
	e	Government grants (contributions)	1e	1,191,432			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f $					
	h	**Total.** Add lines 1a-1f . . . . . ▶		8,567,169			
Program Service Revenue			Business Code				
	2a	NET PATIENT SERVICES REVENUE	622110	206,933,890	206,933,890		
	b	MEDICARE/MEDICAID	622110	134,554,533	134,554,533		
	c	ELECTRONIC MED RECORDS	622110	2,263,528	2,263,528		
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a–2f . . . . . ▶		343,751,951			
	3	Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		2,641,985			2,641,985
	4	Income from investment of tax-exempt bond proceeds . . ▶		29,539			29,539
	5	Royalties . . . . . ▶		953			953
			(i) Real / (ii) Personal				
	6a	Gross rents	2,284,034				
	b	Less rental expenses	362,483				
	c	Rental income or (loss)	1,921,551				
	d	Net rental income or (loss) . . . . . ▶		1,921,551	1,895,271	26,280	
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	13,699,955 / 151,894				
	b	Less cost or other basis and sales expenses	11,930,324 / 43,083				
	c	Gain or (loss)	1,769,631 / 108,811				
	d	Net gain or (loss) . . . . . ▶		1,878,442			1,878,442
Other Revenue	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	REBATES	900099	1,510,682			1,510,682
	b	CAFETERIA	722210	1,323,926			1,323,926
	c	OTHER RELATED REVENUE	900099	999,722	998,822	900	
	d	All other revenue		-281,944	216,065		-498,009
	e	**Total.** Add lines 11a–11d . . . . . ▶		3,552,386			
	12	**Total revenue.** See Instructions . . . . . ▶		362,343,976	346,862,109	27,180	6,887,518

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	6,784,063	6,784,063		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,223,407		2,223,407	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	103,747,042	85,259,170	18,487,872	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,282,845	5,068,731	1,214,114	
9 Other employee benefits	17,837,026	14,784,318	3,052,708	
10 Payroll taxes	7,778,192	6,203,594	1,574,598	
11 Fees for services (non-employees)				
a Management				
b Legal	5,250		5,250	
c Accounting	191,798		191,798	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	59,198,131	49,172,535	10,025,596	
12 Advertising and promotion	1,226,628	32,794	1,193,834	
13 Office expenses	8,927,512	3,700,339	5,227,173	
14 Information technology	7,805,226	4,888,668	2,916,558	
15 Royalties				
16 Occupancy	8,323,172	4,488,046	3,835,126	
17 Travel	382,097	238,127	143,970	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	5,975,621	2,166	5,973,455	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	18,506,619	14,834,611	3,672,008	
23 Insurance	2,824,670	116,438	2,708,232	
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 & DRUG	44,074,155	43,860,058	214,097	
b PROVISION FOR BAD DEBTS	22,764,478	22,764,478		
c CORPORATE ASSESSMENT FE	10,766,427		10,766,427	
d COMMUNITY & RESIDENCY P	7,708,241	7,708,241		
e All other expenses	3,351,008	2,722,971	628,037	
25 **Total functional expenses.** Add lines 1 through 24e	346,683,608	272,629,348	74,054,260	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		10,686,998	1	11,209,863
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		56,929,424	4	45,239,830
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	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	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		5,303,554	8	5,247,099
	9	Prepaid expenses and deferred charges		1,846,593	9	4,211,164
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 173,521,262			
	b	Less accumulated depreciation	10b 2,446,924	160,130,135	10c	171,074,338
	11	Investments—publicly traded securities		177,862,187	11	180,313,489
	12	Investments—other securities See Part IV, line 11		17,215,024	12	13,585,545
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets		189,701	14	10,393,501
	15	Other assets See Part IV, line 11		17,794,720	15	54,865,660
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		447,958,336	16	496,140,489
Liabilities	17	Accounts payable and accrued expenses		40,037,286	17	32,262,447
	18	Grants payable			18	
	19	Deferred revenue		4,679	19	25,408
	20	Tax-exempt bond liabilities		118,528,255	20	114,648,381
	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	
	23	Secured mortgages and notes payable to unrelated third parties		1,978,492	23	1,466,733
	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		14,524,138	25	18,156,311
	26	**Total liabilities.** Add lines 17 through 25		175,072,850	26	166,559,280
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		270,969,173	27	305,775,657
	28	Temporarily restricted net assets		1,916,313	28	23,805,552
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	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		272,885,486	33	329,581,209
	34	Total liabilities and net assets/fund balances		447,958,336	34	496,140,489

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	362,343,976
2	Total expenses (must equal Part IX, column (A), line 25)	2	346,683,608
3	Revenue less expenses Subtract line 2 from line 1	3	15,660,368
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	272,885,486
5	Net unrealized gains (losses) on investments	5	3,806,376
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	37,228,979
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	329,581,209

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:
Software Version:
EIN: 74-1282696
Name: ST JOSEPH REGIONAL HEALTH CENTER

Form 990, Part III - Line 4c: Program Service Accomplishments (See the Instructions)

(Code) (Expenses $ 195,852,506 including grants of $ 6,784,063) (Revenue $ 249,180,119)

IN ADDITION TO THE EMERGENCY DEPARTMENT WHICH OPERATES IN BRYAN AND COLLEGE STATION AND EMERGENCY MEDICAL SERVICES PROGRAMS PROVIDED BY SJRHC, THE HEALTH CARE FACILITY IS THE LARGEST PROVIDER OF CARDIAC SERVICES IN THE REGION, OFFERING LEADING-EDGE DIAGNOSTICS AND COMPREHENSIVE TREATMENT OPTIONS FROM STATE-OF-THE-ART CARDIAC CATHETERIZATION LABS AND VASCULAR SUITES TO DEDICATED CARDIAC OPERATING ROOMS CARDIAC PATIENTS ALSO HAVE ACCESS TO A COMPREHENSIVE CARDIAC REHABILITATION PROGRAM WOMEN'S AND CHILDREN'S SERVICES IS THE LARGEST OBSTETRICS PROGRAM IN THE REGION, DELIVERING MORE THAN 2300 BABIES EACH YEAR IN A PRIVATE, HOME-LIKE SETTING THE PEDIATRIC PROGRAM IS HOUSED IN A DEDICATED UNIT WITH AN EXPERIENCED AND COMPASSIONATE STAFF ST JOSEPH WAS THE FIRST TO BRING A MULTIDISCIPLINARY CANCER CENTER TO THE BRAZOS VALLEY THE COMBINATION OF MEDICAL ONCOLOGY, RADIATION ONCOLOGY, RESEARCH AND THE LATEST TECHNOLOGY KEEPS THE J C LEE M D CANCER PAVILION AT THE FOREFRONT OF CANCER CARE IN THE REGION SJRHC HAS THE ONLY DEDICATED INPATIENT CANCER UNIT IN THE REGION SJRHC HAS THE REGION'S ONLY FREESTANDING INPATIENT REHABILITATION FACILITY TREATMENT PLANS FOR BRAIN, SPINAL CORD, JOINT AND ON-THE-JOB INJURIES, AS WELL AS A STROKE RECOVERY PROGRAM USE AN INTEGRATED APPROACH TO HELP IMPROVE THE INDEPENDENCE AND QUALITY OF LIFE FOR REHAB PATIENTS ST JOSEPH JOINT UNIVERSITY IS A TOTAL JOINT REPLACEMENT PROGRAM THAT CREATES A NEW AND UNIQUE EXPERIENCE THE 10-BED UNIT OPTIMIZES RECOVERY IN A SUPPORTIVE, LEARNING ENVIRONMENT SO PATIENTS CAN FULLY RECOVER MOBILITY AND IMPROVE THEIR QUALITY OF LIFE THE TEXAS BRAIN AND SPINE INSTITUTE IS A COLLABORATIVE PROGRAM WITH THE TEXAS A&M HEALTH SCIENCE CENTER COLLEGE OF MEDICINE AND LOCAL NEUROSCIENCE SPECIALISTS A COLLABORATION OF MORE THAN 20 SPECIALISTS IN THE NEUROSCIENCES FIELD, IT OFFERS THE LATEST TREATMENT AND RESEARCH FOR NEUROLOGICAL DISORDERS OTHER SPECIALIZED PROGRAMS INCLUDE SLEEP DISORDERS, SURGICAL WEIGHT LOSS, OCCUPATIONAL MEDICINE, PULMONARY REHABILITATION, WOUND CARE, IMAGING AND LABORATORY SERVICES SJRHC IS THE REGION'S ONLY PRIMARY STROKE CENTER, AS ACCREDITED BY THE JOINT COMMISSION

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			
(1) JAMES E BLAIR III CHAIRPERSON	2 00 12 00	X		X				0	0	0
(1) ANTHONY MORELOS VICE CHAIRPERSON	1 00 6 00	X		X				0	0	0
(2) ROBERT UPCHURCH SECRETARY	1 00 6 00	X		X				0	0	0
(3) ANTONIO ARREOLA-RISA TRUSTEE	1 00 6 00	X						0	0	0
(4) PAUL BATISTA TRUSTEE	1 00 6 00	X						0	0	0
(5) MICHAEL COHEN MD TRUSTEE	1 00 6 00	X						0	0	0
(6) CHARLES A ELLISON TRUSTEE	1 00 6 00	X						0	0	0
(7) GINA FLORES TRUSTEE	1 00 6 00	X						0	0	0
(8) JOHN GRUBE TRUSTEE	1 00 7 00	X						0	0	0
(9) CAROLINE MCDONALD TRUSTEE	1 00 6 00	X						0	0	0
(10) GEORGE NELSON TRUSTEE	1 00 6 00	X						0	0	0
(11) STEVE OGDEN TRUSTEE	1 00 6 00	X						0	0	0
(12) TIMOTHY RABROKER TRUSTEE	1 00 6 00	X						0	0	0
(13) MARK SCARMARDO TRUSTEE	1 00 6 00	X						0	0	0
(14) MICHAEL STEINES MD TRUSTEE	1 00 48 00	X						0	782,658	21,115
(15) JAMES W POPE EX-OFFICIO TRUSTEE	1 00 49 00	X						0	1,209,729	53,832
(16) ODETTE BOLANO PRES/CEO, EX-OFFICIO TRUSTEE PART YR	40 00 9 00	X		X				457,998	0	0
(17) JAMES P SCHUESSLER INTERIM PRES/CEO, EX-OFFICIO TRUSTEE STARTING 9/9/	40 00 9 00	X		X				106,000	0	0
(18) MARY BROUSSARD TRUSTEE THRU 2/2014	1 00 6 00	X						0	0	0
(19) REBA RAGSDALE TRUSTEE THRU 2/2014	1 00 6 00	X						0	0	0
(20) BRYAN COLE PHD TRUSTEE THRU 2/2014	1 00 6 00	X						0	0	0
(21) SR NANCY SURMA OSF EX-OFFICIO TRUSTEE	1 00 49 00	X						0	0	0
(22) KATHLEEN KRUSIE COO	40 00 9 00			X				380,185	0	28,372
(23) DANIEL GOGGIN CFO	40 00 9 00			X				373,307	0	28,371
(24) HERMAN BLANTON CHIEF MEDICAL OFFICER	40 00 9 00				X			186,685	0	11,721

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			
(26) MICHAEL RUSSO VP/INFORMATION SERVICES	40 00 9 00				X			250,010	0	28,109
(1) MICHAEL COSTA VP/HUMAN RESOURCES	40 00 9 00				X			244,613	0	27,503
(2) STEVE CRICHTON VP/SUPPORT SERVICES	40 00 9 00				X			200,310	0	19,140
(3) DONOVAN FRENCH VP/STRATEGY & SERVICE LINES	40 00 9 00				X			176,646	0	15,552
(4) RICARDO DIAZ VP/CLINICAL SUPPORT	40 00 9 00				X			230,876	0	22,008
(5) STEWART BROOKS PHYSICIAN ASSISTANT	40 00 0 00					X		185,377	0	24,772
(6) JON CHRISTOPHER TEACLE PHYSICIAN ASSISTANT	40 00 0 00					X		186,824	0	23,451
(7) JOSEPH HLAVIN PHYSICIAN ASSISTANT	40 00 0 00					X		186,654	0	23,709
(8) LAURA SURVANT EXECUTIVE DIRECTOR	40 00 0 00					X		183,321	0	10,539
(9) GARY HINES CLINICAL STAFF PHARMACIST	40 00 0 00					X		160,473	0	18,044

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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 11, 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)

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 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)

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

11 ☐ 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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g

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- 9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 2014 (line 6, column (f) divided by line 11, column (f))	**14**
15	Public support percentage for 2013 Schedule A, Part II, line 14	**15**

16a **33 1/3% support test—2014.** 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—2013.** 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—2014.** 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—2013.** 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 9 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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 2014 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2013 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2014** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2013** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2014.** 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—2013.** 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 11 of Part I If you checked 11a of Part I, complete Sections A and B If you checked 11b of Part I, complete Sections A and C If you checked 11c of Part I, complete Sections A, D, and E If you checked 11d 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 11a or 11b 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 (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) 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 IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990) .*	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 II of Schedule L (Form 990).*	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 9(a)) 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 9(a)) 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 IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer b 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		
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI.*	11c		

Part IV Supporting Organizations (continued)

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

			Yes	No
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? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in Part VI the role played by the organization in this regard.*	3b		

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

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

Section A - Adjusted Net Income

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

Section B - Minimum Asset Amount

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

Section C - Distributable Amount

				Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7	☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)			

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 2014 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-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2014			
a From 2009.			
b From 2010.			
c From 2011.			
d From 2012.			
e From 2013.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2014 from Section D, line 7 $ _____			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2015.** Add lines 3j and 4c			
8 Breakdown of line 7			
a From 2010.			
b From 2011.			
c From 2012.			
d From 2013.			
e From 2014.			

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

Return Reference	Explanation

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493320073245

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

2014

Open to Public Inspection

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

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

Name of the organization	Employer identification number
ST JOSEPH REGIONAL HEALTH CENTER	74-1282696

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

2 Political expenditures ▶ $ _____

3 Volunteer hours _____

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-

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a If zero or less, enter -0-		
i Subtract line 1f from line 1c If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000
Over $17,000,000	$1,000,000

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

	For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		25,859
j	Total Add lines 1c through 1i			25,859
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1	THE HOSPITAL PAYS DUES TO THE AMERICAN HOSPITAL ASSOCIATION, TEXAS HOSPITAL ASSOCIATION AND CATHOLIC HEALTH ASSOCIATION, OF WHICH A PORTION RELATES TO LOBBYING

Part IV Supplemental Information *(continued)*

Return Reference	Explanation

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to 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

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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

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

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

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

Part II Conservation Easements. Complete if the organization answered "Yes" to 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, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, 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" to 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 in 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 in 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" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

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

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

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

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

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

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

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

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

- a Board designated or quasi-endowment ▶
- b Permanent endowment ▶
- c Temporarily restricted endowment ▶

The percentages in 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)		
(ii) related organizations	3a(ii)		
b If "Yes" to 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' to 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		9,836,268		9,836,268
b Buildings		104,589,144	1,140,141	103,449,003
c Leasehold improvements				
d Equipment		35,617,361	1,241,381	34,375,980
e Other		23,478,489	65,402	23,413,087
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				171,074,338

Part VII **Investments—Other Securities.** Complete if the organization answered 'Yes' to 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		
Other		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

Part VIII **Investments—Program Related.** Complete if the organization answered 'Yes' to 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
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	22,132,640
(2) DUE FROM AFFILIATES	4,761,952
(3) RECEIVABLE FROM RELATED PARTIES	5,067,933
(4) BENEFICIAL INTEREST IN FOUNDATION	22,903,135
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	54,865,660

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

1 (a) Description of liability	(b) Book value
Federal income taxes	
CHARITABLE GIFT ANNUITY LIABILITY	105,543
DUE TO AFFILIATES	6,897,158
DERIVATIVE LIABILITY	7,929,611
COST REPORT SETLEMENT PAYABLE	-1,647,587
PHYSICIAN INCOME GUARANTEE	4,871,586
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	18,156,311

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' to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	356,696,918
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains (losses) on investments	2a	3,806,376		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d	362,483		
e	Add lines **2a** through **2d**			2e	4,168,859
3	Subtract line **2e** from line **1**			3	352,528,059
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	9,815,917		
c	Add lines **4a** and **4b**			4c	9,815,917
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	362,343,976

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

1	Total expenses and losses per audited financial statements			1	338,938,102
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	-961,443		
e	Add lines **2a** through **2d**			2e	-961,443
3	Subtract line **2e** from line **1**			3	339,899,545
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	6,784,063		
c	Add lines **4a** and **4b**			4c	6,784,063
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	346,683,608

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
PART X, LINE 2	THE SYSTEM, THE HOSPITAL, THE FOUNDATION, SJM, BURLESON, BSJM, MADISON, BELLVILLE, SHP, ACO, AND SJPA ARE NOT-FOR-PROFIT ORGANIZATIONS AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE (THE CODE) AND ARE EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE ALLIANCE IS A FOR-PROFIT CORPORATION INCORPORATED UNDER THE TEXAS BUSINESS CORPORATION ACT FEDERAL INCOME TAX RETURNS ARE FILED ON A SEPARATE-ENTITY BASIS THERE ARE NO MATERIAL UNRECORDED TAX LIABILITIES OR UNCERTAIN TAX POSITIONS AS OF DECEMBER 31, 2014 OR 2013

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to 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*.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year ☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for *free* care ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care ☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		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 eligibile 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	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		20,993	18,608,746	28,496,109	-9,887,363	0 %
b Medicaid (from Worksheet 3, column a)		27,333	24,874,867	20,467,337	4,407,530	1 360 %
c Costs of other means-tested government programs (from Worksheet 3, column b)		3,144	6,564,406	6,677,962	-113,556	0 %
d **Total** Financial Assistance and Means-Tested Government Programs		51,470	50,048,019	55,641,408	-5,593,389	1 360 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,694,668		3,694,668	1 140 %
f Health professions education (from Worksheet 5)			3,478,266	749,027	2,729,239	0 840 %
g Subsidized health services (from Worksheet 6)		264,348	61,192,585	42,478,200	18,714,385	5 780 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)		15,112	7,643,413		7,643,413	2 360 %
j **Total.** Other Benefits		279,460	76,008,932	43,227,227	32,781,705	10 120 %
k **Total.** Add lines 7d and 7j		330,930	126,056,951	98,868,635	27,188,316	11 480 %

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

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

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 Heathcare 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 22,764,478		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	90,531,042
6	Enter Medicare allowable costs of care relating to payments on line 5	6	78,391,313
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	12,139,729
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? **2**

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

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group ST JOSEPH REGIONAL MEDICAL CENTER

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 2013			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
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	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) HTTP //WWW ST-JOSEPH ORG/WORKFILES/BVREGIONALREPORT2013			
b	☐ Other website (list url)			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 2013			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		No
a	If "Yes" (list url)			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	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)?	12a		No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to 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)*

