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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 07-01-2014 , and ending 06-30-2015

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------|
| B Check if applicable <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization Catholic Health Initiatives Colorado | | D Employer identification number 84-0405257 |
| | Doing business as | | |
| | Number and street (or P O box if mail is not delivered to street address) | Room/suite | E Telephone number (303) 290-6500 |
| | 188 INVERNESS DRIVE WEST | | |
| | City or town, state or province, country, and ZIP or foreign postal code ENGLEWOOD, CO 80112 | | G Gross receipts \$ 1,736,199,417 |
| F Name and address of principal officer GARY CAMPBELL 188 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 | | | |
| H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions) | | | |
| I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () <input type="checkbox"/> (insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | H(c) Group exemption number <input type="checkbox"/> 0928 | |
| J Website: <input type="checkbox"/> www.centura.org | | | |

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------|
| K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <input type="checkbox"/> | L Year of formation 1968 | M State of legal domicile CO |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------|

Part I

Summary

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------|
| Activities & Governance | 1 Briefly describe the organization's mission or most significant activities CATHOLIC HEALTH INITIATIVES-COLORADO IS A FAITH BASED ORGANIZATION THAT INVESTS IN CHARITY CARE, COMMUNITY PROGRAMS, AND SPONSORSHIPS DESIGNED TO NURTURE THE HEALTH OF THE PEOPLE OF COLORADO | | |
| | | | |
| | | | |
| | | | |
| | | | |
| 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets | | | |
| 3 Number of voting members of the governing body (Part VI, line 1a) | 3 | 9 | |
| 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 0 | |
| 5 Total number of individuals employed in calendar year 2014 (Part V, line 2a) | 5 | 12,958 | |
| 6 Total number of volunteers (estimate if necessary) | 6 | 1,350 | |
| 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 3,617,009 | |
| b Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0 | |
| Revenue | 8 Contributions and grants (Part VIII, line 1h) | Prior Year | Current Year |
| | 9 Program service revenue (Part VIII, line 2g) | 15,528,671 | 22,191,854 |
| | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 1,634,871,764 | 1,672,394,856 |
| | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 22,222,401 | 21,902,297 |
| | 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 16,797,442 | 18,976,309 |
| Expenses | 13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) | 1,689,420,278 | 1,735,465,316 |
| | 14 Benefits paid to or for members (Part IX, column (A), line 4) | 4,082,932 | 7,220,296 |
| | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 0 | 0 |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | 600,940,337 | 634,291,888 |
| | b Total fundraising expenses (Part IX, column (D), line 25) <input type="checkbox"/> 0 | 0 | 0 |
| | 17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 0 | 0 |
| | 18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 987,605,634 | 992,804,309 |
| | 19 Revenue less expenses Subtract line 18 from line 12 | 1,592,628,903 | 1,634,316,493 |
| Net Assets or Fund Balances | | Beginning of Current Year | End of Year |
| | 20 Total assets (Part X, line 16) | 96,791,375 | 101,148,823 |
| | 21 Total liabilities (Part X, line 26) | | |
| | 22 Net assets or fund balances Subtract line 21 from line 20 | 1,789,639,759 | 1,863,697,328 |
| | | 456,534,765 | 460,818,593 |
| | | 1,333,104,994 | 1,402,878,735 |

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 | <input type="checkbox"/> Signature of officer | 2016-05-16 |
| | <input type="checkbox"/> DAN ENDERSON SVP CFO/TREASURER | Date |
| | Type or print name and title | |

| | | | | | |
|------------------------|---------------------------------------------------------------------------------------------|--------------------------------------|------|-------------------------------------------------|-------------------|
| Paid Preparer Use Only | Print/Type preparer's name PAMELA KROHN | Preparer's signature PAMELA KROHN | Date | Check <input type="checkbox"/> if self-employed | PTIN P01210500 |
| | Firm's name <input type="checkbox"/> CATHOLIC HEALTH INITIATIVES | | | Firm's EIN <input type="checkbox"/> 47-0617373 | |
| | Firm's address <input type="checkbox"/> 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 | | | Phone no (303) 298-9100 | |

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

WE EXTEND THE HEALING MINISTRY OF CHRIST BY CARING FOR THOSE WHO ARE ILL AND BY NURTURING THE HEALTH OF THE PEOPLE IN OUR COMMUNITIES

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

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?