ST JOSEPH REGIONAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
Financial Assistance Policy (FAP)				
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000% and FPG family income limit for eligibility for discounted care of 250 000000000000%			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url)			
b	☑ The FAP application form was widely available on a website (list url)			
c	☐ A plain language summary of the FAP was widely available on a website (list url)			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ Other (describe in Section C)			
Billing and Collections				
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 non-payment?	17	Yes	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
e	☐ None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

ST JOSEPH REGIONAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**19**		No
	If "Yes," check all actions in which the hospital facility or a third party engaged			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ 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 18 (check all that apply)			
a	☑ Notified individuals of the financial assistance policy on admission			
b	☐ Notified individuals of the financial assistance policy prior to discharge			
c	☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e	☑ Other (describe in Section C)			
f	☐ None of these efforts were made			
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**21**	Yes	
	If "No," indicate why			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☑ Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		No
	If "Yes," explain in Section C			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		No
	If "Yes," explain in Section C			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group GRIMES ST JOSEPH HEALTH CENTER

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 2013			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
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	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) HTTP //WWW ST-JOSEPH ORG/WORKFILES/BVREGIONALREPORT2013			
b	☐ Other website (list url)			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 2013			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		No
a	If "Yes" (list url)			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	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)?	12a		No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to 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)*

GRIMES ST JOSEPH HEALTH CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
Financial Assistance Policy (FAP)				
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000% and FPG family income limit for eligibility for discounted care of 250.000000000000%			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☑ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url)			
b	☑ The FAP application form was widely available on a website (list url)			
c	☐ A plain language summary of the FAP was widely available on a website (list url)			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ Other (describe in Section C)			
Billing and Collections				
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 non-payment?	17	Yes	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
e	☐ None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

GRIMES ST JOSEPH HEALTH CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
19	Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**19**		No
	If "Yes," check all actions in which the hospital facility or a third party engaged			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ 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 18 (check all that apply)			
a	☑ Notified individuals of the financial assistance policy on admission			
b	☐ Notified individuals of the financial assistance policy prior to discharge			
c	☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e	☑ Other (describe in Section C)			
f	☐ None of these efforts were made			
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**21**	Yes	
	If "No," indicate why			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)				
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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☑ Other (describe in Section C)			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		No
	If "Yes," explain in Section C			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		No
	If "Yes," explain in Section C			

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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 Additional Data Table	

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? _____

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

Form and Line Reference	Explanation
PART I, LINE 7	A COST-TO-CHARGE RATIO WAS USED TO COMPLETE THE CHARITY CARE (LINE 7A) PROGRAM THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2 THAT ACCOMPANIES THE INSTRUCTIONS TO THIS SCHEDULE COST ACCOUNTING DATA AND GENERAL LEDGER AMOUNTS, LESS BAD DEBT AND COST OF CHARITY CARE, WERE USED TO COMPLETE THE MEDICAID (LINE 7B) AND OTHER MEANS TESTED GOVERNMENT PROGRAMS (LINE 7C) LINES THE HOSPITAL'S COST ACCOUNTING RECORDS WERE USED TO COMPLETE THE OTHER BENEFITS SECTION (LINE 7E - 7I)

Form and Line Reference	Explanation
PART I, LINE 7G	SUBSIDIZED HEALTH SERVICES INCLUDE OB/NEWBORN, AMBULANCE SERVICES, PHYSICIAN CLINICS, AND INPATIENT RENAL DIALYSIS

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 24B - BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE SCHEDULE H, PART I, COLUMN F PERCENTAGE EQUALS $22,764,478

Form and Line Reference	Explanation
PART III, LINE 2	THE BAD DEBT EXPENSE REPORTED ON PART III, LINE 2, IS THE BAD DEBT EXPENSE REPORTED ON FORM 990, PART IX

Form and Line Reference	Explanation
PART III, LINE 3	THE HOSPITAL WAS UNABLE TO MAKE AN ESTIMATE OF THE ORGANIZATION'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY

Form and Line Reference	Explanation
PART III, LINE 4	ACCOUNTS RECEIVABLE FINANCIAL STATEMENT FOOTNOTE PATIENT RECEIVABLES CONSIST OF AMOUNTS DUE FROM THIRD-PARTY PAYORS, INCLUDING FEDERAL AND STATE INDEMNITY AND MANAGED CARE PROGRAMS, MANAGED CARE HEALTH PLANS AND COMMERCIAL INSURANCE COMPANIES, AND INDIVIDUAL PATIENTS FOR HEALTH CARE SERVICES RENDERED THE SYSTEM DOES NOT REQUIRE COLLATERAL OR OTHER SECURITY ON ITS PATIENT RECEIVABLES PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE SYSTEM ANALYZES ITS HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON SPECIFIC ACCOUNTS, HISTORICAL WRITE-OFF EXPERIENCE, AND CURRENT MARKET CONDITIONS THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE SYSTEM ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE REALIZATION OF AMOUNTS DUE UNLIKELY FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, WHICH INCLUDE BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLES AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL, THE SYSTEM RECORDS A PROVISION FOR BAD DEBTS ON THE BASIS OF ITS PAST EXPERIENCE THE DIFFERENCE BETWEEN THE STANDARD RATES AND THE AMOUNT ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS

Form and Line Reference	Explanation
PART III, LINE 8	NO MEDICARE SHORTFALL IS REPORTED THE AMOUNTS REPORTED FOR MEDICARE ARE FROM THE MEDICARE COST REPORT - WHICH IS BASED ON THE METHODOLOGY REQUIRED FOR COMPLETING THE MEDICARE COST REPORT

Form and Line Reference	Explanation
PART III, LINE 9B	IN ACCORDANCE WITH ST JOSEPH HEALTH SYSTEM POLICY #17 ST JOSEPH HEALTH SYSTEM HAS ESTABLISHED THE FOLLOWING PAYMENT OPTIONS TO ASSIST GUARANTORS OF PATIENT ACCOUNTS IN DISCHARGING THEIR FINANCIAL REPONSIBILITIES TO THE HOSPITAL A COMPLETED FINANCIAL ASSISTANCE (UNCOMPENSATED SERVICES) APPLICATION ACCOMPANIED BY THE REQUIRED DOCUMENTATION WHICH ESTABLISHED THE QUALIFICATIONS FOR A FINANCIAL ASSISTANCE (CHARITY) DISCOUNT AT OR PRIOR TO THE DELIVERY OF HEALTH CARE SERVICES IF THE SERVICES ARE SCHEDULED IF UNSCHEDULED SERVICES ARE PROVIDED, THE FINANCIAL ASSISTANCE APPLICATION AND DOCUMENTATION MUST BE COMPLETED AND PROVIDED TO A ST JOSEPH HEALTH SYSTEM TEAM MEMBER AT THE DATE DETERMINED BY THE ST JOSEPH HEALTH SYSTEM TEAM MEMBER FINANCIAL ASSISTANCE COLLECTION PROCESS - UNTIL FINANCIAL ASSISTANCE APPLICATION (CHARITY CARE/UNCOMPENSATED CARE) HAS BEEN DETERMINED EITHER BY A COMPLETED AND APPROVED FINANCIAL ASSISTANCE APPLICATION OR BY THE PATIENT/RESPONSIBLE PARTY'S RESIDENCE BEING IN AN IMPOVERISHED ZIP CODE WHICH QUALIFIES FOR FINANCIAL ASSISTANCE PER THE SYSTEM FINANCIAL ASSISTANCE POLICY (SJHS #70), THE STANDARD COLLECTION PROCESS REQUIRING PAYMENT FOR THE ACCOUNT WILL BE ENFORCED LASTLY, A PATIENT MAY QUALIFY AS UN UNINSURED PATIENT AND RECEIVE A DISCOUNT FROM BILLED CHARGES IF THEY ARE NOT CURRENTLY RECEIVING ASSISTANCE UNDER ST JOSEPH HEALTH SYSTEM'S FINANCIAL ASSISTANCE POLICY, AND EITHER THE PATIENT MUST NOT HAVE ANY HEALTH INSURANCE COVERAGE OR THE PROCEDURE TO THE PATIENT MUST NOT BE COVERED BY THE HEALTH INSURANCE BENEFITS, AS CONFIRMED BY THE HEALTH BENEFITS PLAN

Form and Line Reference	Explanation
PART VI, LINE 2	IN SERVING OUR COMMUNITY, ST JOSEPH REGIONAL HEALTH CENTER ASSESSES COMMUNITY HEALTH NEEDS ON AN ON-GOING BASIS USING A VARIETY OF INFORMATION, ALTHOUGH THE PRIMARY ASSESSMENT TOOL IS THE BRAZOS VALLEY HEALTH ASSESSMENT SURVEY USING INFORMATION FROM NEEDS ASSESSMENTS, WE WORK TO IMPROVE THE HEALTH OF OUR COMMUNITY THROUGH THE DELIVERY OF CHARITY AND UNREIMBURSED INDIGENT HEALTH CARE, ACCESS TO PRIMARY CARE THROUGH NETWORK DEVELOPMENT IN OUR REGION, AND COMMUNITY-BASED HEALTH EDUCATION AWARENESS AND PREVENTION PROGRAMS GRIMES ST JOSEPH HEALTH CENTER IS AN INTEGRAL PART OF ST JOSEPH REGIONAL HEALTH CENTER AND SPECIFIC AMOUNTS FOR GRIMES HAVE BEEN QUOTED SEPARATELY IN THIS DOCUMENT WHERE AVAILABLE COMMUNITY HEALTH INITIATIVES COMPLETED BY ST JOSEPH IN 2013 WERE BASED ON RESULTS FROM THE 2013 BRAZOS VALLEY REGIONAL HEALTH STATUS ASSESSMENT, AS WELL AS STATE AND NATIONAL DATA THESE SOURCES IDENTIFIED THE LEADING CAUSES OF DEATH IN THE BRAZOS VALLEY AS CORONARY HEART DISEASE, CANCER, STROKE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, AND DIABETES THE MOST FREQUENTLY REPORTED CHRONIC DISEASES AND CONDITIONS INCLUDED OBESITY, HYPERTENSION, HIGH CHOLESTEROL, ARTHRITIS, RHEUMATISM, DIABETES, CONGESTIVE HEART FAILURE, EMPHYSEMA AND COPD ST JOSEPH REGIONAL HEALTH CENTER REPRESENTATIVES, THROUGH THE BRAZOS VALLEY HEALTH PARTNERSHIP, WERE INVOLVED IN THE UPDATED HEALTH STATUS ASSESSMENT OF THE BRAZOS VALLEY, WHICH WAS COMPLETED IN SEPTEMBER 2013

Form and Line Reference	Explanation
PART VI, LINE 3	INFORMATION CONCERNING FINANCIAL ASSISTANCE FOR PATIENTS IS COMMUNICATED VIA CONSENT FOR ADMISSION AND REGISTRATION COMPLETION, SIGNAGE POSTED IN EMERGENCY ROOMS AND OTHER CONSPICUOUS PATIENT TRAFFIC AREAS, FINANCIAL COUNSELORS, PATIENT COMMUNICATIONS, PATIENT BILLS AND ST JOSEPH HEALTH SYSTEM WEBSITE

Form and Line Reference	Explanation
PART VI, LINE 4	ST JOSEPH REGIONAL HEALTH CENTER PROVIDES HEALTH SERVICES TO AN AREA THAT EXCEEDS SEVEN COUNTIES IN THE BRAZOS VALLEY THE SEVEN PRIMARY COUNTIES INCLUDE BRAZOS, LEON, MADISON, BURLESON, GRIMES, WASHINGTON AND ROBERTSON COUNTIES 60% OF THE TOTAL POPULATION SERVED IS LOCATED IN THE BRYAN-COLLEGE STATION METROPOLITAN AREA, MAKING BRAZOS COUNTY THE SYSTEM'S PRIMARY SERVICE AREA THE OTHER SIX COUNTIES CUMULATIVELY ACCOUNT FOR 40% OF THE INPATIENT ADMISSIONS TO THE REGIONAL HEALTH CENTERIN BRYAN

Form and Line Reference	Explanation
PART VI, LINE 5	SEVERAL THOUSAND LIVES WERE AFFECTED BY THE FOLLOWING COMMUNITY HEALTH IMPROVEMENT ADVOCAC Y PROGRAMS COMMUNITY HEALTH IMPROVEMENT ADVOCACYPRENATAL CAREPRENATAL CARE WAS PROVIDED IN RURAL COMMUNITIES WITH DIRECT REFERRAL TO THE DELIVERY SITE AT ST JOSEPH REGIONAL HEALTH CENTER THIS DELIVERY SITE PROVIDES MORE COMPREHENSIVE AND COORDINATED CARE THAN IS AVAIL ABLE LOCALLY ST JOSEPH REGIONAL HEALTH CENTER ALSO PARTNERS WITH THE PRENATAL CLINIC IN BRYAN TO PROVIDE PRENATAL CARE FOR UNINSURED MOTHERS AND THOSE COVERED UNDER MEDICAID APP ROXIMATELY 95% OF MOTHERS RECEIVING CARE AT THE PRENATAL CLINIC DELIVER THEIR BABIES AT ST JOSEPH REGIONAL HEALTH CENTER THIS FURTHER IMPROVES THE EARLY ONSET OF PRENATAL CARE AN D REDUCES THE NUMBER OF LOW BIRTH-WEIGHT BABIES IN THE BRAZOS VALLEY EXPECTANT PARENTS AR E PROVIDED MANY OPPORTUNITIES FOR EDUCATION BEFORE THE BIRTH OF THEIR CHILD, SUCH AS CHILD BIRTH, NEWBORN CARE, BREASTFEEDING AND INFANT CPR CLASSES THESE CLASSES ARE OFFERED FREE-OF-CHARGE TO MEDICAID RECIPIENTS ADDITIONALLY, TEENAGE MOTHERS DELIVERING BABIES AT ST J OSEPH RECEIVE A POST-PARTUM CONSULTATION WITH SOCIAL SERVICES AND ARE REFERRED TO OTHER CO MMUNITY AGENCIES AS NEEDED HEALTH EDUCATORS FROM SJRHC PROVIDE INFORMATION AND RESOURCES FOR THE TEEN PARENTING CLASSES AT SCHOOL DISTRICTS IN THE BRAZOS VALLEY HEART DISEASE AND STROKEST JOSEPH REGIONAL HEALTH CENTER PROMOTES HEART HEALTH EACH YEAR IN THE BRAZOS VALL EY THROUGH HEARTSCORE, A LOW-COST BLOOD PRESSURE, BLOOD GLUCOSE AND CHOLESTEROL SCREENING PROGRAM EACH FACILITY PROVIDES THEIR PARTICIPANTS HEALTH EDUCATION MATERIALS FROM THE AME RICAN HEART ASSOCIATION DETAILED RESULTS ARE MAILED TO EACH PARTICIPANT AFTER THE EVENT NEARLY 20% OF PARTICIPANTS WERE IDENTIFIED WITH HIGH CARDIAC RISK AND ENCOURAGED TO VISIT A HEALTHCARE PROVIDER ST JOSEPH ALSO OFFERS DISCOUNTED BLOOD SCREENINGS TO GOLD MEDALLIO N CLUB MEMBERS AND FREE BLOOD PRESSURE CHECKS TO THE GENERAL COMMUNITY OVER 2,300 COMMUNI TY MEMBERS WERE SCREENED AT ST JOSEPH FACILITIES AND HEALTH EDUCATION FAIRS ACROSS THE BR AZOS VALLEY ADDITIONALLY, A REGISTERED DIETITIAN CONTINUES TO EDUCATE THE PUBLIC ON THE S T JOSEPH BEST BETS PROGRAM, WHICH IDENTIFIES HEART-HEALTHY OPTIONS AT AREA RESTAURANTS F REE GROCERY STORE TOURS ARE PROVIDED THROUGH THIS PROGRAM TO BRAZOS VALLEY RESIDENTS, OFFE RING NUTRITIONAL EDUCATION INCLUDING PORTION CONTROL AND READING FOOD LABELS A ST JOSEPH DIETITIAN OFFERS MONTHLY EDUCATION FOR CARDIAC REHABILITATION PATIENTS, INCLUDING NUTRITI ONAL COUNSELING AND SUPPORT, AS A PART OF THEIR FOLLOW-UP CARE ST JOSEPH REGIONAL HEALTH CENTER CONTINUES TO MAINTAIN ITS STATUS AS THE REGION'S ONLY ACCREDITED CHEST PAIN CENTER THE CHEST PAIN CENTER'S PROTOCOL-DRIVEN AND SYSTEMATIC APPROACH TO PATIENT MANAGEMENT ALL OWS PHYSICIANS TO REDUCE TIME TO TREATMENT DURING THE CRITICAL EARLY STAGES OF A HEART ATT ACK, WHEN TREATMENTS ARE MOST EFFECTIVE, AND TO BETTER MONITOR PATIENTS WHEN IT IS NOT CLE AR WHETHER THEY ARE HAVING A CORONARY EVENT SUCH OBSERVATION HELPS ENSURE THAT A PATIENT IS NEITHER SENT HOME TOO EARLY NOR NEEDLESSLY ADMITTED ST JOSEPH REGIONAL HEALTH CENTER W AS AWARDED THE AMERICAN STROKE ASSOCIATION'S (ASA) GET WITH THE GUIDELINES-STROKE GOLD PLU S QUALITY ACHIEVEMENT AWARD THIS IS CURRENTLY THE HIGHEST LEVEL OF RECOGNITION THE AMERIC AN STROKE ASSOCIATION DESIGNATES AND RECOGNIZES ST JOSEPH'S COMMITMENT AND SUCCESS IN IMP LEMENTING EXCELLENT CARE FOR STROKE PATIENTS ACCORDING TO EVIDENCE-BASED GUIDELINES AS TH E REGION'S ONLY JOINT COMMISSION CERTIFIED PRIMARY STROKE CENTER, ST JOSEPH IS REQUIRED T O ORGANIZE A MULTIDISCIPLINARY STROKE TEAM TO COORDINATE CARE AMONG FIRST RESPONDERS, EMER GENCY ROOM STAFF, PHYSICIANS, DIAGNOSTIC STAFF, REHABILITATION STAFF AND OTHER HEALTH PROV IDERS WHO CARE FOR STROKE PATIENTS THE TEAM IMPLEMENTED BEST PRACTICE PROTOCOLS SHOWN TO PROVIDE THE BEST OUTCOMES WHEN DIAGNOSING AND TREATING STROKE PATIENTS THE TEAM SET UP HU NDREDS OF HOURS OF TRAINING AND EDUCATIONAL SESSIONS FOR STAFF INVOLVED IN ANY ASPECT OF S TROKE CARE EDUCATION PROGRAMS ARE ALSO A CONTINUING PART OF STROKE PREVENTION EDUCATION F OR ALL COMMUNITY RESIDENTS IN THE SEVEN-COUNTY AREA OBESITY AWARENESS AND PREVENTIONST JO SEPH COLLABORATED WITH THE TEXAS A&M SCHOOL OF RURAL PUBLIC HEALTH TO OFFER PROGRAMS TO AD DRESS OBESITY AND ITS HEALTH IMPACT, GIVEN IT IS THE MOST SIGNIFICANT HEALTH PROBLEM IN EV ERY COUNTY THAT ST JOSEPH SERVES FIT & STRONG! IS A PHYSICAL ACTIVITY AND BEHAVIORAL CHA NGE, EVIDENCE-BASED PROGRAM THAT IS STRUCTURED AROUND TWO KEY COMPONENTS PHYSICAL ACTIVITY AND HEALTH EDUCATION/GROUP PROBLEM-SOLVING THIS PROGRAM, WHICH WAS THE FIRST TO BE IMPLE MENTED IN TEXAS, WAS OFFERED IN BRYAN AND COLLEGE STATION (BRAZOS COUNTY) AND NAVASOTA (GR IMES COUNTY) SIXTEEN PEOPLE, INCLUDING SEVERAL ST JOSEPH TEAM MEMBERS, ATTENDED THE INST RUCTOR TRAINING FORTY-SIX (46) PARTICIPANTS COMPLETED THE INITIAL 8-WEEK/24-SESSION PROGR AM AND REPORTED INCREASED SELF-EFFICACY (CONFIDENC