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 \$ 1,393,123,491 including grants of \$ 7,220,296) (Revenue \$ 1,671,888,064)

SEE SCHEDULE H

4b

(Code) (Expenses \$ including grants of \$) (Revenue \$)

4c

(Code) (Expenses \$ including grants of \$) (Revenue \$)

4d







Other program services (Describe in Schedule O)

(Expenses \$ including grants of \$) (Revenue \$)

4e





Total program service expenses 1,393,123,491

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 | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional  | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 | No |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H  | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?  | 20b Yes | |

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? <i>If "Yes," complete Schedule I, Parts I and II</i>  | 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? <i>If "Yes," complete Schedule I, Parts I and III</i> | 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? <i>If "Yes," complete Schedule J</i>  | 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 24a | | No |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | |
| 25a | Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</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? <i>If "Yes," complete Schedule L, Part I</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? <i>If "Yes," complete Schedule L, Part II</i> | 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? <i>If "Yes," complete Schedule L, Part III</i> | 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? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | | No |
| b | A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 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? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | | No |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | | No |
| 30 | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 | | No |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | | No |
| 32 | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 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? <i>If "Yes," complete Schedule R, Part I</i> | 33 | | No |
| 34 | Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>  | 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)? <i>If "Yes," complete Schedule R, Part V, line 2</i>  | 35b | Yes | |
| 36 | Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 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? <i>If "Yes," complete Schedule R, Part VI</i> | 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. | | |
| 1b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | | |
| c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | 1c | |
| 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 | 12,958 |
| 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? <i>If "No" to line 3b, provide an explanation in Schedule O.</i> | | 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? <i>If "No," provide an explanation in Schedule O.</i> | | 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 | | |
| | 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 | | |
| 1b | Enter the number of voting members included in line 1a, above, who are independent | | |
| 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? | | 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? | | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | | No |
| 6 | Did the organization have members or stockholders? | 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? | Yes | |
| 7b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | Yes | |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | |
| 8a | The governing body? | Yes | |
| 8b | Each committee with authority to act on behalf of the governing body? | 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 | | 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? | | No |
| 10b | 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? | | |
| 11a | Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? | Yes | |
| 11b | 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 | Yes | |
| 12b | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | Yes | |
| 12c | Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done | Yes | |
| 13 | Did the organization have a written whistleblower policy? | Yes | |
| 14 | Did the organization have a written document retention and destruction policy? | 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? | | |
| 15a | The organization's CEO, Executive Director, or top management official | | No |
| 15b | Other officers or key employees of the organization | 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? | Yes | |
| 16b | 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? | | No |

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
CAROL TRAVIS

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 | | | |
| (1) GARY CAMPBELL CEO/PRESIDENT | 1 00 0 00 | X | | X | | | | 0 | 0 | 0 |
| (2) THOMAS LEMON BOARD MEMBER | 1 00 0 | X | | | | | | 0 | 0 | 0 |
| (3) TERRY O'ROURKE BOARD MEMBER | 1 00 0 | X | | | | | | 0 | 0 | 0 |
| (4) RICHARD REINER BOARD MEMBER | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (5) MICHAEL ROWAN FACHE BOARD MEMBER/EVP CHI COO | 1 00 59 00 | X | | | | | | 0 | 2,500,443 | 53,656 |
| (6) TERRY SHAW BOARD MEMBER | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (7) DEAN SWINDLE CPA BOARD MEMBER/EVP CHI CFO | 1 00 59 00 | X | | | | | | 0 | 1,755,692 | 259,351 |
| (8) BLAIR TIKKER BOARD MEMBER | 1 00 0 | X | | | | | | 0 | 0 | 0 |
| (9) PATRICIA WEBB BOARD MEMBER | 1 00 60 00 | X | | | | | | 0 | 998,235 | 164,266 |
| (10) Dan Enderson Treasurer/SVP Chief Finance Officer | 1 00 0 00 | | | X | | | | 0 | 0 | 0 |
| (11) KRIS ORDELHEIDE SECRETARY/SVP LEGAL SVCS | 1 00 0 00 | | | X | | | | 0 | 0 | 0 |
| (12) Jeffrey Brickman Group Chief Executive Officer | 40 00 0 00 | | | | X | | | 965,499 | 0 | 181,677 |
| (13) Janiece MCNichols CFO-St Anthony North | 50 00 0 | | | | X | | | 227,658 | 0 | 24,240 |
| (14) DANIEL REEVES CFO - PENROSE ST FRANCIS | 40 00 0 00 | | | | X | | | 335,485 | 0 | 34,802 |

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 | | | |
| (15) MARGARET SABIN | 40 00 | | | | X | | | 962,711 | 0 | 170,865 |
| CEO - PENROSE ST FRANCIS | 0 00 | | | | | | | | | |
| (16) DAVID THOMPSON | 40 00 | | | | X | | | 419,268 | 0 | 22,398 |
| CFO - ST ANTHONY | 1 00 | | | | | | | | | |
| (17) Camille Azar | 40 00 | | | | | X | | 742,160 | 0 | 37,126 |
| Physician | 0 | | | | | | | | | |
| (18) Michael Drewek | 40 00 | | | | | X | | 774,265 | 0 | 37,786 |
| Physician | 0 | | | | | | | | | |
| (19) Alexander Fraley | 40 00 | | | | | X | | 685,125 | 0 | 37,611 |
| Physician | 0 | | | | | | | | | |
| (20) A STEWART LEVY | 40 00 | | | | | X | | 797,673 | 0 | 37,587 |
| PHYSICIAN | 0 | | | | | | | | | |
| (21) Mark ROBINSON | 50 00 | | | | | X | | 717,053 | 0 | 35,934 |
| Physician | 0 | | | | | | | | | |

| | | | | |
|----|-------------------------------------------------------|-----------|-----------|-----------|
| 1b | Sub-Total | | | |
| c | Total from continuation sheets to Part VII, Section A | | | |
| d | Total (add lines 1b and 1c) | 6,626,897 | 5,254,370 | 1,097,299 |