Form and Line Reference	Explanation
PART VI, LINE 5	E TO EXERCISE), INCREASED PHYSICAL ACTIVITY ADHERENCE, IMPROVEMENT IN LOWER-EXTREMITY MUSC ULAR STRENGTH, IMPROVEMENT IN AEROBIC CAPACITY AND A REDUCTION IN JOINT PAIN AND STIFFNESS SELF-REPORTED BODY MASS INDEX (BMI) MEASURES INDICATED A DECREASE IN BMI AT THE END OF T HE 8-WEEK PROGRAM IN 2013, ADDITIONAL FIT & STRONGI PROGRAMS WILL BE SCHEDULED IN BRAZOS, GRIMES, AND MADISON COUNTIES TOBACCO CESSATION INPATIENT PROGRAMS AT ST JOSEPH REGIONAL HEALTH CENTER PROVIDE TOBACCO CESSATION EDUCATION EVERY INDIVIDUAL WHO IS ADMITTED TO ST JOSEPH REGIONAL HEALTH CENTER WHO HAS USED TOBACCO PRODUCTS WITHIN THE LAST YEAR IS OFFE RED COUNSELING AND LITERATURE ON TOBACCO CESSATION ST JOSEPH REGIONAL HEALTH CENTER, ALO NG WITH THE COLLEGE STATION MEDICAL CENTER, ADOPTED A SMOKE-FREE CAMPUS POLICY, WHICH COMP ELS PATIENTS, VISITORS, AND STAFF TO REFRAIN FROM SMOKING WHILE ON HEALTH CARE CAMPUSES AN D HELPS CREATE THE HEALTHIEST ENVIRONMENT POSSIBLE FOR GUESTS DIABETES MANAGEMENT EDUCATI ONST JOSEPH REGIONAL HEALTH CENTER PROVIDES COMMUNITY EDUCATION FOR DIABETES PREVENTION A ND MANAGEMENT A CERTIFIED DIABETES EDUCATOR AND A DIETITIAN TEACH MONTHLY DIABETES EDUCAT ION CLASSES FOR DIABETICS AND THEIR GUESTS LOCAL HEALTHCARE PROVIDERS ALSO REFER NEWLY DI AGNOSED PATIENTS TO THE MONTHLY DIABETES EDUCATION CLASS ST JOSEPH DIETITIANS ALSO PROVI DE CLASS INFORMATION TO DIABETES PATIENTS IN ALL OF OUR FACILITIES EIGHT (8) COMMUNITY HE ALTH EDUCATION SEMINARS PROMOTING DIABETES AWARENESS WERE ALSO OFFERED IN AND AROUND THE B RAZOS VALLEY IN 2013, THIS PROGRAM REACHED OVER 150 RESIDENTS SUPPORT GROUPSHAVING A SUP PORT SYSTEM IS ESSENTIAL TO OUR COMMUNITY'S HEALTH AND WELL BEING ST JOSEPH REGIONAL HEA LTH CENTER PUBLICATIONS AND WEBSITE HIGHLIGHT A LISTING OF FIFTEEN (15) AREA SUPPORT GROUP S OFFERED AT ST JOSEPH FACILITIES AND THROUGHOUT THE COMMUNITY, MANY OF WHICH MEET IN ST JOSEPH FACILITIES ARE FACILITATED BY ST JOSEPH TEAM MEMBERS SENIOR LIFE SERVICESAS OUR P OPULATION AGES, CARE FOR OLDER ADULTS BECOMES INCREASINGLY IMPORTANT ST JOSEPH REGIONAL HEALTH CENTER, THROUGH ITS AFFILIATES, OFFERS THIS GROUP MANY OPPORTUNITIES FOR CARE AND G ROWTH, INCLUDING ASSISTED LIVING, INTERMEDIATE AND SKILLED NURSING CARE AT ST JOSEPH MANO R IN BRYAN AND BURLESON ST JOSEPH MANOR IN CALDWELL THE GOLD MEDALLION CLUB PROVIDES HEA LTH EDUCATION CLASSES AND SEMINARS, SOCIAL OUTINGS, AND HOSPITAL BENEFITS FOR OVER 4,500 M EMBERS AGES 50 AND UP IN 2013, 527 MEMBERS ATTENDED SEMINARS, 711 MEMBERS ATTENDED VARIOU S SOCIAL EVENTS AND 488 MEMBERS TRAVELED ON DAY TRIPS, DOMESTIC AND INTERNATIONAL TRIPS S T JOSEPH HELPLINE, AN IN-HOME PERSONAL EMERGENCY RESPONSE SERVICE, OFFERS SAFETY, SECURIT Y AND INDEPENDENCE TO 470 SENIORS TO SAFELY LIVE AT HOME FIFTY-TWO (52) HELPLINE SUBSCRIB ERS RECEIVE A DISCOUNTED RATE BASED ON THEIR INCOME LIFELONG FITNESS IS ALSO ENCOURAGED T HROUGH THE ST JOSEPH WELLNESS PROGRAM, WHICH OFFERS CARDIAC REHABILITATION, WATER AEROBIC S AND PHYSICAL STRENGTH TRAINING OTHER EDUCATIONAL OPPORTUNITIES PROVIDED AS WELL

Form and Line Reference	Explanation
PART VI, LINE 6	- ST JOSEPH REGIONAL HEALTH CENTER (SJRHC) IS THE ANCHOR FACILITY FOR ST JOSEPH HEALTH SY STEM, A HEALTH MINISTRY OF THE SISTERS OF ST FRANCIS OF SYLVANIA, OHIO ESTABLISHED IN 193 6, SJRHC IS A 255-BED HEALTH CARE CENTER OFFERING THE COMMUNITY'S LEAD LEVEL III TRAUMA CE NTER, AN EXTENSIVE INPATIENT AND OUTPATIENT SURGERY PROGRAM, AND IS KNOWN THROUGHOUT THE R EGION FOR ITS CARDIAC, CANCER, AND REHABILITATION PROGRAMS - GRIMES ST JOSEPH HEALTH CENT ER (GSJHC) IS A 25-BED CRITICAL ACCESS HOSPITAL IN NAVASOTA, TEXAS OFFERING A LEVEL IV TRA UMA CENTER, INPATIENT, OUTPATIENT, AND DAY SURGERY SERVICES THE HOSPITAL WAS ESTABLISHED BY GRIMES COUNTY AND HAS BEEN AN INTEGRAL PART OF THE COMMUNITY SINCE ITS INCEPTION IN 19 96 IT BECAME PART OF ST JOSEPH REGIONAL HEALTH CENTER ST JOSEPH HAS A LONG-TERM LEASE T O MANAGE AND OPERATE GSJHC, WHICH IS OWNED BY GRIMES COUNTY THE OTHER FACILITIES IN THE ST JOSEPH HEALTH SYSTEM ARE AS FOLLOWS - BURLESON ST JOSEPH HEALTH CENTER (BSJHC) IS A 25-B ED CRITICAL ACCESS HOSPITAL IN CALDWELL, TEXAS OFFERING A LEVEL IV TRAUMA CENTER, INPATIEN T AND OUTPATIENT SERVICES THE HOSPITAL WAS ESTABLISHED BY BURLESON COUNTY AND HAS BEEN AN INTEGRAL PART OF THE COMMUNITY SINCE ITS INCEPTION IT JOINED THE ST JOSEPH HEALTH SYSTEM IN 1995 ST JOSEPH HAS A LONG-TERM LEASE TO MANAGE AND OPERATE BURLESON ST JOSEPH HEALTH CENTER, WHICH IS OWNED BY THE BURLESON COUNTY HOSPITAL DISTRICT AND PROVIDES SERVICES TO A N UNDER-SERVED RURAL COMMUNITY - MADISON ST JOSEPH HEALTH CENTER (MSJHC) IS A 25-BED CRI TICAL ACCESS HOSPITAL IN MADISONVILLE, TEXAS OFFERING A LEVEL IV TRAUMA CENTER, INPATIENT AND OUTPATIENT SERVICES THE HOSPITAL WAS ESTABLISHED BY MADISON COUNTY AND HAS BEEN AN IN TEGRAL PART OF THE COMMUNITY SINCE ITS INCEPTION IT JOINED THE ST JOSEPH HEALTH SYSTEM I N 1995 ST JOSEPH OWNS AND OPERATES MSJHC, WHICH SERVES MADISON AND THE SURROUNDING COUNT IES ALL THREE CRITICAL ACCESS HOSPITALS PROVIDE COMPREHENSIVE CARE IN A GENERAL ACUTE CARE HOSPITAL SETTING, OFFERING INPATIENT AS WELL AS OUTPATIENT SERVICES IN EMERGENCY CARE, TH ERAPY AND ATHLETIC INJURIES AND MORE THEY OFFER IMAGING SERVICES DURING NORMAL BUSINESS H OURS AND INSOME CASES AFTER HOURS AND ON WEEKENDS ALL THREE FACILITIES ARE ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) OTHER ROLES ST JOSEPH REGIONAL EMERGENCY MEDICAL SERVICES (SJR EMS) SJREMS IS THE OLDEST PRIVATE PRE-HOSP ITAL EMERGENCY MEDICAL SERVICE IN THE BRAZOS COUNTY AND OPERATES A FLEET OF 14 AMBULANCES, STAFFED BYEMERGENCY MEDICAL TECHNICIANS AND PARAMEDICS WHO RESPOND TO MORE THAN 15,000 SE RVICE REQUESTS EACH YEAR SJREMS IS A NETWORK OF AMBULANCE SERVICES THAT INCLUDES THE BRYA N-COLLEGE STATION AREA AS WELL AS BURLESON, GRIMES AND MADISON COUNTIES COLLECTIVELY, THE GOAL OF SJR EMS IS TO OFFER HIGHQUALITY PRE-HOSPITAL MEDICINE WITH COMPASSION TO ALL WITH IN THE BRAZOS VALLEY IN BRYAN-COLLEGE STATION, SJR EMS PROVIDES NON-EMERGENCY MEDICAL RESP ONSE, CRITICAL GROUND AMBULANCE TRANSPORTATION, AND BACK-UP TO THE BRYAN AND COLLEGE STATI ON FIRE DEPARTMENTS, WHICH ARE THE PRIMARY 911 EMERGENCY MEDICAL RESPONDERS IN BRAZOS COUN TY IN BURLESON AND GRIMES COUNTIES, ST JOSEPH HOLDS THE 911 EMERGENCY RESPONSE CONTRACTS SJR EMS CURRENTLY SERVES 12 MUNICIPALITIES WITH ADVANCED LIFE SUPPORT CARE FROM 8 UNITS LO CATED IN BEDIAS, NAVASOTA, SOMERVILLE, CALDWELL, STONEHAM, MADISONVILLE, BRYAN, AND COLLEG E STATION SERVING AS A GATEWAY FOR SURROUNDING FACILITIES WITH 150,000 SQUARE MILE SERVICE AREA IN 2011,,SJR EMS RESPONDED TO A TOTAL OF 13,685 911 CALLS AND NON-EMERGENCY CALLS THESE CALLS INCLUDED SERVICES TO RURAL RESIDENTS THREE SJR EMS AMBULANCES ARE HOUSED IN GR IMES COUNTY, ONE OF WHICH IS LOCATED IN THE RURAL COMMUNITY OF STONEHAM THIS LOCATION WAS CHOSEN AFTER RESEARCH OF THE POPULATION GROWTH BY THE EMS DIRECTOR, TASK FORCE AND 911 CO ORDINATOR, WITH A GOAL OF REDUCING AMBULANCE RESPONSE TIME NOT ONLY ISRAPID RESPONSE CRIT ICAL WITH TRAUMA PATIENTS, BUT EARLY RECOGNITION AND TREATMENT FOR HEART ATTACK AND STROKE ARE ESSENTIAL TO SAVING LIVES DEFIBRILLATION IS MOST BENEFICIAL WHEN PERFORMED AS SOON A S POSSIBLE AFTER SUDDEN CARDIAC ARREST HAVING SJR EMS IN THIS RURAL LOCATION HELPSFULFILL SUCH A NEED IN RURAL GRIMES COUNTY CERTIFIED CHEST PAIN CENTER AND LEVEL II STROKE FACILI TY SJRHC, THE FIRST HOSPITAL IN THE REGION TO BECOME A CERTIFIED CHEST PAIN CENTER, ALSO R ECEIVED A FIVE-STAR RATING FROM HEALTHGRADES FORCORONARY INTERVENTIONAL PROCEDURES, ONE OF THE MOST COMMON PROCEDURES DONE TO HELP IMPROVE BLOOD FLOW TO THE HEART AN IMPORTANT PAR T OF GOOD CARDIAC OUTCOMES, ESPECIALLY FOR HEART ATTACK PATIENTS, IS RAPID DIAGNOSIS AND I NTERVENTION IN 2011 SJRHC WAS ABLE TO CLINICALLY INTERVENE IN 100% OF HEART ATTACK PATIEN TS WITHIN 90 MINUTES OF ARRIVAL TO THE EMERGENCY ROOM THAT LEVEL OF PERFORMANCE HAS BEEN SHOWN TO SAVE LIVES AND REQUIRES TREMENDOUS TEAMWORK AND DEDICATION SJRHC IS THE ONLY FAC ILITY THAT IS BOTH A LEVEL II STATE CERTIFIED FACI

Form and Line Reference	Explanation
PART VI, LINE 6	LITY AND IS ACCREDITED BY THE JOINT COMMISSION AS A CERTIFIED PRIMARY STROKE CENTER THE D EPARTMENT OF STATE HEALTH SERVICES HAS DESIGNATEDSJRHC AS A STATE OF TEXAS PRIMARY (LEVEL II) STROKE FACILITY - THE FIRST SUCH DESIGNATION IN THE REGION THIS DESIGNATION REPRESENT S THE COMMITMENT THAT SJRHC HAS TOWARDS TREATING PATIENTS WITH STROKE IN OUR COMMUNITY TH E STROKE CENTER IS COMPRISED OF A LARGE TEAM OF MEDICAL SPECIALISTS THAT ARE ABLE TO PROVI DE AROUND-THE-CLOCK CARE FOR PATIENTS SUFFERING FROM A STROKE IN ORDER TO RECEIVE A LEVEL II STROKE FACILITY DESIGNATION, A HOSPITAL MUST BE ABLE TO PROVIDE STROKE TREATMENT 24 HO URSA DAY, 7 DAYS A WEEK AND MEET ALL THE REQUIREMENTS SET FORTH BY THE DEPARTMENT OF STATE HEALTH SERVICES PATIENTS THAT PRESENT TO PRIMARY STROKE CENTERS FOR THEIR CARE HAVE IMPR OVED OUTCOMES AS COMPARED TO PATIENTS THAT DO NOT, UNDERSCORING, THE NEED AND IMPORTANCE O F THIS FACILITY IN THE AREA THE DESIGNATION OF PRIMARY STROKE FACILITY IS NEW AMONG HOSPI TALS IN TEXAS THERE ARE ONLY 21 SUCH FACILITIES IN THE STATE AND SJRHC IS CURRENTLY THE O NLY DESIGNATED FACILITY IT ITS REGION THEBRAZOS VALLEY IS IN REGION 7, AS DEFINED BY THE DEPARTMENT OF STATE HEALTH SERVICES, WHICH INCLUDES 30 COUNTIES SURROUNDING THE REGIONAL H EADQUARTERS IN TEMPLE THIS STATE DESIGNATION IS A REFLECTION OF INCREDIBLE TEAMWORK RURAL HEALTH CLINICSST JOSEPH'S IS COMMITTED TO RURAL HEALTH AND MEETING THE NEEDS OF RURAL CO MMUNITIES THE RURAL CLINICS ARE SET UP IN FURTHERANCE OF OUR MISSION TO PROVIDE EXCELLENT HEALTH CARE AND TO PROMOTE WELLNESS THROUGHOUT THE BRAZOS VALLEY IN TOTAL, THE 5 RURAL H EALTH CLINICS HAD59,760 PATIENT VISITS ATTENDED TO BY 9 PROVIDERS AND 8 MID-LEVEL PROVIDER S BURLESON COUNTYST JOSEPH CALDWELL FAMILY MEDICINE CLINIC IS A FAMILY MEDICINE CLINIC PR OVIDING HEALTH AND WELLNESS SERVICES TO ADULTS AND CHILDREN THE CLINIC OFFERS A FULL RANG E OF PRIMARY CARE, INCLUDING MINOR EMERGENCIES AND OFFICE SURGERY, GENERAL FAMILY MEDICINE , COMPREHENSIVE AND ROUTINEPHYSICALS, WELL WOMAN EXAMS, IMMUNIZATIONS, ALLERGY INJECTIONS, MINOR SUTURING, LAB SERVICES, DIAGNOSIS AND TREATMENT OF ACUTE ILLNESS SPECIALISTS VISIT ON A BI-WEEKLY BASIS LEE COUNTYST JOSEPH LEXINGTON FAMILY MEDICINE CLINIC IS A FAMILY ME DICINE CLINIC PROVIDING HEALTH AND WELLNESS SERVICES TO ADULTS AND CHILDREN THE CLINIC'S FULL RANGE OF PRIMARY CARE SERVICES INCLUDES PATIENT EDUCATION, SUTURING, TREATMENT OF EYE AND EAR PROBLEMS, COMPREHENSIVE AND ROUTINEPHYSICALS, WELL WOMAN EXAMS, IMMUNIZATIONS, AL LERGY INJECTIONS, INITIAL MANAGEMENT OF PATIENTS AND SOCIAL SERVICES THEY ALSO OFFER LAB TESTING, MINOR SURGICAL PROCEDURES, CHRONIC MEDICAL CONDITIONING, RADIOLOGY AND ADD TESTIN G MADISON COUNTYST JOSEPH NORMANGEE FAMILY HEALTH CENTER IS STAFFED WITH A FULL-TIME PHY SICIAN AND PHYSICIAN ASSISTANT THE CLINIC OFFERS A VARIETY OF PRIMARY CARE SERVICES INCLU DING GENERAL FAMILY MEDICAL SERVICES, CARE FOR MINOR INJURIES AND TEXAS HEALTH STEP EXAM THE CLINIC ALSO OFFERS BLOOD DRAWS,ROUTINE AND COMPREHENSIVE PHYSICALS, PREVENTATIVE HEALT H EXAMS, WELL WOMAN EXAMS, MANAGEMENT OF HIGH BLOOD PRESSURE, CHOLESTEROL, DIABETES, ADD/A DHD AND CARE FOR ACUTE MINOR ILLNESS AND INJURIES BELLVILLE ST JOSEPH HEALTH CENTERBELLVI LLE ST JOSEPH HEALTH CENTER (BELLVILLE) WAS ACQUIRED IN MARCH 1, 2013 BY ST JOSEPH HEALT H SYSTEM BELLVILLE IS A 32-BED ACUTE CARE FACILITY IN BELLVILLE, TEXAS OFFERING 24-HOUR E MERGENCY CARE, INPATIENT AND OUTPATIENT SERVICES FORMERLY KNOWN AS BELLVILLE GENERAL HOSP ITAL, THE FACILITY WAS ESTABLISHED IN 1928 AND PROVIDES THE ONLY HOSPITAL SERVICES WITHIN AUSTIN COUNTY