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▶577

| | | Yes | No |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| 3 | Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> | 3 | 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? <i>If "Yes," complete Schedule J for such individual</i> | 4 | Yes |
| 5 | Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> | 5 | No |

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|----------------------------------------------------------------------------------------------------------|--------------------------------|---------------------|
| COLORADO SPRINGS CARDIOLOGISTS | MEDICAL SERVICES | 8,637,612 |
| FRONT RANGE ORTHOPEDICS 4105 BRIARGATE PARKWAY SUITE 300 COLORADO SPRINGS, CO 80920 | MEDICAL SERVICES | 3,881,607 |
| ACADEMY WOMENS HEALTHCARE 6071 E WOODMEN POAD COLORADO SPRINGS, CO 80923 | MEDICAL SERVICES | 2,174,787 |
| COLORADO ORTHOPEDIC SPECIALIST PLLC 4105 BRIARGATE PARKWAY SUITE 300 COLORADO SPRINGS, CO 80920 | MEDICAL SERVICES | 2,119,571 |
| CARDIAC & THORACIC SURGERY ASSOCIATION 2222 N NEVADA AVE SUITE 5011 COLORADO SPRINGS, CO 80907 | MEDICAL SERVICES | 2,091,723 |

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 ▶144

Part VIII

Statement of Revenue

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

| | | | | (A) | (B) | (C) | (D) |
|-----------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------|---------------------------------------------|----------------------------------|--------------------------------------------------------------|
| | | | | Total revenue | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512-514 |
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns | 1a | 0 | | | |
| | b | Membership dues | 1b | 0 | | | |
| | c | Fundraising events | 1c | 0 | | | |
| | d | Related organizations | 1d | 12,265,666 | | | |
| | e | Government grants (contributions) | 1e | 296,385 | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 9,629,803 | | | |
| | g | Noncash contributions included in lines 1a-1f \$ | | 0 | | | |
| | h | Total. Add lines 1a-1f | | 22,191,854 | | | |
| Program Service Revenue | 2a | Patient Services | Business Code | | | | |
| | | | 900099 | 1,635,165,940 | 1,634,659,148 | 506,792 | 0 |
| | b | Equity changes of unconsolidated orgs | 900099 | 31,083,891 | 31,083,891 | 0 | 0 |
| | c | Rental Income | 900099 | 5,796,182 | 5,796,182 | 0 | 0 |
| | d | Education | 611710 | 348,843 | 348,843 | 0 | 0 |
| | e | | | 0 | 0 | 0 | 0 |
| | f | All other program service revenue | | 0 | 0 | 0 | 0 |
| | g | Total. Add lines 2a-2f | | 1,672,394,856 | | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | 9,914,088 | 0 | -17,243 | 9,931,331 |
| | 4 | Income from investment of tax-exempt bond proceeds | | 0 | 0 | 0 | 0 |
| | 5 | Royalties | | 0 | 0 | 0 | 0 |
| | 6a | Gross rents | (i) Real | | | | |
| | | | 735,353 | | | | |
| | | | (ii) Personal | | | | |
| | | | 0 | | | | |
| | b | Less rental expenses | | 0 | | | |
| | c | Rental income or (loss) | | 735,353 | | | |
| | d | Net rental income or (loss) | | 735,353 | 0 | 0 | 735,353 |
| | 7a | Gross amount from sales of assets other than inventory | (i) Securities | | | | |
| | | | 11,923,789 | | | | |
| | | | (ii) Other | | | | |
| | | | 64,420 | | | | |
| | b | Less cost or other basis and sales expenses | | 0 | | | |
| | c | Gain or (loss) | | 11,923,789 | | | |
| | d | Net gain or (loss) | | 11,988,209 | 0 | 0 | 11,988,209 |
| | 8a | Gross income from fundraising events (not including \$ 0 of contributions reported on line 1c) See Part IV, line 18 | | | | | |
| | | | a | 0 | | | |
| | b | Less direct expenses | b | 0 | | | |
| | c | Net income or (loss) from fundraising events | | 0 | | 0 | 0 |
| | 9a | Gross income from gaming activities See Part IV, line 19 | | | | | |
| | | | a | 0 | | | |
| | b | Less direct expenses | b | 0 | | | |
| | c | Net income or (loss) from gaming activities | | 0 | 0 | 0 | 0 |
| | 10a | Gross sales of inventory, less returns and allowances | | | | | |
| | | | a | 1,124,910 | | | |
| | b | Less cost of goods sold | b | 734,101 | | | |
| | c | Net income or (loss) from sales of inventory | | 390,809 | 0 | 0 | 390,809 |
| | Miscellaneous Revenue | | Business Code | | | | |
| | 11a | Cafeteria | 722100 | 6,025,430 | 0 | | 6,025,430 |
| | b | Pharmacy Services | 446110 | 3,098,886 | 0 | 3,098,886 | 0 |
| | c | Child Care | 624410 | 587,515 | 0 | | 587,515 |
| | d | All other revenue | | 8,138,316 | 0 | 28,574 | 8,109,742 |
| | e | Total. Add lines 11a-11d | | 17,850,147 | | | |
| | 12 | Total revenue. See Instructions | | 1,735,465,316 | 1,671,888,064 | 3,617,009 | 37,768,389 |