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	TX

Additional Data

Software ID:
Software Version:
EIN: 74-1282696
Name: ST JOSEPH REGIONAL HEALTH 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
ST JOSEPH REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 5 THE ASSESSMENT COVERED A NINE-COUNTY REGION CONSISTING OF THE FOLLOWING COUNTIES BRAZOS, BURLESON, GRIMES, LEON, MADISON, MONTGOMERY, ROBERTSON, WALKER, AND WASHINGTON RESIDENTS OF THESE COUNTIES PARTICIPATED IN INTERVIEWS, HOUSEHOLD SURVEYS, AND COMMUNITY DISCUSSION GROUPS (CDG'S) A SECONDARY DATA ANALYSIS AND COMPILATION WAS ALSO COMPLETED BY THE CENTER FOR COMMUNITY HEALTH DEVELOPMENT THE FULL CHNA CAN BE FOUND AT THE FOLLOWING ADDRESS HTTP //WWW ST-JOSEPH ORG/WORKFILES/BVREGIONALREPORT2013 PDF

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Form and Line Reference	Explanation
GRIMES ST JOSEPH HEALTH CENTER	PART V, SECTION B, LINE 5 THE ASSESSMENT COVERED A NINE-COUNTY REGION CONSISTING OF THE FOLLOWING COUNTIES BRAZOS, BURLESON, GRIMES, LEON, MADISON, MONTGOMERY, ROBERTSON, WALKER, AND WASHINGTON RESIDENTS OF THESE COUNTIES PARTICIPATED IN INTERVIEWS, HOUSEHOLD SURVEYS, AND COMMUNITY DISCUSSION GROUPS (CDG'S) A SECONDARY DATA ANALYSIS AND COMPILATION WAS ALSO COMPLETED BY THE CENTER FOR COMMUNITY HEALTH DEVELOPMENT THE FULL CHNA CAN BE FOUND AT THE FOLLOWING ADDRESS HTTP //WWW ST-JOSEPH ORG/WORKFILES/BVREGIONALREPORT2013 PDF

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Form and Line Reference	Explanation
ST JOSEPH REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 6A OTHER HOSPITAL FACILITIES PARTICIPATING IN THE CHNA WERE COLLEGE STATION MEDICAL CENTER, HUNTSVILLE MEMORIAL HOSPITAL, KINGWOOD MEDICAL CENTER, MEMORIAL HERMANN THE WOODLANDS, SCOTT & WHITE HEALTH SYSTEM, ST LUKE'S THE WOODLANDS, ST JOSEPH REGIONAL HEALTH SYSTEM (INCLUDING ST JOSEPH REGIONAL HEALTH CENTER, BURLESON ST JOSEPH HEALTH CENTER, MADISON ST JOSEPH HEALTH CENTER, AND GRIMES ST JOSEPH HEALTH CENTER)

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

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Form and Line Reference	Explanation
GRIMES ST JOSEPH HEALTH CENTER	PART V, SECTION B, LINE 6A OTHER HOSPITAL FACILITIES PARTICIPATING IN THE CHNA WERE COLLEGE STATION MEDICAL CENTER, HUNTSVILLE MEMORIAL HOSPITAL, KINGWOOD MEDICAL CENTER, MEMORIAL HERMANN THE WOODLANDS, SCOTT & WHITE HEALTH SYSTEM, ST LUKE'S THE WOODLANDS, ST JOSEPH REGIONAL HEALTH SYSTEM (INCLUDING ST JOSEPH REGIONAL HEALTH CENTER, BURLESON ST JOSEPH HEALTH CENTER, MADISON ST JOSEPH HEALTH CENTER, AND GRIMES ST JOSEPH HEALTH CENTER)

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Form and Line Reference	Explanation
ST JOSEPH REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 11 ST JOSEPH HEALTH SYSTEM'S INITIATIVE FOR 2014 FOCUSED ON THE AREAS OF GREATEST NEED USING INFORMATION FROM THE CHNA, ST JOSEPH HEALTH SYSTEM PROVIDED PROGRAMS TO IMPROVE THE HEALTH OF RESIDENTS SUCH AS COMMUNITY-BASED HEALTH SCREENINGS, EDUCATION, AWARENESS AND PREVENTION PROGRAMS, AS WELL AS IMPROVING ACCESS TO PRIMARY CARE PROVIDERS AND PROVIDING PROGRAMS AIMED AT HELPING SEDENTARY RESIDENTS BECOME MORE ACTIVE (ADDRESSING OBESITY) ST JOSEPH HEALTH SYSTEM ALSO PROVIDES UNCOMPENSATED HEALTH SERVICES TO RESIDENTS WHO QUALIFY FOR CHARITABLE CARE OR ARE COVERED THROUGH STATE AND FEDERAL PROGRAMS, SUCH AS MEDICARE AND MEDICAID, WHERE THE REIMBURSEMENT FOR SERVICES WE PROVIDE ARE LESS THAN THE COST OF PROVIDING THAT SERVICE

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Form and Line Reference	Explanation
GRIMES ST JOSEPH HEALTH CENTER	PART V, SECTION B, LINE 11 ST JOSEPH HEALTH SYSTEM'S INITIATIVE FOR 2014 FOCUSED ON THE AREAS OF GREATEST NEED USING INFORMATION FROM THE CHNA, ST JOSEPH HEALTH SYSTEM PROVIDED PROGRAMS TO IMPROVE THE HEALTH OF RESIDENTS SUCH AS COMMUNITY-BASED HEALTH SCREENINGS, EDUCATION, AWARENESS AND PREVENTION PROGRAMS, AS WELL AS IMPROVING ACCESS TO PRIMARY CARE PROVIDERS AND PROVIDING PROGRAMS AIMED AT HELPING SEDENTARY RESIDENTS BECOME MORE ACTIVE (ADDRESSING OBESITY) ST JOSEPH HEALTH SYSTEM ALSO PROVIDES UNCOMPENSATED HEALTH SERVICES TO RESIDENTS WHO QUALIFY FOR CHARITABLE CARE OR ARE COVERED THROUGH STATE AND FEDERAL PROGRAMS, SUCH AS MEDICARE AND MEDICAID, WHERE THE REIMBURSEMENT FOR SERVICES WE PROVIDE ARE LESS THAN THE COST OF PROVIDING THAT 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
ST JOSEPH REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 20E PATIENTS ARE PROCESSED TO CHARITY CARE IF THEY LIVE IN A CERTAIN ZIP CODE AND HAVE NOT PAID THEIR BILL

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
GRIMES ST JOSEPH HEALTH CENTER	PART V, SECTION B, LINE 20E PATIENTS ARE PROCESSED TO CHARITY CARE IF THEY LIVE IN A CERTAIN ZIP CODE AND HAVE NOT PAID THEIR BILL

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
ST JOSEPH REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 22D THE MAXIMUM AMOUNT THAT WILL BE CHARGED TO A PATIENT WHO HAS BEEN DEEMED ELIGIBLE FOR ST JOSEPH'S FINANCIAL ASSISTANCE PROGRAM IS BASED UPON THEIR INCOME LEVEL FOR PATIENTS WHOSE INCOME IS LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES, THE PATIENT WILL HAVE NO FINANCIAL OBLIGATION FOR THE SERVICES RECEIVED FOR PATIENTS WHOSE INCOME IS GREATER THAN OR EQUAL TO 200% OF FPG BUT LESS THAN 250% OF FPG, THEIR OBLIGATION WILL BE 10% OF BILLED CHARGES, NOT TO EXCEED 20% OF THE PATIENT'S ANNUAL FAMILY INCOME 10% OF BILLED CHARGES HAS BEEN DETERMINED TO BE WELL BELOW THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR PATIENTS WHO QUALIFY FOR CATASTROPHIC FINANCIAL ASSISTANCE, THEIR OBLIGATION WILL BE 20% OF BILLED CHARGES, NOT TO EXCEED 20% OF THE PATIENT'S ANNUAL FAMILY INCOME 20% OF BILLED CHARGES HAS BEEN DETERMINED TO BE WELL BELOW THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES

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
GRIMES ST JOSEPH HEALTH CENTER	PART V, SECTION B, LINE 22D THE MAXIMUM AMOUNT THAT WILL BE CHARGED TO A PATIENT WHO HAS BEEN DEEMED ELIGIBLE FOR ST JOSEPH'S FINANCIAL ASSISTANCE PROGRAM IS BASED UPON THEIR INCOME LEVEL FOR PATIENTS WHOSE INCOME IS LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES, THE PATIENT WILL HAVE NO FINANCIAL OBLIGATION FOR THE SERVICES RECEIVED FOR PATIENTS WHOSE INCOME IS GREATER THAN OR EQUAL TO 200% OF FPG BUT LESS THAN 250% OF FPG, THEIR OBLIGATION WILL BE 10% OF BILLED CHARGES, NOT TO EXCEED 20% OF THE PATIENT'S ANNUAL FAMILY INCOME 10% OF BILLED CHARGES HAS BEEN DETERMINED TO BE WELL BELOW THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR PATIENTS WHO QUALIFY FOR CATASTROPHIC FINANCIAL ASSISTANCE, THEIR OBLIGATION WILL BE 20% OF BILLED CHARGES, NOT TO EXCEED 20% OF THE PATIENT'S ANNUAL FAMILY INCOME 20% OF BILLED CHARGES HAS BEEN DETERMINED TO BE WELL BELOW THE AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16	FINANCIAL ASSISTANCE POLICY WEBSITE AVAILABILITY

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
ST JOSEPH REGIONAL MEDICAL CENTER PART V, SECTION B, LINE 16A WEBSITE	HTTP //WWW ST-JOSEPH ORG/FINANCIALASSISTANCEPOLICY

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
ST JOSEPH REGIONAL MEDICAL CENTER PART V, SECTION B, LINE 16B WEBSITE	HTTP //WWW ST-JOSEPH ORG/FINANCIALASSISTANCEPOLICY

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
GRIMES ST JOSEPH HEALTH CENTER PART V, SECTION B, LINE 16A WEBSITE	HTTP //WWW ST-JOSEPH ORG/FINANCIALASSISTANCEPOLICY

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
GRIMES ST JOSEPH HEALTH CENTER PART V, SECTION B, LINE 16B WEBSITE	HTTP //WWW ST-JOSEPH ORG/FINANCIALASSISTANCEPOLICY

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," to 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*.**

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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" to 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 non-cash assistance	(h) Purpose of grant or assistance
(1) ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN,TX 77802	74-2847594	501(C)(3)	1,282,477		N/A	N/A	PROGRAM SUPPORT
(2) ST JOSEPH REGIONAL HEALTH PARTNERS 2801 FRANCISCAN DRIVE BRYAN,TX 77802	45-4088170	501(C)(3)	800,033		N/A	N/A	PROGRAM SUPPORT
(3) BURLESON ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN,TX 77802	74-2913931	501(C)(3)	919,855		N/A	N/A	PROGRAM SUPPORT
(4) BELLVILLE ST JOSEPH HEALTH CENTER 44 N CUMMINGS BELLVILLE,TX 77418	27-4005511	501(C)(3)	3,770,868		N/A	N/A	PROGRAM SUPPORT
(5) ST JOSEPH HEALTH PARTNERS ACO 2801 FRANCISCAN DRIVE BRYAN,TX 77802	46-3265423	501(C)(3)	10,830		N/A	N/A	PROGRAM SUPPORT

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . ▶ 5

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" to 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 non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance

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

Return Reference	Explanation
PART I, LINE 2	ST JOSEPH REGIONAL HEALTH CENTER HAS A CENTRALIZED GRANT SYSTEM IN PLACE TO HELP ENSURE THAT GRANTS ARE (1) APPROPRIATELY PREPARED AND REVIEWED BY MANAGEMENT FOR COMPLETENESS AND ACCURACY, (2) MONITORED FOR APPROPRIATE DISTRIBUTION TO THE APPLICANT/RECIPIENT HOSPITAL COST CENTER (RECIPIENT), AND (3) MONITORED FOR APPROPRIATE DISTRIBUTION OF FUNDS BY THE APPLICANT (RECIPIENT)

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" to 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*.**

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☑ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☑ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes 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	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
	☑ Compensation committee	☐ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☐ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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

For each individual whose compensation must be reported in 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 in prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	TEMPORARY HOUSING ALLOWANCES ARE TREATED AS WAGES TO THE EMPLOYEE AND THEY ARE TAXED ACCORDINGLY NONE OF THE INDIVIDUALS LISTED IN THIS SCHEDULE RECEIVED HOUSING BENEFITS DURING 2014 THE EMPLOYER REIMBURSES EMPLOYEES $10 50 A MONTH FOR HEALTH CLUB MEMBERSHIPS AND IT IS TREATED AS WAGES AND TAXED ACCORDINGLY ALL EMPLOYEES LISTED IN THE FORM 990, PART VII, SECTION A, LINE 1A ARE ELIGIBLE FOR THIS STIPEND
PART I, LINE 3	PART II, COMPENSATION OF SR NANCY SURMA SR NANCY SURMA, OSF, PHD WORKS 40 HOURS A WEEK FOR SYLVANIA FRANCISCAN HEALTH BUT DOES NOT RECEIVE A W-2 ALL COMPENSATION EARNED WAS PAID TO THE SISTERS OF ST FRANCIS OF SYLVANIA OHIO'S CONGREGATION IN ACCORDANCE WITH IRS REVENUE RULING 77-290 PART II, COMPENSATION OF ODETTE BOLANO ODETTE BOLANO, PRESIDENT/CEO OF ST JOSEPH REGIONAL HEALTH CENTER RECEIVED COMPENSATION FROM ASCENCION, AN UNRELATED ORGANIZATION PART II, COMPENSATION OF JAMES SCHUESSLER JAMES SCHUESSLER, INTERIM PRESIDENT/CEO OF ST JOSEPH REGIONAL HEALTH CENTER RECEIVED COMPENSATION FROM B E SMITH, AN UNRELATED ORGANIZATION
PART I, LINE 4B	DURING THE 2014 CALENDAR YEAR CATHOLIC HEALTH INITIATIVES (CHI), A RELATED ORGANIZATION, MAINTAINED A SUPPLEMENTAL NON-QUALIFIED DEFERRED COMPENSATION PLAN FOR MBO CEOS AND OTHER CHI EMPLOYEES AT THE LEVEL OF SENIOR VICE PRESIDENT AND ABOVE THE FOLLOWING REPORTABLE INDIVIDUAL WAS ELIGIBLE TO PARTICIPATE IN THAT PLAN NAME OF INDIVIDUAL JAMES POPE DURING 2014 THE FOLLOWING CONTRIBUTIONS WERE MADE BY CHI TO THE DEFERRED COMPENSATION PLAN JAMES POPE - $19,200

Additional Data

Software ID:
Software Version:
EIN: 74-1282696
Name: ST JOSEPH REGIONAL HEALTH CENTER

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 (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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 in prior Form 990
1 MICHAEL STEINES MD, TRUSTEE	(I)	0	0	0	0	0	0	0
	(II)	609,219	173,439	0	5,142	15,973	803,773	0
1 JAMES W POPE, EX-OFFICIO TRUSTEE	(I)	0	0	0	0	0	0	0
	(II)	680,651	373,556	155,522	29,600	24,232	1,263,561	0
2 ODETTE BOLANO, PRES/CEO, EX-OFFICIO TRUSTEE PART YR	(I)	457,998	0	0	0	0	457,998	0
	(II)	0	0	0	0	0	0	0
3 KATHLEEN KRUSIE, COO	(I)	331,743	48,442	0	10,400	17,972	408,557	0
	(II)	0	0	0	0	0	0	0
4 DANIEL GOGGIN, CFO	(I)	324,960	48,347	0	10,400	17,971	401,678	0
	(II)	0	0	0	0	0	0	0
5 HERMAN BLANTON, CHIEF MEDICAL OFFICER	(I)	186,685	0	0	7,523	4,198	198,406	0
	(II)	0	0	0	0	0	0	0
6 MICHAEL RUSSO, VP/INFORMATION SERVICES	(I)	218,647	31,363	0	9,681	18,428	278,119	0
	(II)	0	0	0	0	0	0	0
7 MICHAEL COSTA, VP/HUMAN RESOURCES	(I)	215,150	29,463	0	9,879	17,624	272,116	0
	(II)	0	0	0	0	0	0	0
8 STEVE CRICHTON, VP/SUPPORT SERVICES	(I)	174,730	25,580	0	7,943	11,197	219,450	0
	(II)	0	0	0	0	0	0	0
9 DONOVAN FRENCH, VP/STRATEGY & SERVICE LINES	(I)	154,461	22,185	0	4,561	10,991	192,198	0
	(II)	0	0	0	0	0	0	0
10 RICARDO DIAZ, VP/CLINICAL SUPPORT	(I)	202,569	28,307	0	3,656	18,352	252,884	0
	(II)	0	0	0	0	0	0	0
11 STEWART BROOKS, PHYSICIAN ASSISTANT	(I)	185,377	0	0	6,634	18,138	210,149	0
	(II)	0	0	0	0	0	0	0
12 JON CHRISTOPHER TEACLE, PHYSICIAN ASSISTANT	(I)	186,824	0	0	6,143	17,308	210,275	0
	(II)	0	0	0	0	0	0	0
13 JOSEPH HLAVIN, PHYSICIAN ASSISTANT	(I)	166,654	20,000	0	5,589	18,120	210,363	0
	(II)	0	0	0	0	0	0	0
14 LAURA SURVANT, EXECUTIVE DIRECTOR	(I)	178,239	5,082	0	3,675	6,864	193,860	0
	(II)	0	0	0	0	0	0	0
15 GARY HINES, CLINICAL STAFF PHARMACIST	(I)	158,486	0	1,987	6,506	11,538	178,517	0
	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part 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

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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	BRAZOS COUNTY HEALTH FACILITIES DEVELOPMENT CORP	76-0082643	105911BV2	06-18-2008	30,075,687	REFUND 2007 BONDS / CONSTR / RENOV		X		X		X
B	BRAZOS COUNTY HEALTH FACILITIES DEVELOPMENT CORP	76-0082643		05-15-2014	25,255,000	REFUND 2002 BONDS & PAY DEBT ISSUANCE COSTS		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	3,020,000			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	33,414,868	25,573,596		
4	Gross proceeds in reserve funds	3,339,182	318,596		
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	586,513	328,061		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	26,489,173			
11	Other spent proceeds	3,000,000	24,926,939		
12	Other unspent proceeds				
13	Year of substantial completion	2009	2014		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X		X					
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?	X		X					
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	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				
2	Are there any lease arrangements that may result in private business use of bond-financed property?	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					
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				
c	Are there any research agreements that may result in private business use of bond-financed property?		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 %				
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 %				
6	Total of lines 4 and 5		0 %		0 %				
7	Does the bond issue meet the private security or payment test?		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				
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				

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				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X		X				
b	Exception to rebate?		X		X				
c	No rebate due?	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				
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		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				
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				
7	Has the organization established written procedures to monitor the requirements of section 148?		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				

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

Return Reference	Explanation
PART III, LINE 9 AND PART IV, LINE 7, PART V	IN CONNECTION WITH THE ACQUISITION BY CATHOLIC HEALTH INITIATIVES (CHI) NOVEMBER 2014, ST JOSEPH REGIONAL HEALTH CENTER BECAME SUBJECT TO CHI'S WRITTEN POLICIES AND PROCEDURES

Return Reference	Explanation
PART III, LINE 7	ST JOSEPH REGIONAL HEALTH CENTER MONITORS THE PRIVATE BUSINESS USE PERCENTAGE FOR EACH BOND ISSUE, AND THEREFORE, HAS NOT CALCULATED THE AMOUNT OF PRIVATE PAYMENTS BECAUSE ST JOSEPH HAS NOT CALCULATED THE AMOUNT OF PRIVATE PAYMENTS, SOLELY FOR SCHEDULE K REPORTING PURPOSES, WE HAVE ASSUMED THAT THE PRIVATE PAYMENT TEST HAS NOT BEEN MET

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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	(d) Corrected? 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? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? 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) BRAZOS VALLEY PATHOLOGY	BOARD MEMBER MICHAEL COHEN IS A DIRECTOR FOR BRAZOS VALLEY PATHOLOGY	254,024	BRAZOS VALLEY PATHOLOGY SERVICES THAT ARE PAID BY ST JOSEPH REGIONAL HEALTH CENTER		No

Part V Supplemental Information

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

Return Reference	Explanation

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SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization	Employer identification number
ST JOSEPH REGIONAL HEALTH CENTER	74-1282696

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 4	EFFECTIVE NOVEMBER 1, 2014 THE ORGANIZATION'S PARENT CORPORATION WAS TRANSFERRED FROM SYLVANIA FRANCISCAN HEALTH TO CATHOLIC HEALTH INITIATIVES (CHI) AS A RESULT A PORTION OF THE BYLAWS WERE UPDATED TO REFLECT THIS CHANGE IN OWNERSHIP

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	BYLAWS SECTION 1 MEMBERSHIP THE MEMBERSHIP OF THE CORPORATION SHALL CONSIST OF ONE (1) CLASS AND THE ONLY MEMBER OF THE CORPORATION SHALL BE ST JOSEPH SERVICES CORPORATION, D/B/A ST JOSEPH HEALTH SYSTEM, A TEXAS NON-PROFIT CORPORATION (HEREINAFTER REFERRED TO AS ST JOSEPH HEALTH SYSTEM OR "SJHS" OR THE MEMBER)

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE POWER TO ELECT ALL MEMBERS OF THE BOARD OF TRUSTEES OF IS RESERVED EXCLUSIVELY TO ST JOSEPH SERVICES CORPORATION AS SOLE MEMBER, BUT SHALL BE SUBJECT TO THE APPROVAL OF THE CORPORATE MEMBER OF ST JOSEPH SERVICES CORPORATION WHEN REQUIRED BY ITS ARTICLES OF INCORPORATION OR BYLAWS

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	ACTION BY THE MEMBER OF THE CORPORATION SHALL BE REQUIRED, AND SHALL BE SUFFICIENT, A) TO ADOPT OR CHANGE THE PHILOSOPHY, OBJECTIVES, PURPOSES OR ETHICAL OR RELIGIOUS STANDARDS OF THE CORPORATION AND OF ORGANIZATIONS CONTROLLED BY THE CORPORATION, B) TO REMOVE THE TRUSTEES AT WILL, WITH OR WITHOUT CAUSE AS PROVIDED IN ARTICLE V, SECTION 2, C) TO ELECT, APPOINT AND REMOVE ANY OFFICER AND CHAIRPERSON OF ANY COMMITTEE OF THE CORPORATION, D) TO AMEND OR REPEAL THE ARTICLES OF INCORPORATION AND THE BYLAWS OF THE CORPORATION AS PROVIDED IN ARTICLE XIII, E) TO DISSOLVE OR TERMINATE THE EXISTENCE OF THE CORPORATION OR TO REVOKE ANY PROCEEDING FOR ITS VOLUNTARY DISSOLUTION AND TO DETERMINE THE DISTRIBUTION OF ASSETS UPON ANY APPROVED DISSOLUTION OR TERMINATION IN ACCORDANCE WITH THE ARTICLES OF INCORPROATION, F) TO SATISFY ALL REQUIREMENTS APPLICABLE TO NON-PROFIT CORPORATIONS UNDER STATE LAW, G) TO TAKE ANY ACTION NECESSARY TO CONFORM THE PURPOSES AND ACTIVITIES OF THE CORPORATION AND OF ORGANIZATIONS CONTROLLED BY THE CORPORATION WITH THE TRADITIONS, TEACHINGS AND CANON LAW OF THE ROMAN CATHOLIC CHURCH AS THEY MAY BE IN EFFECT FROM TIME TO TIME, H) TO APPROVE ANY TRANSACTION, AGREEMENT, ARRANGEMENT OR CLAIM TO WHICH THE CORPORATION IS A PARTY THAT INVOLVES A POTENTIAL CONFLICT OF INTEREST AS DEFINED IN ARTICLE IX, I) TO APPROVE ANY MERGER OR CONSOLIDATION OF THE CORPORATION AND ANY SALE OF SUBSTANTIALLY ALL OF ITS ASSETS, J) TO AUTHORIZE THE CREATION OF ANY SUBSIDIARY ORGANIZATION OR THE AFFILIATION OF THE CORPORATION WITH ANY OTHER ENTITY FOR THE PURPOSE OF THE JOINT CONDUCT OF BUSINESS OR OTHER PROGRAMS, WHETHER IN THE FORM OF PARTICIPANT IN A CORPORATION, PARTNERSHIP, JOINT VENTURE, CO-TENANCY OR ANY OTHER FORM OF OWNERSHIP AND CONTROL, K) TO APPROVE THE CONVEYANCE OF REAL PROPERTY OR THE GRANTING OF MORTGAGES OR TRUST DEEDS OR THE CREATION OF OTHER LIENS UPON REAL PROPERTY OWNED BY THE CORPORATION, L) TO APPROVE CONVEYING ANY TANGIBLE PERSONAL PROPERTY, INCURRING ANY DEBT OR SERIES OF DEBTS, GUARANTEEING OF ANY DEBT OR SERIES OF DEBTS, OR THE GRANTING OF ANY SECURITY INTEREST OR OTHER LIEN IN THE PROPERTY OF THE CORPORATION IN EXCESS OF THE AMOUNT PRESCRIBED FROM TIME TO TIME BY THE MEMBER, M) TO APPROVE ANY CAPITAL EXPENDITURE OR GRANT, OR SERIES OF CAPITAL EXPENDITURES OR GRANTS IN EXCESS OF THE AMOUNT PRESCRIBED FROM TIME TO TIME BY THE MEMBER, N) TO APPROVE THE ANNUAL OPERATING AND CAPITAL BUDGETS OF THE CORPORATION AND RELATED ORGANIZATIONS, O) TO APPROVE OF THE ADDITION OR TERMINATION OF SERVICES, P) TO APPROVE THE CORPORATION'S AUDITOR, Q) TO APPROVE THE CORPORATION'S STRATEGIC PLAN, R) TO EXERCISE THE POWER OF APPROVAL RESERVED BY THE CORPORATION OVER ACTIONS OF THE GOVERNING BODIES OF ITS SUBSIDIARY ORGANIZATIONS OR AFFILIATED ENTITIES, AND S) TO APPROVE OF ANY OTHER ACT FOR WHICH MEMBERSHIP APPROVAL IS REQUIRED UNDER APPLICABLE CANON OR CIVIL LAW, THE ARTICLES OF INCORPORATION, OR THESE BYLAWS THE MEMBERS OF THE BOARD OF TRUSTEES SHALL BE RELIEVED FROM LIABILITY FOR MANAGERIAL ACTS OR OMISSIONS IMPOSED UPON MEMBERS OF BOARDS OF TRUSTEES BY LAW, TO THE EXTENT THAT, AND AS LONG AS, ANY DISCRETIONARY POWER IN THE MANAGEMENT OF CORPORATE AFFAIRS IS EXERCISED BY THE MEMBER PURSUANT TO THIS SECTION AND THE ARTICLES OF INCORPORATION

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11	THE FORM 990 AND ACCOMPANYING SCHEDULES WERE MADE AVAILABLE TO ALL TRUSTEES EITHER ELECTRONICALLY OR BY HARD COPY, DEPENDING UPON THE TRUSTEES PREFERENCE, BEFORE THE COMPANY FINALIZED AND SENT THE DOCUMENTS TO THE IRS THIS DRAFT WAS ALSO AVAILABLE AT THE ADMINISTRATIVE OFFICES OF THE REPORTING ENTITY FOR TRUSTEES'S REVIEW BEFORE THE FINAL FORM 990 AND ACCOMPANYING SCHEDULES WERE FINALIZED AND SENT TO THE IRS THE REVIEW WAS UNDER THE DIRECTION OF THE CFO AND/OR TAX RETURN PREPARERS, PLANTE & MORAN, PLLC, IF REQUESTED BY THE TRUSTEES

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	DESCRIPTION OF PERSONS COVERED UNDER THE CONFLICT OF INTEREST POLICY IN ACCORDANCE WITH THE ST JOSEPH HEALTH SYSTEM POLICY NO 38, "CONFLICT OF INTEREST" ANY BOARD MEMBER, TRUSTEE, GOVERANCE COUNCIL MEMBER, BOARD COMMITTEE MEMBER, CORPORATE OFFICER, EXECUTIVE, MEDICAL STAFF MEMBER,LICENSED INDEPENDENT PRACTICTIONER (LIP), DEPARTMENT DIRECTOR, SUPERVISOR, OR OTHER INDIVIDUAL THAT HAS A FINANCIAL INTEREST DESCRIPTION OF PROCESS TO MONITOR TRANSACTION FOR CONFLICTS OF INTEREST IN ACCORDANCE WITH THE ST JOSEPH HEALTH SYSTEM POLICY NO 38, "CONFLICT OF INTEREST", SECTION 6, DISCLOSURE STATEMENT "A CONFLICT OF INTEREST SHALL BE RETAINED BY THE CORPORATION IN ITS ADMINISTRATIVE OFFICE THIS STATEMENT SHALL BE RENEWED AT LEAST ANNUALLY AT THE REQUEST OF THE CORPORATION AND AT ANY TIME THAT A CONFLICT OF INTEREST MAY ARISE" TO HELP ENSURE THAT DISCLOSURE STATEMENTS ARE COMPLETED ANNUALLY BY ALL BOARD OF TRUSTEE MEMBERS, THE CEO'S OFFICE SUMMARIZES ALL CONFLICTS OF INTEREST DISCLOSED BY EACH ENTITY'S TRUSTEES IN 2012, THE SUMMARY WAS PRESENTED AS AN AGENDA ITEM AT EACH ENTITY'S BOARD OF TRUSTEES MEETINGS HELD IN APRIL 2012, THE AGENDA ITEM WAS TITLED, "CONFLICT OF INTEREST DISCLOSURE REVIEW" OR SIMILAR DESCRIPTION THE REVIEW IS PERFORMED BY THE OFFICE OF THE CEO WHERE DISCLOSURE STATEMENTS ARE ALSO FILED FOR TRUSTEES OTHER DESIGNATED PERSONS DISCLOSURE STATEMENTS ARE FILED IN INDIVIDUAL PERSONNEL FILES IF EMPLOYED BY ST JOSEPH REGIONAL HEALTH CENTER WHEN A CONFLICT OF INTEREST IS IDENTIFIED, THE INTERESTED PERSON SHALL LEAVE THE MEETING AT WHICH THE DETERMINATION OF A CONFLICT OF INTEREST IS DISCUSSED AND VOTED UPON

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15B	OFFICES & POSITIONS FOR WHICH PROCESS WAS USED THE EXECUTIVE COMMITTEE OF THE SJHS BOARD OF TRUSTEES ENGAGED AN INDEPENDENT COMPENSATION CONSULTANT THAT COMPILED AND PRESENTED RECOMMENDATIONS BASED ON HEALTHCARE MARKET DATA FOR ORGANIZATIONS OF SIMILAR SIZE AND REVENUE THE EXECUTIVE COMMITTEE PRESENTED THE RECOMMENDATIONS TO THE FULL SJHS BOARD OF TRUSTEES FOR APPROVAL AT ITS REGULARLY SCHEDULED MEETING THE EXECUTIVE COMMITTEE AND THE SJHS BOARD OF TRUSTEES MAINTAIN DOCUMENTATION AND MINUTES OF ITS DELIBERATIONS THE FOLLOWING POSITIONS WERE REVIEWED BY THE EXECUTIVE COMMITTEE AND APPROVED BY THE BOARD OF TRUSTEES PRESIDENT, COO, SENIOR VICE PRESIDENT, CEO/ADMINISTRATOR, EXECUTIVE DIRECTOR THE EXECUTIVE COMMITTEE IS COMPRISED OF CURRENT MEMBERS OF THE BOARD OF TRUSTEES, WHO ARE INDEPENDENT OF SJHS SETTLEMENT, HAVE NO PERSONAL INTEREST IN THE COMPENSATION ARRANGEMENTS, AND ARE NOT RELATED TO, OR UNDER THE CONTROL OF ANY INDIVIDUAL WHOSE COMPENSATION ARRANGEMENT IS BEING REVIEWED AND HAVE NO MATERIAL BUSINESS RELATIONSHIP WITH SJHS THIS PROCESS WAS LAST UNDERTAKEN IN 2014

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY & FINANCIAL STATEMENTS ARE NOT MADE AVAILABLE TO THE PUBLIC

Return Reference	Explanation
FORM 990, PART VI, LINES 13 AND 14	WHISTLEBLOWER POLICY AND DOCUMENT RETENTION AND DESTRUCTION POLICY THE ORGANIZATION FOLLOWS THE POLICIES OF THE ST JOSEPH HEALTH SYSTEM TO WHICH IT IS AN AFFILIATE THE POLICY INCLUDES THE WHISTLEBLOWER POLICY AND THE DOCUMENT RETENTION POLICY, WHICH ARE DOCUMENTED AND APPROVED BY THE PRESIDENT AND CEO OF THE SYSTEM THE BYLAWS OF ST JOSEPH STATE "THE PRESIDENT/CEO SHALL HAVE ALL AUTHORITY AND RESPONSIBILITY NECESSARY TO OPERATE THE CORPORATION IN ALL ITS ACTIVITIES AND DEPARTMENTS, SUBJECT ONLY TO SUCH POLICIES AS MAY BE ISSUED BY THE BOARD THE PRESIDENT/CEO SHALL ACT AS A DULY AUTHORIZED REPRESENTATIVE OF THE BOARD AND OF THE CORPORATION IN ALL MATTERS IN WHICH IT HAS NOT DESIGNATED SOME OTHER PERSON TO ACT " THEREFORE, THE PRESIDENT/CEO, BY THE AUTHORITY GRANTED TO HIM IN THE ABOVE PARAGRAPH, APPROVES THE POLICIES THE TWO POLICIES WERE APPROVED BY THE ST JOSEPH HEALTH SYSTEM BOARD AT THE LAST 2012 BOARD MEETING

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN FEES PROGRAM SERVICE EXPENSES 35,953,554 MANAGEMENT AND GENERAL EXPENSES 205,743 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 36,159,297 PURCHASED SERVICES PROGRAM SERVICE EXPENSES 9,458,830 MANAGEMENT AND GENERAL EXPENSES 8,446,398 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 17,905,228 BILLING & COLLECTION FEES PROGRAM SERVICE EXPENSES 1,081,441 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1,081,441 OTHER FEES PROGRAM SERVICE EXPENSES 1,976,585 MANAGEMENT AND GENERAL EXPENSES 1,179,470 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,156,055 PURCHASED MAINTENANCE PROGRAM SERVICE EXPENSES 702,125 MANAGEMENT AND GENERAL EXPENSES 193,985 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 896,110

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN BENEFICIAL INTEREST IN FOUNDATION 21,483,124 REVALUATION OF BALANCE SHEET DUE TO CHI ACQUISITION 15,737,536 GAIN UNDER INTEREST RATE SWAP AGREEMENTS 848,274 OTHER ADJUSTMENTS -839,955

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE COMMITTEE THAT ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT AND SELECTION OF THE INDEPENDENT ACCOUNTANT HAS NOT CHANGED ITS OVERSIGHT PROCESS OR SELECTION PROCESS FROM THE PRIOR YEAR

Return Reference	Explanation
FORM 990 SCHEDULE R, PART II	THE RELATED TAX-EXEMPT ORGANIZATIONS ARE ALL MEMBERS OF GROUP EXEMPTION #0928

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
ST JOSEPH REGIONAL HEALTH CENTER

Employer identification number
74-1282696

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

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

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(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	
See Additional Data Table												

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
See Additional Data Table									

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

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

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

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

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE R, PART III	THE RELATED TAX EXEMPT ORGANIZATIONS ARE ALL MEMBERS OF GROUP EXEMPTION #0928

Additional Data

Software ID:
Software Version:
EIN: 74-1282696
Name: ST JOSEPH REGIONAL HEALTH CENTER