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. | 7,220,296 | 7,220,296 | | |
| 2 | Grants and other assistance to domestic individuals. See Part IV, line 22. | | | | |
| 3 | Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | | | | |
| 4 | Benefits paid to or for members. | | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees. | | | | |
| 6 | 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. | 514,885,184 | 418,601,654 | 96,283,530 | |
| 8 | Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions). | 26,251,744 | 21,342,668 | 4,909,076 | |
| 9 | Other employee benefits. | 57,366,020 | 46,638,574 | 10,727,446 | |
| 10 | Payroll taxes. | 35,788,940 | 29,096,408 | 6,692,532 | |
| 11 | Fees for services (non-employees): | | | | |
| a | Management. | | | | |
| b | Legal. | 135,022 | | 135,022 | |
| c | Accounting. | | | | |
| 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). | 401,522,947 | 327,250,506 | 74,272,441 | 0 |
| 12 | Advertising and promotion. | 6,134,350 | 4,987,227 | 1,147,123 | |
| 13 | Office expenses. | 42,293,526 | 34,384,637 | 7,908,889 | |
| 14 | Information technology. | | | | |
| 15 | Royalties. | | | | |
| 16 | Occupancy. | 36,779,137 | 29,901,438 | 6,877,699 | |
| 17 | Travel. | 2,668,776 | 2,169,715 | 499,061 | |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials. | | | | |
| 19 | Conferences, conventions, and meetings. | 1,169,670 | 950,941 | 218,729 | |
| 20 | Interest. | 8,520,614 | 6,927,259 | 1,593,355 | |
| 21 | Payments to affiliates. | | | | |
| 22 | Depreciation, depletion, and amortization. | 108,900,357 | 88,535,991 | 20,364,366 | |
| 23 | Insurance. | 10,549,404 | 8,576,665 | 1,972,739 | |
| 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 | Bad debts. | 49,314,457 | 49,314,457 | | |
| b | State Provider Tax. | 72,890,624 | 72,890,624 | | |
| c | Repairs and maintenance. | 28,752,356 | 28,752,356 | | |
| d | Medical Supplies. | 215,582,075 | 215,582,075 | | |
| e | All other expenses. | 7,590,994 | 0 | 7,590,994 | 0 |
| 25 | Total functional expenses. Add lines 1 through 24e. | 1,634,316,493 | 1,393,123,491 | 241,193,002 | 0 |
| 26 | Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). | | | | |