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
(1) ALEGENT CREIGHTON CLINIC 12809 W DODGE RD OMAHA, NE 68154 47-0765154	HEALTHCARE	NE	501(C)(3)	LINE 3	ACH	Yes	
(1) ALEGENT CREIGHTON HEALTH 12809 W DODGE RD OMAHA, NE 68154 47-0757164	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(2) ALEGENT CREIGHTON HEALTH FOUNDATION 12809 W DODGE RD OMAHA, NE 68154 47-0648586	FUNDRAISING	NE	501(C)(3)	LINE 7	ACH	Yes	
(3) ALEGENT HEALTH - BERGAN MERCY HEALTH SYSTEM 7500 MERCY RD OMAHA, NE 68124 47-0484764	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(4) ALEGENT HEALTH - COMMUNITY MEMORIAL HOSPITAL OF MISSOURI VALLEY IA 631 N 8TH ST MISSOURI VALLEY, IA 51555 42-0776568	HEALTHCARE	IA	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(5) ALEGENT HEALTH - IMMANUEL MEDICAL CENTER 6901 N 72ND ST OMAHA, NE 68122 47-0376615	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(6) ALEGENT HEALTH - MEMORIAL HOSPITAL SCHUYLER 104 W 17TH ST SCHUYLER, NE 68661 47-0399853	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(7) ALEGENT HEALTH - MERCY HOSPITAL CORNING IOWA PO BOX 368 CORNING, IA 50841 42-0782518	HEALTHCARE	IA	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(8) ALVERNA APARTMENTS 300 SE 8TH AVE LITTLE FALLS, MN 56345 41-1351177	LTERM CARE	MN	501(C)(3)	LINE 9	CHI	Yes	
(9) APPLETREE COURT 601 OAK ST BRECKENRIDGE, MN 56520 41-1850500	SENIOR LIVING	MN	501(C)(3)	LINE 9	SFH	Yes	
(10) BISHOP DRUMM RETIREMENT CENTER 1111 6TH AVE DES MOINES, IA 50314 42-0725196	LTERM CARE	IA	501(C)(3)	LINE 9	CHI-IA CORP	Yes	
(11) BORNEMANN HEALTHCARE CORPORATION 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-2187242	HEALTHCARE	PA	501(C)(3)	LINE 11	CHI	Yes	
(12) CARRINGTON HEALTH CENTER 800 N 4TH ST CARRINGTON, ND 58421 45-0227311	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(13) CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 47-0617373	HEALTHCARE	CO	501(C)(3)	LINE 9	N/A	Yes	
(14) CATHOLIC HEALTH INITIATIVES - COLORADO 188 INVERNESS DRIVE WEST STE 500 ENGLEWOOD, CO 80112 84-0405257	HEALTHCARE	CO	501(C)(3)	LINE 3	CHI	Yes	
(15) CATHOLIC HEALTH INITIATIVES - IOWA CORP 1111 6TH AVE DES MOINES, IA 50314 42-0680448	HEALTHCARE	IA	501(C)(3)	LINE 3	CHI	Yes	
(16) CATHOLIC HEALTH INITIATIVES COLORADO FOUNDATION 6385 CORPORATE DR STE 301 COLORADO SPRINGS, CO 80919 84-0902211	FUNDRAISING	CO	501(C)(3)	LINE 7	CHIC	Yes	
(17) CATHOLIC HEALTH INITIATIVES NATIONAL FOUNDATION 6385 CORPORATE DR COLORADO SPRINGS, CO 80919 27-0930004	FUNDRAISING	CO	501(C)(3)	LINE 11	CHI	Yes	
(18) CATHOLIC HEALTH INITIATIVES VIRTUAL HEALTH SERVICES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-0992796	HEALTHCARE	CO	501(C)(3)	LINE 11	CHINS	Yes	
(19) CENTENNIAL MEDICAL GROUP INC 2700 STEWART PKWY ROSEBURG, OR 97471 26-3946191	PHYSICIANS	OR	501(C)(3)	LINE 9	MMC	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(21) CENTRAL KANSAS MEDICAL CENTER 3515 BROADWAY GREAT BEND, KS 67530 48-0543724	SURGERY CENTER	KS	501(C)(3)	LINE 3	CHI	Yes	
(1) CHI HEALTH CONNECT AT HOME - FARGO 4816 AMBER VALLEY PKWY S FARGO, ND 58104 27-1966847	HEALTHCARE	MN	501(C)(3)	LINE 9	CHI	Yes	
(2) CHI INSTITUTE FOR RESEARCH AND INNOVATION 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-1050565	HEALTHCARE	CO	501(C)(3)	LINE 11	CHI	Yes	
(3) CHI KENTUCKY INC 3900 OLYMPIC BLVD STE 400 ERLANGER, KY 41018 20-2741651	HEALTHCARE	KY	501(C)(3)	LINE 11	CHI	Yes	
(4) CHI NATIONAL HOME CARE 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-1261716	HEALTHCARE	CO	501(C)(3)	LINE 9	CHI NS	Yes	
(5) CHI NATIONAL SERVICES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-2532084	HEALTHCARE	CO	501(C)(3)	LINE 11	CHI	Yes	
(6) CHI NEBRASKA 6940 O ST STE 200 LINCOLN, NE 68510 36-3233121	HEALTHCARE	NE	501(C)(3)	LINE 11	CHI	Yes	
(7) CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE MEDICAL CENTER 6624 FANNIN ST HOUSTON, TX 77030 74-1161938	HEALTHCARE	TX	501(C)(3)	LINE 3	SLHS	Yes	
(8) CHI ST VINCENT HOSPITAL HOT SPRINGS 300 WERNER ST HOT SPRINGS, AR 71913 71-0236913	HEALTHCARE	AR	501(C)(3)	LINE 3	CHISVHS	Yes	
(9) CHI ST VINCENT HOT SPRINGS 300 WERNER ST HOT SPRINGS, AR 71913 26-1125064	HOLDING CO	AR	501(C)(3)	LINE 11	SVIMC	Yes	
(10) CHI ST VINCENT MEDICAL GROUP HOT SPRINGS 1 MERCY LANE STE 201 HOT SPRINGS, AR 71913 26-1125131	HEALTHCARE	AR	501(C)(3)	LINE 3	CHISVHS	Yes	
(11) COMMUNITY LIMITED CARE DIALYSIS CENTER 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 23-7419853	HOLDING CO	OH	501(C)(2)		GSH	Yes	
(12) COMMUNITY MEMORIAL HOSPITAL MEDICAL SERVICE FOUNDATION 631 N 8TH ST MISSOURI VALLEY, IA 51555 42-1294399	FUNDRAISING	IA	501(C)(3)	LINE 11	AH-CMHMV	Yes	
(13) CONTINUING CARE HOSPITAL 150 NORTH EAGLE CREEK DR LEXINGTON, KY 40509 61-1400619	LT ACH	KY	501(C)(3)	LINE 3	SJHS	Yes	
(14) COVENANT HOME CARE 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2028429	HOME HEALTH	PA	501(C)(3)	LINE 11	CHI NHC	Yes	
(15) ENUMCLAW REGIONAL HOSPITAL ASSOCIATION 1450 BATTERSBY AVE ENUMCLAW, WA 98022 91-0715805	HEALTHCARE	WA	501(C)(3)	LINE 3	FHS	Yes	
(16) FLAGET HEALTHCARE INC 4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 61-1345363	HEALTHCARE	KY	501(C)(3)	LINE 3	KOH	Yes	
(17) FLAGET MEMORIAL HOSPITAL FOUNDATION INC 4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 56-2351341	FUNDRAISING	KY	501(C)(3)	LINE 11	FH	Yes	
(18) FRANCISCAN FOUNDATION 1717 SOUTH J ST TACOMA, WA 98405 91-1145592	FUNDRAISING	WA	501(C)(3)	LINE 9	FHS	Yes	
(19) FRANCISCAN HEALTH SYSTEM 1717 SOUTH J ST TACOMA, WA 98405 91-0564491	HEALTHCARE	WA	501(C)(3)	LINE 3	CHI	Yes	

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(41) FRANCISCAN HEALTH VENTURES FKA SJMGROUP TACOMA FNC CTR BLDG 1145 BROADWAY TACOMA, WA 98402 43-1882377	PHYSICIANS	MO	501(C)(3)	LINE 9	CHI	Yes	
(1) FRANCISCAN MEDICAL GROUP 1313 BROADWAY STE 200 TACOMA, WA 98402 91-1939739	HEALTHCARE	WA	501(C)(3)	LINE 9	FHS	Yes	
(2) FRANCISCAN VILLA OF SOUTH MILWAUKEE INC 3601 S CHICAGO AVE SOUTH MILWAUKEE, WI 53172 39-1093829	HEALTHCARE	WI	501(C)(3)	LINE 9	CHI	Yes	
(3) GLOBAL HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 20-1536108	MINISTRIES	CO	501(C)(3)	LINE 11	CHI	Yes	
(4) GOOD SAMARITAN COLLEGE OF NURSING & HEALTH SCIENCE 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-1778403	EDUCATION	OH	501(C)(3)	LINE 2	GSH	Yes	
(5) GOOD SAMARITAN FOUNDATION OF CINCINNATI INC 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-1206047	FUNDRAISING	OH	501(C)(3)	LINE 11	GSH	Yes	
(6) GOOD SAMARITAN HOSPITAL PO BOX 1990 KEARNEY, NE 68848 47-0379755	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(7) GOOD SAMARITAN HOSPITAL FOUNDATION 111 W 31ST ST KEARNEY, NE 68847 47-0659443	FUNDRAISING	NE	501(C)(3)	LINE 7	GSH	Yes	
(8) GOOD SAMARITAN HOSPITAL FOUNDATION - DAYTON 110 N MAIN ST STE 500 DAYTON, OH 45402 23-7296923	FUNDRAISING	OH	501(C)(3)	LINE 7	SHP	Yes	
(9) HARRISON MEDICAL CENTER 2520 CHERRY AVE BREMERTON, WA 98310 91-0565546	HEALTHCARE	WA	501(C)(3)	LINE 3	FHS	Yes	
(10) HARRISON MEDICAL CENTER FOUNDATION 2520 CHERRY AVE BREMERTON, WA 98310 91-1197626	FUNDRAISING	WA	501(C)(3)	LINE 7	HMC	Yes	
(11) HEALTH SET 2420 W 26TH AVE STE 460D DENVER, CO 80211 84-1102943	LOW INC CARE	CO	501(C)(3)	LINE 7	CHIC	Yes	
(12) HEALTHCARE AND WELLNESS FOUNDATION 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 76-0761782	FUNDRAISING	MN	501(C)(3)	LINE 11	SFMC	Yes	
(13) HIGHLINE MEDICAL CENTER 16251 SYLVESTER RD SW BURIEN, WA 98166 91-0712166	HEALTHCARE	WA	501(C)(3)	LINE 3	FHS	Yes	
(14) HOUSE OF MERCY 1111 6TH AVE DES MOINES, IA 50314 42-1323808	SHELTER	IA	501(C)(3)	LINE 7	CHI-IA CORP	Yes	
(15) JEWISH HOSPITAL AND ST MARY'S HEALTHCARE INC 539 S 4TH ST LOUISVILLE, KY 40202 61-1029768	HEALTHCARE	KY	501(C)(3)	LINE 3	KOH	Yes	
(16) KENTUCKYONE HEALTH MEDICAL GROUP INC 539 S 4TH ST LOUISVILLE, KY 40202 61-1352729	HEALTHCARE	KY	501(C)(3)	LINE 9	JHSMH	Yes	
(17) KENTUCKYONE HEALTH INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1029769	HEALTHCARE	KY	501(C)(3)	LINE 9	CHI	Yes	
(18) LAKEWOOD HEALTH CENTER 600 MAIN AVE S BAUDETTE, MN 56623 41-0758434	HEALTHCARE	MN	501(C)(3)	LINE 3	CHI	Yes	
(19) LINUS OAKES INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-0821381	SENIOR LIVING	OR	501(C)(3)	LINE 9	MMC	Yes	

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(61) LISBON AREA HEALTH SERVICES 905 MAIN ST LISBON, ND 58054 82-0558836	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(1) LUFKIN VISION ACQUISITIONS PO BOX 1447 LUFKIN, TX 75901 82-0563768	PROPERTY MGMT	TX	501(C)(3)	LINE 11	MHSET	Yes	
(2) MEMORIAL HEALTH CARE SYSTEM FOUNDATION INC 2525 DE SALES AVE CHATTANOOGA, TN 37404 62-1839548	FUNDRAISING	TN	501(C)(3)	LINE 7	MHCS	Yes	
(3) MEMORIAL HEALTH CARE SYSTEM INC 2525 DE SALES AVE CHATTANOOGA, TN 37404 62-0532345	HEALTHCARE	TN	501(C)(3)	LINE 3	CHI	Yes	
(4) MEMORIAL HEALTH PARTNERS FOUNDATION INC 5600 BRAINERD RD STE 500 CHATTANOOGA, TN 37411 03-0417049	HEALTHCARE	TN	501(C)(3)	LINE 9	MHCS	Yes	
(5) MEMORIAL HEALTH SYSTEM OF EAST TEXAS PO BOX 1447 LUFKIN, TX 75902 75-0755367	HEALTHCARE	TX	501(C)(3)	LINE 3	CHI	Yes	
(6) MEMORIAL MEDICAL CENTER - LIVINGSTON PO BOX 1447 LUFKIN, TX 75902 76-0436439	HEALTHCARE	TX	501(C)(3)	LINE 3	MHSET	Yes	
(7) MEMORIAL MEDICAL CENTER - SAN AUGUSTINE PO BOX 1447 LUFKIN, TX 75902 75-2663904	HEALTHCARE	TX	501(C)(3)	LINE 3	MHSET	Yes	
(8) MEMORIAL MULTISPECIALTY ASSOCIATES 1201 FRANK AVE LUFKIN, TX 95904 75-2721155	PHYSICIANS	TX	501(C)(3)	LINE 11	MHSET	Yes	
(9) MEMORIAL SPECIALTY HOSPITAL PO BOX 1447 LUFKIN, TX 95902 75-2492741	HEALTHCARE	TX	501(C)(3)	LINE 3	MHSET	Yes	
(10) MERCY AUXILIARY OF CENTRAL IOWA 1111 6TH AVE DES MOINES, IA 50314 42-6076069	AUXILIARY	IA	501(C)(3)	LINE 11	MF-DM IA	Yes	
(11) MERCY CLINICS INC 1111 6TH AVE DES MOINES, IA 50314 42-1193699	PHYSICIANS	IA	501(C)(3)	LINE 9	CHI-IA CORP	Yes	
(12) MERCY COLLEGE OF HEALTH SCIENCES 1111 6TH AVE DES MOINES, IA 50314 42-1511682	EDUCATION	IA	501(C)(3)	LINE 2	CHI-IA CORP	Yes	
(13) MERCY FOUNDATION OF DES MOINES IA 1111 6TH AVE DES MOINES, IA 50314 23-7358794	FUNDRAISING	IA	501(C)(3)	LINE 7	CHI-IA CORP	Yes	
(14) MERCY FOUNDATION INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-6088946	FUNDRAISING	OR	501(C)(3)	LINE 7	MMC	Yes	
(15) MERCY HEALTH CARE FOUNDATION PO BOX 368 CORNING, IA 50841 42-1461064	FUNDRAISING	IA	501(C)(3)	LINE 11	AHMH-CORNING	Yes	
(16) MERCY HEALTHCARE FOUNDATION 570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0435338	FUNDRAISING	ND	501(C)(3)	LINE 11	MHVC	Yes	
(17) MERCY HOSPITAL FOUNDATION COUNCIL BLUFFS 800 MERCY DR COUNCIL BLUFFS, IA 51503 42-1178204	FUNDRAISING	IA	501(C)(3)	LINE 11	AHBMHS	Yes	
(18) MERCY HOSPITAL OF DEVILS LAKE 1031 7TH ST NE DEVILS LAKE, ND 58301 45-0227012	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(19) MERCY HOSPITAL OF DEVILS LAKE FOUNDATION 1031 7TH ST NE DEVILS LAKE, ND 58301 35-2367360	FUNDRAISING	ND	501(C)(3)	LINE 7	MHDL	Yes	

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(81) MERCY HOSPITAL OF VALLEY CITY 570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0226553	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(1) MERCY MEDICAL CENTER 1301 15TH AVE WEST WILLISTON, ND 58801 45-0231183	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(2) MERCY MEDICAL CENTER - CENTERVILLE ONE ST JOSEPHS DRIVE CENTERVILLE, IA 52544 42-0680308	HEALTHCARE	IA	501(C)(3)	LINE 3	CHI-IA CORP	Yes	
(3) MERCY MEDICAL CENTER INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-0386868	HEALTHCARE	OR	501(C)(3)	LINE 3	CHI	Yes	
(4) MERCY MEDICAL FOUNDATION 1301 15TH AVE WEST WILLISTON, ND 58801 45-0381803	FUNDRAISING	ND	501(C)(3)	LINE 11	MMC	Yes	
(5) MERCY PROFESSIONAL PRACTICE ASSOCIATES INC 1111 6TH AVE DES MOINES, IA 50314 42-1470935	PHYSICIANS	IA	501(C)(3)	LINE 9	CHI-IA CORP	Yes	
(6) NEBRASKA HEART HOSPITAL 7500 S 91ST ST LINCOLN, NE 68526 39-2031968	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(7) OAKES COMMUNITY HOSPITAL 1200 N 7TH ST OAKES, ND 58474 45-0231675	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(8) OAKES COMMUNITY HOSPITAL FOUNDATION 1200 N 7TH ST OAKES, ND 58474 71-0966606	FUNDRAISING	ND	501(C)(3)	LINE 11	OCH	Yes	
(9) PINEYWOODS MEDICAL DEVELOPMENT CORP PO BOX 1447 LUFKIN, TX 75902 75-2493116	PROPERTY MGMT	TX	501(C)(3)	LINE 11	MHSET	Yes	
(10) PUEBLO STEPUP 1925 E ORMAN AVE STE G52 PUEBLO, CO 81004 84-1234295	COMMUNITY	CO	501(C)(3)	LINE 7	CHIC	Yes	
(11) REGIONAL HOSPITAL FOR RESPIRATORY AND COMPLEX CARE 12844 MILITARY RD S TUKWILA, WA 98168 91-1170040	HEALTHCARE	WA	501(C)(3)	LINE 3	FHS	Yes	
(12) SET OF COLORADO SPRINGS INC 2864 S CIRCLE DR STE 450 COLORADO SPRINGS, CO 80906 84-1183335	LTERM CARE	CO	501(C)(3)	LINE 7	CHIC	Yes	
(13) SAINT CLARE'S COMMUNITY CARE INC 25 POCONO RD DENVILLE, NJ 07834 22-2876836	HEALTHCARE	NJ	501(C)(3)	LINE 11	SCHS	Yes	
(14) SAINT CLARE'S FOUNDATION INC 25 POCONO RD DENVILLE, NJ 07834 22-2502997	FUNDRAISING	NJ	501(C)(3)	LINE 7	SCHS	Yes	
(15) SAINT CLARE'S HEALTH SERVICES INC 25 POCONO RD DENVILLE, NJ 07834 22-3639733	MANAGEMENT	NJ	501(C)(3)	LINE 11	CHI	Yes	
(16) SAINT CLARE'S HOSPITAL INC 25 POCONO RD DENVILLE, NJ 07834 22-3319886	HEALTHCARE	NJ	501(C)(3)	LINE 3	SCHS	Yes	
(17) SAINT ELIZABETH FOUNDATION 555 S 70TH ST LINCOLN, NE 68510 47-0625523	FUNDRAISING	NE	501(C)(3)	LINE 7	SERMC	Yes	
(18) SAINT ELIZABETH HEALTH SERVICES 555 S 70TH ST LINCOLN, NE 68510 36-3233120	HEALTHCARE	NE	501(C)(3)	LINE 3	SERMC	Yes	
(19) SAINT ELIZABETH REGIONAL MEDICAL CENTER 555 S 70TH ST LINCOLN, NE 68510 47-0379836	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	