Part X

Balance Sheet

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

| | | | | (A) | | (B) |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------------|-----|---------------|
| | | | | Beginning of year | | End of year |
| Assets | 1 | Cash—non-interest-bearing | | 48,783,379 | 1 | 45,054,652 |
| | 2 | Savings and temporary cash investments | | 51,549 | 2 | 48,410 |
| | 3 | Pledges and grants receivable, net | | | 3 | |
| | 4 | Accounts receivable, net | | 243,233,475 | 4 | 258,124,317 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 0 | 5 | 0 |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L | | 0 | 6 | |
| | 7 | Notes and loans receivable, net | | 4,106,948 | 7 | 2,046,623 |
| | 8 | Inventories for sale or use | | 32,420,945 | 8 | 33,131,058 |
| | 9 | Prepaid expenses and deferred charges | | 5,903,750 | 9 | 9,137,443 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a | 1,933,382,177 | | |
| | b | Less accumulated depreciation | 10b | 765,375,300 | 10c | 1,168,006,877 |
| | 11 | Investments—publicly traded securities | | | 11 | |
| | 12 | Investments—other securities See Part IV, line 11 | | 163,216,309 | 12 | 92,870,970 |
| | 13 | Investments—program-related See Part IV, line 11 | | 0 | 13 | |
| | 14 | Intangible assets | | 4,405,144 | 14 | 15,306,397 |
| | 15 | Other assets See Part IV, line 11 | | 176,671,518 | 15 | 239,970,581 |
| | 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 1,789,639,759 | 16 | 1,863,697,328 |
| Liabilities | 17 | Accounts payable and accrued expenses | | 210,880,329 | 17 | 220,734,660 |
| | 18 | Grants payable | | | 18 | |
| | 19 | Deferred revenue | | 17,837,861 | 19 | 18,577,036 |
| | 20 | Tax-exempt bond liabilities | | | 20 | |
| | 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 | | 0 | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | | 23 | |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 0 | 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 | | 227,816,575 | 25 | 221,506,897 |
| | 26 | Total liabilities. Add lines 17 through 25 | | 456,534,765 | 26 | 460,818,593 |
| 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 | | 1,333,084,773 | 27 | 1,402,858,514 |
| | 28 | Temporarily restricted net assets | | 10,221 | 28 | 10,221 |
| | 29 | Permanently restricted net assets | | 10,000 | 29 | 10,000 |
| | 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 | | 1,333,104,994 | 33 | 1,402,878,735 |
| | 34 | Total liabilities and net assets/fund balances | | 1,789,639,759 | 34 | 1,863,697,328 |

Part XI Reconciliation of Net Assets

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

| | | | |
|----|---------------------------------------------------------------------------------------------------------------|----|---------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 1,735,465,316 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 1,634,316,493 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 101,148,823 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 1,333,104,994 |
| 5 | Net unrealized gains (losses) on investments | 5 | -9,716,229 |
| 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 | -21,658,853 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 1,402,878,735 |

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 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | |
| 2a | Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | 2a | No |
| 2b | Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | 2b | Yes |
| 2c | If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O | 2c | Yes |
| 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 | Yes |
| 3b | 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 | Yes |

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 Catholic Health Initiatives Colorado | Employer identification number 84-0405257 |
|------------------------------------------------------------------|----------------------------------------------|

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? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|-----------------------------------|----------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------|----|---------------------------------------------------|-------------------------------------------------|
| | | | Yes | No | | |
| | | | | | | |
| | | | | | | |
| Total | | | | | | |

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization 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 IIISupport 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. | | |
| 2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization. | | |

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

| | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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? | | |
| 2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s). | | |
| 3 By reason of the relationship described in (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. | | |

Section E. Type III Functionally-Integrated Supporting Organizations

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions) | | | |
| a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below. | | | |
| b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below. | | | |
| c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions). | | | |
| 2 <u>Activities Test</u> 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. | | | |
| 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. | | | |
| 3 <u>Parent of Supported Organizations</u> 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. | | | |
| 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. | | | |

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 | <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) | | |

| 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

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 Catholic Health Initiatives Colorado | Employer identification number 84-0405257 |
|------------------------------------------------------------------|----------------------------------------------|

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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4a | Was a correction made? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b | If "Yes," describe in Part IV | |

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

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

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

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 | | | | | | | | | | | | | | | |
| <table><tr><td>If the amount on line 1e, column (a) or (b) is:</td><td>The lobbying nontaxable amount is:</td></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table> | | 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 | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e | | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000 | | | | | | | | | | | | | | |
| g Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | | |
| h Subtract line 1g from line 1a If zero or less, enter -0- | | | | | | | | | | | | | | | |
| i Subtract line 1f from line 1c If zero or less, enter -0- | | | | | | | | | | | | | | | |
| j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | |

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|--------------------------------------------------------------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 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) | (b) |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|--------------|
| | | Yes | No Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | |
| a | Volunteers? | | No |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No |
| c | Media advertisements? | | No |
| d | Mailings to members, legislators, or the public? | | No |
| e | Publications, or published or broadcast statements? | | No |
| f | Grants to other organizations for lobbying purposes? | Yes | 44,534 |
| 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? | | No |
| j | Total. Add lines 1c through 1i. | | 44,534 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No |
| b | If "Yes," enter the amount of any tax incurred under section 4912. | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912. | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | |

Part III-A

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

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

Part III-B

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

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

Part IV

Supplemental Information

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

| Return Reference | Explanation |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY | THE ENTITY'S CONTROLLING ORGANIZATION, CATHOLIC HEALTH INITIATIVES, PAYS ANNUAL DUES TO THE AMERICAN HOSPITAL ASSOCIATION, A PORTION OF WHICH IS ALLOCATED TO LOBBYING. THE AMOUNT SHOWN IN LINE 1F REPRESENTS THIS ENTITY'S SHARE OF THE ALLOCATED LOBBYING EXPENSES. American Hospital Association \$2,950. Additionally, Centura paid annual dues to Colorado Health Association, a portion of which is allocated to lobbying. The amount that represents this entity's share of the allocated lobbying expenses is as follows: Colorado Health Association \$41,584. |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

[illegible]

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 Catholic Health Initiatives Colorado | Employer identification number 84-0405257 |
|------------------------------------------------------------------|----------------------------------------------|

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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |
| 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |

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 |
| b | Total acreage restricted by conservation easements |
| c | Number of conservation easements on a certified historic structure included in (a) |
| d | Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register |

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

▶ \$ _____

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

Cat No 52283D

Schedule D (Form 990) 2014

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
- c Beginning balance

d Additions during the year

e Distributions during the year

f Ending balance

| | |
|----|--------|
| | Amount |
| 1c | |
| 1d | |
| 1e | |
| 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 | b (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
- (i) unrelated organizations

(ii) related organizations

3a(i)

3a(ii)

3b

Yes

No
- b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?
- 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 | | 75,042,859 | | 75,042,859 |
| b Buildings | | 1,229,884,423 | 223,241,289 | 1,006,643,134 |
| c Leasehold improvements | | | 134,392,643 | -134,392,643 |
| d Equipment | | 550,238,514 | 392,661,324 | 157,577,190 |
| e Other | | 78,216,381 | 15,080,044 | 63,136,337 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).) ▶ | | | | 1,168,006,877 |

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

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

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

Part XIII Supplemental Information

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

| Return Reference | Explanation |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule D, Part X, Line 2 FIN 48 (ASC 740) footnote | Catholic Health Initiatives-Colorado's (CHIC) financial information is included in the consolidated audited financial statements of Catholic Health Initiatives (CHI), a related organization. CHI's FIN 48 (ASC 740) footnote for the year ended June 30, 2015, reads as follows: "CHI is a tax-exempt Colorado corporation and has been granted an exemption from federal income tax under Section 501(c)(3) of the Internal Revenue Code. CHI owns certain taxable subsidiaries and engages in certain activities that are unrelated to its exempt purpose and therefore subject to income tax. Management reviews its tax positions annually and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated financial statements." |
| | |
| | |
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| | |
| | |
| | |

[illegible]

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
Catholic Health Initiatives Colorado

Employer identification number
84-0405257

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

7

Financial Assistance and Certain Other Community Benefits at Cost

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|-------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| a Financial Assistance at cost (from Worksheet 1) | | | 18,060,690 | 0 | 18,060,690 | 1 14 % |
| b Medicaid (from Worksheet 3, column a) | | | 122,936,901 | 0 | 122,936,901 | 7 76 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | 10,094,800 | 0 | 10,094,800 | 0 64 % |
| d Total Financial Assistance and Means-Tested Government Programs | 0 | 0 | 151,092,391 | 0 | 151,092,391 | 9 53 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 7,676,460 | 0 | 7,676,460 | 0 48 % |
| f Health professions education (from Worksheet 5) | | | 3,257,547 | 0 | 3,257,547 | 0 21 % |
| g Subsidized health services (from Worksheet 6) | | | 2,545,219 | 0 | 2,545,219 | 0 16 % |
| h Research (from Worksheet 7) | | | 164,165 | 0 | 164,165 | 0 01 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 572,102 | 0 | 572,102 | 0 04 % |
| j Total Other Benefits | 0 | 0 | 14,215,493 | 0 | 14,215,493 | 0 90 % |
| k Total . Add lines 7d and 7j | 0 | 0 | 165,307,884 | 0 | 165,307,884 | 10 43 % |

Part IICommunity 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 |
|------------------------------------------------------------|-------------------------------------------------|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1Physical improvements and housing | | | | | 0 | 0 % |
| 2Economic development | | | | | 0 | 0 % |
| 3Community support | | | | | 0 | 0 % |
| 4Environmental improvements | | | | | 0 | 0 % |
| 5Leadership development and training for community members | | | | | 0 | 0 % |
| 6Coalition building | | | | | 0 | 0 % |
| 7Community health improvement advocacy | | | | | 0 | 0 % |
| 8Workforce development | | | | | 0 | 0 % |
| 9Other | | | | | 0 | 0 % |
| 10Total | 0 | 0 | 0 | 0 | 0 | 0 % |

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?

1Yes

No

2Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

249,314,457

3Enter 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.

30

4Provide 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

5Enter total revenue received from Medicare (including DSH and IME).

5421,478,417

6Enter Medicare allowable costs of care relating to payments on line 5.

6545,978,739

7Subtract line 6 from line 5. This is the surplus (or shortfall).

7-124,500,322

8Describe 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

9aDid the organization have a written debt collection policy during the tax year?

9aYes

No

bIf "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.