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(101) SAINT FRANCIS MEDICAL CENTER 2620 W FAIDLEY GRAND ISLAND, NE 68803 47-0376601	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(1) SAINT FRANCIS MEDICAL CENTER FOUNDATION PO BOX 9804 GRAND ISLAND, NE 68802 47-0630267	FUNDRAISING	NE	501(C)(3)	LINE 7	SFMC	Yes	
(2) SAINT JOSEPH BEREA HOSPITAL FOUNDATION INC 305 ESTILL ST BEREA, KY 40403 26-0152877	FUNDRAISING	KY	501(C)(3)	LINE 7	SJHS	Yes	
(3) SAINT JOSEPH HEALTH SYSTEM INC 424 LEWIS HARGETT CIRCLE STE 160 LEXINGTON, KY 40503 61-1334601	HEALTHCARE	KY	501(C)(3)	LINE 3	KOH	Yes	
(4) SAINT JOSEPH HOSPITAL FOUNDATION INC ONE SAINT JOSEPH DRIVE LEXINGTON, KY 40504 61-1159649	FUNDRAISING	KY	501(C)(3)	LINE 11	SJHS	Yes	
(5) SAINT JOSEPH LONDON FOUNDATION INC 1001 SAINT JOSEPH LANE LONDON, KY 40741 26-0438748	FUNDRAISING	KY	501(C)(3)	LINE 7	SJHS	Yes	
(6) SAINT JOSEPH MEDICAL FOUNDATION INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 31-1539059	PHYSICIANS	KY	501(C)(3)	LINE 3	SJHS	Yes	
(7) SAINT JOSEPH MOUNT STERLING FOUNDATION INC 225 FALCON DR MOUNT STERLING, KY 40353 27-2884584	FUNDRAISING	KY	501(C)(3)	LINE 7	SJHS	Yes	
(8) SAINT JOSEPH'S HOSPITAL FOUNDATION 30 WEST 7TH ST DICKINSON, ND 58601 36-3418207	FUNDRAISING	ND	501(C)(3)	LINE 11	SJHHC	Yes	
(9) SAMARITAN BEHAVIORAL HEALTH INC 601 S EDWIN C MOSES BLVD DAYTON, OH 45417 02-0633634	HEALTHCARE	OH	501(C)(3)	LINE 7	SHP	Yes	
(10) SAMARITAN HEALTH PARTNERS 110 N MAIN ST STE 500 DAYTON, OH 45402 31-1107411	HEALTHCARE	OH	501(C)(3)	LINE 11	CHI	Yes	
(11) SCHUYLER MEMORIAL HOSPITAL FOUNDATION INC 104 W 17TH ST SCHUYLER, NE 68661 36-3630014	FUNDRAISING	NE	501(C)(3)	LINE 11	AHMHS	Yes	
(12) SJRMC JOPLIN MISSOURI 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 44-0545809	HEALTHCARE	MO	501(C)(3)	LINE 3	CHI	Yes	
(13) SL AUGUSTA CORP PO BOX 20269 HOUSTON, TX 77225 76-0226623	TITLE HOLDING	TX	501(C)(2)		SLPC	Yes	
(14) ST ANTHONY HOSPITAL 1601 SE COURT AVE PENDLETON, OR 97801 93-0391614	HEALTHCARE	OR	501(C)(3)	LINE 3	CHI	Yes	
(15) ST ANTHONY HOSPITAL FOUNDATION 1601 SE COURT AVE PENDLETON, OR 97801 93-0992727	FUNDRAISING	OR	501(C)(3)	LINE 11	SAH	Yes	
(16) ST ANTHONY'S HOSPITAL ASSOCIATION FOUR HOSPITAL DR MORRILTON, AR 72110 71-0245507	HEALTHCARE	AR	501(C)(3)	LINE 3	SVIMC	Yes	
(17) ST CATHERINE HOSPITAL 401 EAST SPRUCE ST GARDEN CITY, KS 67846 48-0543721	HEALTHCARE	KS	501(C)(3)	LINE 3	CHI	Yes	
(18) ST CATHERINE HOSPITAL DEVELOPMENT FOUNDATION 401 EAST SPRUCE ST GARDEN CITY, KS 67846 20-0598702	FUNDRAISING	KS	501(C)(3)	LINE 11	SCH	Yes	
(19) ST DOMINIC OF ONTARIO OREGON 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 93-0433692	HEALTHCARE	OR	501(C)(4)	#N/A	CHI	Yes	