9bYes

No

Part IVManagement 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 ORTHOCOLORADO LLC | HOSPITAL | 60 % | 0 % | 40 % |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Section A. Hospital Facilities

9

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)

[illegible]

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)

PENROSE HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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 If "Yes," indicate what the CHNA report describes (check all that apply) | 3 | Yes |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>12</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes |
| 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 | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | 7 | Yes |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>www.penrosetfrancis.org/PSF/Community/Community-Benefit</u> | | |
| b <input checked="" type="checkbox"/> Other website (list url) <u>www.centura.org/community-benefits</u> | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>12</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a If "Yes" (list url) <u>www.penrosetfrancis.org/psf/community/community-benefit</u> | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

PENROSE HOSPITAL

Name of hospital facility or letter of facility reporting group

| | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----|
| Financial Assistance Policy (FAP) | | |
| 13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input checked="" type="checkbox"/> Asset level | | |
| d <input checked="" type="checkbox"/> Medical indigency | | |
| e <input checked="" type="checkbox"/> Insurance status | | |
| f <input checked="" type="checkbox"/> Underinsurance discount | | |
| g <input type="checkbox"/> Residency | | |
| h <input type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https //www penrosetfrancis org/financial-help/</u> | | |
| <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) | | |
| b <u>HTTPS //WWW PENROSESTFRANCIS ORG/FINANCIAL-HELP/</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW PENROSESTFRANCIS ORG/FINANCIAL-HELP/</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input type="checkbox"/> 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 <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

PENROSE HOSPITAL

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? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made | 19 | No |
| Policy Relating to Emergency Medical Care | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C) | 21 | Yes |
| 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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 23 | No |
| | | 24 | No |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

ST ANTHONY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

2

| | | 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 | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| 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 | <input checked="" type="checkbox"/> Hospital facility's website (list url) http //www stanthonyhosp org/sah/community/community-benefit/community-benefit/ | | |
| b | <input checked="" type="checkbox"/> Other website (list url) https //www centura org/community-benefits/ | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| http //www stanthonyhosp org/sah/community/community-benefit/community-benefit/ | | | |
| a | If "Yes" (list url) benefit/ | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

ST ANTHONY HOSPITAL

| | | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|----|
| Financial Assistance Policy (FAP) | | | |
| 13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | | |
| c <input checked="" type="checkbox"/> Asset level | | | |
| d <input checked="" type="checkbox"/> Medical indigency | | | |
| e <input checked="" type="checkbox"/> Insurance status | | | |
| f <input checked="" type="checkbox"/> Underinsurance discount | | | |
| g <input type="checkbox"/> Residency | | | |
| h <input type="checkbox"/> Other (describe in Section C) | | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 Explained the method for applying for financial assistance? | 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 <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e <input type="checkbox"/> Other (describe in Section C) | | | |
| 16 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 <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>See Supplemental Narrative</u> | | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>See Supplemental Narrative</u> | | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>See Supplemental Narrative</u> | | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i <input type="checkbox"/> 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 <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | | |

Part V

Facility Information (continued)

ST ANTHONY HOSPITAL

Name of hospital facility or letter of facility reporting group

| | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| <div>19</div> <div>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?</div> <div>If "Yes," check all actions in which the hospital facility or a third party engaged</div> <div><div>a</div><div><input type="checkbox"/></div><div>Reporting to credit agency(ies)</div></div> <div><div>b</div><div><input type="checkbox"/></div><div>Selling an individual's debt to another party</div></div> <div><div>c</div><div><input type="checkbox"/></div><div>Actions that require a legal or judicial process</div></div> <div><div>d</div><div><input type="checkbox"/></div><div>Other similar actions (describe in Section C)</div></div> <div>20</div> <div>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)</div> <div><div>a</div><div><input checked="" type="checkbox"/></div><div>Notified individuals of the financial assistance policy on admission</div></div> <div><div>b</div><div><input type="checkbox"/></div><div>Notified individuals of the financial assistance policy prior to discharge</div></div> <div><div>c</div><div><input checked="" type="checkbox"/></div><div>Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills</div></div> <div><div>d</div><div><input checked="" type="checkbox"/></div><div>Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy</div></div> <div><div>e</div><div><input type="checkbox"/></div><div>Other (describe in Section C)</div></div> <div><div>f</div><div><input type="checkbox"/></div><div>None of these efforts were made</div></div> | 19 | No |
| <div>Policy Relating to Emergency Medical Care</div> | | |
| <div>21</div> <div>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?</div> <div>If "No," indicate why</div> <div><div>a</div><div><input type="checkbox"/></div><div>The hospital facility did not provide care for any emergency medical conditions</div></div> <div><div>b</div><div><input type="checkbox"/></div><div>The hospital facility's policy was not in writing</div></div> <div><div>c</div><div><input type="checkbox"/></div><div>The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)</div></div> <div><div>d</div><div><input type="checkbox"/></div><div>Other (describe in Section C)</div></div> | 21 | Yes |
| <div>Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</div> | | |
| <div>22</div> <div>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</div> <div><div>a</div><div><input type="checkbox"/></div><div>The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged</div></div> <div><div>b</div><div><input type="checkbox"/></div><div>The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged</div></div> <div><div>c</div><div><input type="checkbox"/></div><div>The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged</div></div> <div><div>d</div><div><input checked="" type="checkbox"/></div><div>Other (describe in Section C)</div></div> <div>23</div> <div>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?</div> <div>If "Yes," explain in Section C</div> <div>24</div> <div>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?</div> <div>If "Yes," explain in Section C</div> | 23 | No |
| | 24 | No |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