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(121) ST FRANCIS HOME 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0729978	LTERM CARE	MN	501(C)(3)	LINE 9	CHI	Yes	
(1) ST FRANCIS LIFE CARE CORPORATION 19 POCONO RD DENVILLE, NJ 07834 22-2536017	ELDERLY CARE	NJ	501(C)(3)	LINE 9	SCHS	Yes	
(2) ST FRANCIS MEDICAL CENTER 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0695598	HEALTHCARE	MN	501(C)(3)	LINE 3	CHI	Yes	
(3) ST FRANCIS OF BAKER CITY 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 93-0412495	HEALTHCARE	OR	501(C)(3)	LINE 3	CHI	Yes	
(4) ST JOSEPH COMMUNITY HEALTH 1516 5TH ST NW ALBUQUERQUE, NM 87102 71-0897107	COMMUNITY	NM	501(C)(3)	LINE 11	CHI	Yes	
(5) ST JOSEPH HEALTH MINISTRIES 1929 LINCOLN HWY E STE 150 LANCASTER, PA 17602 23-2342997	HEALTHCARE	PA	501(C)(3)	LINE 11	CHI	Yes	
(6) ST JOSEPH MEDICAL CENTER FOUNDATION 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-2649362	FUNDRAISING	PA	501(C)(3)	LINE 11	SJRHN	Yes	
(7) ST JOSEPH MEDICAL CENTER INC 201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-0591461	HEALTHCARE	MD	501(C)(3)	LINE 3	CHI	Yes	
(8) ST JOSEPH MEDICAL GROUP 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 20-8544021	HEALTHCARE	PA	501(C)(3)	LINE 9	BHC	Yes	
(9) ST JOSEPH PHYSICIAN ENTERPRISE INC 201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-1311775	PHYSICIANS	MD	501(C)(3)	LINE 11	SJMC	Yes	
(10) ST JOSEPH REGIONAL HEALTH NETWORK 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-1352211	HEALTHCARE	PA	501(C)(3)	LINE 3	CHI	Yes	
(11) ST JOSEPH'S AREA HEALTH SERVICES 600 PLEASANT AVE PARK RAPIDS, MN 56470 41-0695603	HEALTHCARE	MN	501(C)(3)	LINE 3	CHI	Yes	
(12) ST JOSEPH'S HOSPITAL AND HEALTH CENTER 30 WEST 7TH ST DICKINSON, ND 58601 45-0226429	HEALTHCARE	ND	501(C)(3)	LINE 3	CHI	Yes	
(13) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-0274448	MANAGEMENT	TX	501(C)(3)	LINE 11	SLHS	Yes	
(14) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - PMC 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 27-3733278	HEALTHCARE	TX	501(C)(3)	LINE 3	SLCDC	Yes	
(15) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - SUGAR LAND 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-1947374	HEALTHCARE	TX	501(C)(3)	LINE 3	SLHS	Yes	
(16) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - THE WOODLANDS 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-0335902	HEALTHCARE	TX	501(C)(3)	LINE 3	SLCDC	Yes	
(17) ST LUKE'S COMMUNITY HEALTH SERVICES 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0536234	HEALTHCARE	TX	501(C)(3)	LINE 3	SLHS	Yes	
(18) ST LUKE'S FOUNDATION 1213 HERMANN DRIVE STE 855 HOUSTON, TX 77004 45-3811485	FUNDRAISING	TX	501(C)(3)	LINE 7	SLHS	Yes	
(19) ST LUKE'S HEALTH SYSTEM CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0536232	MANAGEMENT	TX	501(C)(3)	LINE 11	CHI	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(141) ST LUKE'S HEALTH SYSTEM FOUNDATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0127715	INVESTMENT MGMT	TX	501(C)(3)	LINE 11	SLHS	Yes	
(1) ST LUKE'S HOSPITAL AT THE VINTAGE 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-3734606	HEALTHCARE	TX	501(C)(3)	LINE 3	SLHS	Yes	
(2) ST LUKE'S MEDICAL GROUP 6624 FANNIN ST HOUSTON, TX 77030 76-0458535	PHYSICIANS	TX	501(C)(3)	LINE 3	SLHS	Yes	
(3) ST LUKE'S MEDICAL TOWER CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0531713	PROPERTY MGMT	TX	501(C)(3)	LINE 11	CHI-SLH	Yes	
(4) ST LUKE'S PROPERTIES CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0531716	PROPERTY MGMT	TX	501(C)(3)	LINE 11	SLHS	Yes	
(5) ST LUKE'S SUGAR LAND PROPERTIES CORPORATION 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 45-4120549	PROPERTY MGMT	TX	501(C)(3)	LINE 11	SLCDC-SL	Yes	
(6) ST MARY'S COMMUNITY HOSPITAL 1314 3RD AVE NEBRASKA CITY, NE 68410 47-0443636	HEALTHCARE	NE	501(C)(3)	LINE 3	CHI NEBRASKA	Yes	
(7) ST MARY'S HOSPITAL FOUNDATION 1314 3RD AVE NEBRASKA CITY, NE 68410 47-0707604	FUNDRAISING	NE	501(C)(3)	LINE 7	SMCH	Yes	
(8) ST VINCENT FOUNDATION TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 51-0169537	FUNDRAISING	AR	501(C)(3)	LINE 11	SVIMC	Yes	
(9) ST VINCENT INFIRMARY MEDICAL CENTER TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0236917	HEALTHCARE	AR	501(C)(3)	LINE 3	CHI	Yes	
(10) ST VINCENT MEDICAL GROUP TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0830696	HEALTHCARE	AR	501(C)(3)	LINE 9	SVIMC	Yes	
(11) THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OH 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-0537486	HEALTHCARE	OH	501(C)(3)	LINE 3	CHI	Yes	
(12) THE PHYSICIAN NETWORK 2000 Q ST STE 500 LINCOLN, NE 68503 47-0780857	PHYSICIANS	NE	501(C)(3)	LINE 11	CHI NEBRASKA	Yes	
(13) TOTAL HEALTHCARE 188 INVERNESS DRIVE WEST STE 500 ENGLEWOOD, CO 80112 84-0927232	HEALTHCARE	CO	501(C)(3)	LINE 3	CHIC	Yes	
(14) UNITY FAMILY HEALTHCARE 815 SE 2ND ST LITTLE FALLS, MN 56345 41-0721642	HEALTHCARE	MN	501(C)(3)	LINE 3	CHI	Yes	
(15) VILLA NAZARETH INC 801 PAGE DR FARGO, ND 58103 45-0226714	LTERM CARE	ND	501(C)(3)	LINE 9	CHI	Yes	
(16) VISITING NURSE ASSOCIATION OF ST CLARE'S INC 191 WOODPORT RD SPARTA, NJ 07871 22-1768334	HOME HEALTH	NJ	501(C)(3)	LINE 9	SCHS	Yes	
(17) WOODLANDS DOCTOR GROUP 17200 ST LUKES WAY STE 170 THE WOODLANDS, TX 77384 27-4499340	PHYSICIANS	TX	501(C)(3)	LINE 9	SLCHS	Yes	
(18) ST JOSEPH SERVICES CORPORATION 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2455161	GOVERNANCE	TX	501(C)(3)	LINE 11A, I	SYLVANIA FRANCISCAN HEALTH	Yes	
(19) BURLESON ST JOSEPH HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2759890	HEALTH CARE	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(161) MADISON ST JOSEPH HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2761145	HEALTH CARE	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	
(1) ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2847594	NURSING CARE	TX	501(C)(3)	LINE 9	ST JOSEPH SERVICES CORPORATION	Yes	
(2) BURLESON ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2913931	NURSING CARE	TX	501(C)(3)	LINE 9	ST JOSEPH SERVICES CORPORATION	Yes	
(3) ST JOSEPH FOUNDATION 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2351158	FUNDRAISING	TX	501(C)(3)	LINE 11A, I	ST JOSEPH SERVICES CORPORATION	Yes	
(4) ST JOSEPH PHYSICIAN ASSOCIATES 2801 FRANCISCAN DRIVE BRYAN, TX 77802 20-3159302	PHYSICIAN PRACTICE	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	
(5) SISTERS OF ST FRANCIS 6832 CONVENT BLVD SYLVANIA, OH 43560 34-4450609	RELIGIOUS	OH	501(C)(3)	LINE 1			No
(6) SYLVANIA FRANCISCAN HEALTH 3231 CENTRAL PARK WEST SUITE 106 TOLEDO, OH 43617 34-1412964	CHURCH ORG	OH	501(C)(3)	LINE 1			No
(7) FRANCISCAN LIVING COMMUNITIES 5942 RENAISSANCE PLACE SUITE A TOLEDO, OH 43623 34-1892096	MANAGEMENT SUPPORT	OH	501(C)(3)	LINE 11A, I	SYLVANIA FRANCISCAN HEALTH	Yes	
(8) ST LEONARD 8100 CLYO ROAD CENTERVILLE, OH 45458 34-1940863	LONG TERM CARE FACILITY	OH	501(C)(3)	LINE 9	FRANCISCAN LIVING COMMUNITIES	Yes	
(9) ST LEONARD FOUNDATION 8100 CLYO ROAD CENTERVILLE, OH 45458 32-0102715	FUNDRAISING	OH	501(C)(3)	LINE 7	FRANCISCAN LIVING COMMUNITIES	Yes	
(10) PROVIDENCE CARE CENTER 2025 HAYES AVE SANDUSKY, OH 44870 34-1658625	LONG TERM CARE FACILITY	OH	501(C)(3)	LINE 9	FRANCISCAN LIVING COMMUNITIES	Yes	
(11) THE COMMONS OF PROVIDENCE 5000 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1826097	ASSISTED LIVING FACILITY	OH	501(C)(3)	LINE 9	FRANCISCAN LIVING COMMUNITIES	Yes	
(12) PROVIDENCE RESIDENTIAL COMMUNITY CORPORATION 5055 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1896807	INDEPENDENT LIVING FACILITY	OH	501(C)(3)	LINE 9	FRANCISCAN LIVING COMMUNITIES	Yes	
(13) PROVIDENCE CARE CENTERS 2025 HAYES AVE SANDUSKY, OH 44870 34-1826099	FINANCIAL SUPPORT	OH	501(C)(3)	LINE 11B, II	FRANCISCAN LIVING COMMUNITIES	Yes	
(14) FRANCISCAN CARE CENTER 4111 HOLLAND SYLVANIA ROAD TOLEDO, OH 43623 34-1931806	LONG TERM CARE FACILITY	OH	501(C)(3)	LINE 9	FRANCISCAN LIVING COMMUNITIES	Yes	
(15) ST CLARE COMMONS 12469 FIVE POINT ROAD PERRYSBURG, OH 43551 27-0163752	LONG TERM CARE FACILITY	OH	501(C)(3)	LINE 7	FRANCISCAN LIVING COMMUNITIES	Yes	
(16) TRINITY HOSPITAL TWIN CITY 819 NORTH FIRST STREET DENNISON, OH 44621 27-5401105	HEALTH CARE	OH	501(C)(3)	LINE 3	SYLVANIA FRANCISCAN HEALTH	Yes	
(17) SYLVANIA FRANCISCAN HEALTH FOUNDATION 3231 CENTRAL PARK WEST SUITE 106 TOLEDO, OH 43617 45-5357161	FUNDRAISING	OH	501(C)(3)	LINE 11B, II	SYLVANIA FRANCISCAN HEALTH	Yes	
(18) MADONNA MANOR 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017 61-0654635	LONG TERM CARE FACILITY	KY	501(C)(3)	LINE 1	FRANCISCAN LIVING COMMUNITIES	Yes	
(19) ST JOSEPH REGIONAL HEALTH PARTNERS 2801 FRANCISCAN DRIVE BRYAN, TX 77802 45-4088170	PHYSICIAN SUPPORT	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(181) ST JOSEPH REGIONAL HEALTH PARTNERS ACO 2801 FRANCISCAN DRIVE BRYAN, TX 77802 46-3265423	HEALTH CARE	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	
(1) BELLVILLE ST JOSEPH HEALTH CENTER 44 N CUMMINGS ST BELLVILLE, TX 77418 27-4005511	HEALTH CARE	TX	501(C)(3)	LINE 3	ST JOSEPH SERVICES CORPORATION	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
ALEGENT HEALTH NORTHWEST IMAGING CENTER LLC 3606 N 156TH ST OMAHA, NE 68116 06-1786985	OP DIAGNOSTICS	NE	N/A									
AUDUBON LAND COMPANY LLC 5390 N ACADEMY BLVD STE 300 COLORADO SPRINGS, CO 80918 84-1513085	REAL ESTATE	CO	N/A									
AVANTAS LLC 11128 JOHN GALT BLVD STE 400 OMAHA, NE 68137 39-2045003	STAFFING OF NURSES	NE	N/A									
BERGAN MERCY SURGERY CENTER LLC 7710 MERCY RD STE 200 OMAHA, NE 68124 20-8671994	AMBUL SURG CTR	NE	N/A									
BERYWOOD OFFICE PROPERTIES LLC 400 BERYWOOD TRAIL CLEVELAND, TN 37312 62-1875199	PHYS OFFICE	TN	N/A									
BLUEGRASS REGIONAL IMAGING CENTER 1218 SOUTH BRDWAY STE 310 LEXINGTON, KY 40504 61-1386736	DIAGNOSTIC IMAGING	KY	N/A									
CATHOLIC HEALTH INITIATIVES PHYSICIAN SERVICES LLC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-2945938	PRACTICE MGMT SRVC	DE	N/A									
CENTRAL NEBRASKA HOME CARE SERVICES PO BOX 1146 4502 N SECOND AVE KEARNEY, NE 68848 47-0692112	HEALTHCARE SRVC	NE	N/A									
CENTRAL NEBRASKA REHAB SERVICE 620 DIERS AVE STE 300 GRAND ISLAND, NE 68803 81-0653461	PHYSICAL THERAPY	NE	N/A									
CHI OPERATING INVESTMENT PROGRAM LP 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 47-0727942	INVESTMENTS	CO	N/A									
CHICAMSURG SURGERY CENTERS LLC 188 INVERNESS DRIVE WEST 500 ENGLEWOOD, CO 80112 46-5683027	SURGERY CENTER	CO	N/A									
HC SL VINTAGE I LLC 18000 W SARAH LANE STE 250 BROOKFIELD, WI 53045 27-0453767	PROPERTY HOLDING	WI	N/A									
HEALTHCARE SUPPORT SERVICES PO BOX 9804 GRAND ISLAND, NE 68802 72-1546196	LAUNDRY	NE	N/A									
HEARTLAND ONCOLOGY LLC 2337 E CRAWFORD ST SALINA, KS 67401 46-4265403	ONCOLOGY	KS	N/A									
HIGHLINE IMAGING LLC 275 SW 160TH ST BURIEN, WA 98166 20-0460005	DIAGNOSTIC IMAGING	WA	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
LAKESIDE AMBULATORY SURGICAL CENTER LLC 17031 LAKESIDE HILLS DR OMAHA, NE 68130 20-4267902	AMBUL SURG CTR	NE	N/A									
LAKESIDE ENDOSCOPY CENTER LLC 17001 LAKESIDE HILLS PLZ STE 201 OMAHA, NE 68130 20-5544496	ENDOSCOPY SRVC	NE	N/A									
LINCOLN CK LEASING LLC 6003 OLD CHENEY RD LINCOLN, NE 68516 26-2496856	REAL ESTATE	NE	N/A									
LOUISVILLE SC LTD 3000 RIVERCHASE GALLERIA STE 500 BIRMINGHAM, AL 35244 62-1179566	SURGERY CENTER	AL	N/A									
NEBRASKA SPINE HOSPITAL LLC 6901 N 72ND ST OMAHA, NE 68122 27-0263191	SPINE HOSPITAL	NE	N/A									
NORTH RIVER SURGERY CENTER LLC 2209 WILDWOOD AVE SHERWOOD, AR 72120 71-0799771	AMBUL SURG CTR	AR	N/A									
ORTHOCOLORADO LLC 11650 WEST 2ND PLACE LAKEWOOD, CO 80255 37-1577105	ORTHO HOSPITAL	CO	N/A									
PENINSULA RADIATION ONCOLOGY LLC 315 MLK JR WAY STE 111 TACOMA, WA 98405 87-0808610	HEALTHCARE SRVC	WA	N/A									
PENRAD IMAGING 1390 KELLY JOHNSON BLVD COLORADO SPRINGS, CO 80920 84-1072619	MEDICAL IMAGING	CO	N/A									
PMC HOSPITAL LLC 4600 E SAM HOUSTON PKWY SOUTH PASADENA, TX 77505 27-3280598	HOSPITAL	TX	N/A									
PRAIRIE HEALTH VENTURES LLC 421 S 9TH ST STE 102 LINCOLN, NE 68508 20-4962103	TECH SRVC	NE	N/A									
PREMIER SURGERY CENTER OF LOUISVILLE LP 3000 RIVERCHASE GALLERIA STE 500 BIRMINGHAM, AL 35244 72-1378216	SURGERY CENTER	AL	N/A									
PUEBLO AMBULATORY SURGERY CENTER LLC 188 INVERNESS DRIVE WEST 500 ENGLEWOOD, CO 80112 62-1488737	SURGERY CENTER	CO	N/A									
SAINT JOSEPH - PAML LLC 424 LEWIS HARGETT CIRCLE STE 160 LEXINGTON, KY 40503 45-2116736	MGMT SVCS	KY	N/A									
SAINT JOSEPH - SCA HOLDINGS LLC 1451 HARRODSBURG RD LEXINGTON, KY 40503 45-3801157	OP SURGERY	DE	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner? Yes	(j) No	(k) Percentage ownership
SAINT JOSEPH-ANC HOME CARE SERVICES 1700 EDISON DR MILFORD, OH 45150 26-3330545	HOME HEALTH	KY	N/A									
SCA PREMIER SURGERY CENTER OF LOUISVILLE LLC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 72-1386840	SURGERY CENTER	KY	N/A									
ST FRANCIS LAND COMPANY 5390 N ACADEMY BLVD STE 300 COLORADO SPRINGS, CO 80918 26-3134100	REAL ESTATE	CO	N/A									
ST FRANCIS MEDICAL CENTER ASSOCIATES 1717 SOUTH J ST TACOMA, WA 98405 91-1352698	MED OFFICE	WA	N/A									
ST LUKE'S DIAGNOSTIC CATH LAB LLP 6620 MAIN ST STE 1520 HOUSTON, TX 77030 71-0959365	DIAGNOSTICS	TX	N/A									
ST LUKE'S HOSPITAL AT THE VINTAGE LLC 6624 FANNIN STE 2505 HOUSTON, TX 77030 26-3734516	HOSPITAL	TX	N/A									
ST LUKE'S LAKESIDE HOSPITAL LLC 6624 FANNIN STE 2505 HOUSTON, TX 77030 30-0427437	HOSPITAL	TX	N/A									
ST LUKE'S THE WOODLANDS SLEEP CENTER LLC 6624 FANNIN STE 800 HOUSTON, TX 77030 46-2795726	DIAGNOSTICS	TX	N/A									
SUPERIOR MEDICAL IMAGING LLC 5000 NORTH 26TH ST LINCOLN, NE 68521 26-2884555	OP DIAGNOSTICS	NE	N/A									
SURGERY CENTER OF LEXINGTON LLC 424 LEWIS HARGETT CIRCLE STE 160 LEXINGTON, KY 40503 62-1179539	SURGERY CENTER	DE	N/A									
SURGERY CENTER OF LOUISVILLE LLC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 62-1179537	SURGERY CENTER	KY	N/A									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	**No**							
ALLIANCE HEALTH PROVIDERS OF BRAZOS VALLEY 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2466914	PHYSICIAN HOSPITAL ORGANIZATION	TX	N/A	C			Yes	
SFH ASSURANCE LTD SUITE 6 GRAND PAVILLION COMERCIAL GRAND CAYMAN KY1- CJ 98-1056892	INSURANCE	CJ	N/A	C			Yes	
ALEGENT HEALTHCREIGHTON ST JOSEPH MANAGED CARE SERVICES INC 12809 WEST DODGE RD OMAHA, NE 68154 47-0802396	MANAGED CARE	NE	N/A	C			Yes	
ALL SAINTS INSURANCE COMPANY SPC LTD PO BOX 10073 APO GEORGETOWN,GRAND CAYMAN KY1-1001 CJ	INSURANCE	CJ	N/A	C			Yes	
ALTERNATIVE INSURANCE MANAGEMENT SERVICE 3900 OLYMPIC BLVD STE 400 ERLANGER, KY 41018 84-1112049	MANAGEMENT SERVICES	CO	N/A	C			Yes	
AMERICAN NURSING CARE INC 1700 EDISON DR MILFORD, OH 45150 31-1085414	HOME HEALTH	OH	N/A	C			Yes	
AMERIMED INC 1700 EDISON DR MILFORD, OH 45150 31-1158699	HOME HEALTH	OH	N/A	C			Yes	
BC HOLDING COMPANY INC 1850 BLUEGRASS AVE LOUISVILLE, KY 40215 31-1542851	FITNESS CLUB	KY	N/A	C			Yes	
CADUCEUS MEDICAL ASSOCIATES INC 2525 DE SALES AVE CHATTANOOGA, TN 37404 62-1570736	HEALTHCARE	TN	N/A	C			Yes	
CAPTIVE MANAGEMENT INITIATIVES LTD PO BOX 10073 APO GEORGETOWN,GRAND CAYMAN KY1-1001 CJ 98-0663022	CAPTIVE MANAGEMENT	CJ	N/A	C			Yes	
CARMONA-DESOTO BUILDING HORIZONTAL PROPERTY REGIME INC 300 WERNER ST HOT SPRINGS, AR 71913 71-0771076	HEALTHCARE	AR	N/A	C			Yes	
CATHOLIC HEALTH INITIATIVES CENTER FOR TRANSLATIONAL RESEARCH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-2269511	RESEARCH	CO	N/A	C			Yes	
CGH REALTY COMPANY INC 2500 BERNVILLE RD READING, PA 19603 23-2326801	REAL ESTATE	PA	N/A	C			Yes	
CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE MEDICAL CENTER CONDOMINIUM 6624 FANNIN STE 2505 HOUSTON, TX 77030 45-5079545	CONDO ASSOC	TX	N/A	C			Yes	
CLEARRIVER HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4495960	INSURANCE	TN	N/A	C			Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	**No**							
COMCARE SERVICES INC 5570 DTC PARKWAY ENGLEWOOD, CO 80111 84-0904813	INACTIVE	CO	N/A	C			Yes	
CONSOLIDATED HEALTH SERVICES 1700 EDISON DR MILFORD, OH 45150 31-1378212	HOME HEALTH	OH	N/A	C			Yes	
DES MOINES MEDICAL CENTER INC 1111 6TH AVE DES MOINES, IA 50314 42-0837382	REAL ESTATE	IA	N/A	C			Yes	
EAST TEXAS CLINICAL SERVICES INC 2801 VIA FORTUNA 500 AUSTIN, TX 78746 45-4736213	HEALTHCARE	TX	N/A	C			Yes	
FIRST INITIATIVES INSURANCE LTD PO BOX 10073 APO GEORGETOWN,GRAND CAYMAN KY1-1001 CJ 98-0203038	INSURANCE	CJ	N/A	C			Yes	
FRANCISCAN SERVICES INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2487967	HEALTHCARE	CO	N/A	C			Yes	
GOOD SAMARITAN OUTREACH SERVICES PO BOX 1990 KEARNEY, NE 68848 47-0659440	MEDICAL CLINIC	NE	N/A	C			Yes	
HEALTH SYSTEMS ENTERPRISES INC PO BOX 1990 KEARNEY, NE 68848 47-0664558	MGMT	NE	N/A	C			Yes	
HEALTHCARE MGMT SERVICES ORGANIZATION INC 1717 SOUTH J ST TACOMA, WA 98405 91-1865474	HEALTH ORG	WA	N/A	C			Yes	
HEARTLANDPLAINS HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4368223	INSURANCE	NE	N/A	C			Yes	
HIGHLINE MEDICAL GROUP 15811 AMBAUM BLVD SW STE 170 BURIEN, WA 98166 91-1586438	MEDICAL SERVICES	WA	N/A	C			Yes	
MEDQUEST 1602 WEST 11TH ST WILLISTON, ND 58801 45-0392137	SALE OF DME	ND	N/A	C			Yes	
MERCY PARK APARTMENTS LTD 1111 6TH AVE DES MOINES, IA 50314 42-1202422	HOUSING	IA	N/A	C			Yes	
MERCY SERVICES CORP 2700 STEWART PARKWAY ROSEBURG, OR 97471 93-0824308	RETAIL SALES	OR	N/A	C			Yes	
MHI CLINICAL SERVICES 1201 W FRANK AVE LUFKIN, TX 75904 46-1967952	HEALTHCARE	TX	N/A	C			Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	**No**							
MOUNTAIN MANAGEMENT SERVICES INC 6028 SHALLOWFORD RD CHATTANOOGA, TN 37421 62-1570739	MGMT SVC ORG	TN	N/A	C			Yes	
NAZARETH ASSURANCE COMPANY PO BOX 10073 APO GEORGETOWN,GRAND CAYMAN KY1-1001 CJ 03-0304831	INSURANCE	CJ	N/A	C			Yes	
PATIENT TRANSPORT SERVICES INC 1700 EDISON DR MILFORD, OH 45150 31-1100798	HOME HEALTH	OH	N/A	C			Yes	
PHYSICIANHEALTH SYSTEM NETWORK 1149 MARKET ST TACOMA, WA 98402 91-1746721	HEALTH ORG	WA	N/A	C			Yes	
PROMINENCE HEALTH PLAN SERVICES INC (FKA COLLABHEALTH PLAN SERVICES INC) 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-1224037	ADMIN SERVICES	CO	N/A	C			Yes	
PROMINENCE HEALTH INC (FKA COLLABHEALTH MANAGED SOLUTIONS INC) 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-1222808	HOLDING CO	CO	N/A	C			Yes	
QCA HEALTH PLAN INC 12615 CHENAL PARKWAY STE 300 LITTLE ROCK, AR 72211 71-0794605	INSURANCE	AR	N/A	C			Yes	
QUALCHOICE HOLDINGS INC 12615 CHENAL PARKWAY STE 300 LITTLE ROCK, AR 72211 27-4075520	HOLDING CO	AR	N/A	C			Yes	
QUALCHOICE LIFE AND HEALTH INSURANCE COMPANY INC 12615 CHENAL PARKWAY STE 300 LITTLE ROCK, AR 72211 71-0386640	INSURANCE	AR	N/A	C			Yes	
RIVERLINK HEALTH 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4380824	INSURANCE	OH	N/A	C			Yes	
RIVERLINK HEALTH OF KENTUCKY INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4828332	INSURANCE	KY	N/A	C			Yes	
SAINT CLARE'S PRIMARY CARE INC 66 FORD RD DENVILLE, NJ 07834 22-2441202	BILLING SERVICES	NJ	N/A	C			Yes	
SAMARITAN FAMILY CARE INC 40 W FOURTH ST STE 1700 DAYTON, OH 45402 31-1299450	HEALTHCARE	OH	N/A	C			Yes	
SJH SERVICES CORPORATION 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2307408	HEALTHCARE	CO	N/A	C			Yes	
SJL PHYSICIAN MANAGEMENT SERVICES INC 424 LEWIS HARGETT CR STE 160 LEXINGTON, KY 40503 27-0164198	MGMT	KY	N/A	C			Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	**No**							
SLMT PARKING INC 6624 FANNIN STE 800 HOUSTON, TX 77030 76-0637140	PARKING	TX	N/A	C			Yes	
SOUNDPATH HEALTH INC 32129 WEYERHAEUSER WAY S STE 201 FEDERAL WAY, WA 98001 42-1720801	INSURANCE	WA	N/A	C			Yes	
ST ANTHONY DEVELOPMENT COMPANY 1415 SOUTHGATE PENDLETON, OR 97801 93-1216943	ATHLETIC CLUB	OR	N/A	C			Yes	
ST JOSEPH DEVELOPMENT COMPANY INC 1717 SOUTH J ST TACOMA, WA 98405 91-1480569	RENTAL	WA	N/A	C			Yes	
ST JOSEPH OFFICE PARK ASSOCIATION 1401 HARRODSBURG RD BLDG B70 LEXINGTON, KY 40504 61-1079899	MGMT	KY	N/A	C			Yes	
ST LUKE'S 6620 MAIN CONDOMINIUM ASSOCIATION 6624 FANNIN STE 2505 HOUSTON, TX 77030 30-0355517	CONDO ASSOC	TX	N/A	C			Yes	
ST LUKE'S ANESTHESIOLOGY ASSOCIATES 6624 FANNIN STE 1100 HOUSTON, TX 77030 46-1517163	MEDICAL CLINIC	TX	N/A	C			Yes	
ST LUKE'S EPISCOPAL HOSPITAL PHYSICIAN HOSPITAL ORGANIZATION INC 6720 BERTNER MC4-262 HOUSTON, TX 77030 76-0377932	PHO	TX	N/A	C			Yes	
ST LUKE'S HEALTH SYSTEM HOLDINGS INC (FKA SLEHS HOLDINGS INC) 6624 FANNIN STE 800 HOUSTON, TX 77030 76-0637138	HOLDING CO	TX	N/A	C			Yes	
ST LUKE'S MEDICAL ARTS CENTER I CONDOMINIUM ASSOCIATION 6624 FANNIN STE 2505 HOUSTON, TX 77030 30-0355518	CONDO ASSOC	TX	N/A	C			Yes	
ST LUKE'S MEDICAL TOWER CONDOMINIUM ASSOCIATION 6624 FANNIN STE 2505 HOUSTON, TX 77030 76-0298751	CONDO ASSOC	TX	N/A	C			Yes	
ST VINCENT COMMUNITY HEALTH SERVICES INC TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0710785	HEALTHCARE	AR	N/A	C			Yes	
STABLEVIEW HEALTH INC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-4373713	INSURANCE	KY	N/A	C			Yes	
SUGAR LAND DOCTOR GROUP 1317 LAKE POINTE PARKWAY SUGAR LAND, TX 77478 45-4270163	MEDICAL CLINIC	TX	N/A	C			Yes	
THE TEXAS HEART INSTITUTE AT ST LUKE'S EPISCOPAL HOSPITAL DENTON A COOLEY B 6624 FANNIN STE 2505 HOUSTON, TX 77030 90-0064009	CONDO ASSOC	TX	N/A	C			Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
Yes	**No**							
TOWSON MANAGEMENT INC 7601 OSLER DR TOWSON, MD 21204 52-1710750	MGMT SERVICES	MD	N/A	C				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
BURLESON ST JOSEPH MANOR	B	919,855	ACTUAL AMTS PAID
ST JOSEPH HEALTH PARTNERS	B	800,033	ACTUAL AMTS PAID
ST JOSEPH MANOR	B	1,282,477	ACTUAL AMTS PAID
BELLVILLE ST JOSEPH	B	3,770,868	ACTUAL AMTS PAID
ST JOSEPH HEALTH PARTNERS ACO	B	10,830	ACTUAL AMTS PAID
BURLESON ST JOSEPH HEALTH CENTER	C	1,544,746	ACTUAL AMTS PAID
MADISON ST JOSEPH HEALTH CENTER	C	2,126,049	ACTUAL AMTS PAID
ST JOSEPH FOUNDATION OF BRYAN TEXAS	C	562,899	ACTUAL AMTS PAID
ST JOSEPH PHYSICIAN ASSOCIATES	C	2,211,210	ACTUAL AMTS PAID
BURLESON ST JOSEPH HEALTH CENTER	Q	72,036	CASH
MADISON ST JOSEPH HEALTH CENTER	Q	79,860	CASH
ST JOSEPH MANOR	Q	76,428	CASH
ST JOSEPH PHYSICIAN ASSOCIATES	P	15,400,000	CASH
ST JOSEPH SERVICES CORPORATION	P	10,766,427	CASH
BURLESON ST JOSEPH HEALTH CENTER	O	8,388,000	CASH
ST JOSEPH MANOR	O	5,800,000	CASH
MADISON ST JOSEPH HEALTH CENTER	O	7,851,000	CASH
BURLESON ST JOSEPH MANOR	O	5,415,000	CASH
SYLVANIA FRANCISCAN HEALTH FOUNDATION	C	930,833	CASH
BELLVILLE ST JOSEPH	P	1,830,000	ACTUAL AMTS PAID
BELLVILLE ST JOSEPH	Q	3,732,955	ACTUAL AMTS PAID