MERCY REGIONAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

3

| | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | 3 | Yes |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | 7 | Yes |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url) https //www.mercydurango.org/MDU/Community/Community-Benefit/ | | |
| b <input checked="" type="checkbox"/> Other website (list url) https //www.centura.org/community-benefits/ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a If "Yes" (list url) https //www.mercydurango.org/MDU/Community/Community-Benefit/ | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

MERCY REGIONAL MEDICAL CENTER

| | | Yes | No |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? | 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 | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> 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 | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https //www.mercydurango.org/Financial-Help/</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http //www.mercydurango.org/financial-help/</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http //www.mercydurango.org/financial-help/</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> 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 | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

MERCY 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? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | |
| a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e <input type="checkbox"/> Other (describe in Section C) | | | |
| f <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | |
| 21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d <input type="checkbox"/> Other (describe in Section C) | | | |
| 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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

ST MARY-CORWIN MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

4

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

Name of hospital facility or letter of facility reporting group

ST MARY-CORWIN MEDICAL CENTER

| | | Yes | No |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? | 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 | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | 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 | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>http //www stmarycorwin org/Financial-Help/</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>http //www stmarycorwin org/Financial-Help/</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http //www stmarycorwin org/Financial-Help/</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> 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 | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

ST MARY-CORWIN 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? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| 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 | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d | <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

ST FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

5

| | 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 <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| 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 <input checked="" type="checkbox"/> Hospital facility's website (list url) http //www.penrosetfrancis.org/PSF/Community/Community-Benefit/ | | |
| b <input checked="" type="checkbox"/> Other website (list url) https //www.centura.org/community-benefits/ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a If "Yes" (list url) https //www.penrosetfrancis.org/psf/community/community-benefit/ | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

ST FRANCIS MEDICAL CENTER

| | | Yes | No |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? | 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 | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | 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 | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https //www.penrosetfrancis org/financial-help/</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>https //www.penrosetfrancis org/financial-help/</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https //www.penrosetfrancis org/financial-help/</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> 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 | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V Facility Information (continued)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ST FRANCIS MEDICAL CENTER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of hospital facility or letter of facility reporting group | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table><tr><td></td><td>Yes</td><td>No</td></tr></table> | | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | <table><tr><td>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?</td><td>19</td><td></td><td>No</td></tr><tr><td>If "Yes," check all actions in which the hospital facility or a third party engaged</td><td></td><td></td><td></td></tr><tr><td>a <input type="checkbox"/> Reporting to credit agency(ies)</td><td></td><td></td><td></td></tr><tr><td>b <input type="checkbox"/> Selling an individual's debt to another party</td><td></td><td></td><td></td></tr><tr><td>c <input type="checkbox"/> Actions that require a legal or judicial process</td><td></td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Other similar actions (describe in Section C)</td><td></td><td></td><td></td></tr><tr><td>20</td><td colspan="3">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)</td></tr><tr><td>a <input checked="" type="checkbox"/></td><td colspan="3">Notified individuals of the financial assistance policy on admission</td></tr><tr><td>b <input type="checkbox"/></td><td colspan="3">Notified individuals of the financial assistance policy prior to discharge</td></tr><tr><td>c <input checked="" type="checkbox"/></td><td colspan="3">Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills</td></tr><tr><td>d <input checked="" type="checkbox"/></td><td colspan="3">Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy</td></tr><tr><td>e <input type="checkbox"/></td><td colspan="3">Other (describe in Section C)</td></tr><tr><td>f <input type="checkbox"/></td><td colspan="3">None of these efforts were made</td></tr><tr><td colspan="4">Policy Relating to Emergency Medical Care</td></tr><tr><td>21</td><td colspan="3">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?</td></tr><tr><td></td><td>21</td><td>Yes</td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td>a <input type="checkbox"/></td><td colspan="3">The hospital facility did not provide care for any emergency medical conditions</td></tr><tr><td>b <input type="checkbox"/></td><td colspan="3">The hospital facility's policy was not in writing</td></tr><tr><td>c <input type="checkbox"/></td><td colspan="3">The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)</td></tr><tr><td>d <input type="checkbox"/></td><td colspan="3">Other (describe in Section C)</td></tr><tr><td colspan="4">Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)</td></tr><tr><td>22</td><td colspan="3">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</td></tr><tr><td>a <input type="checkbox"/></td><td colspan="3">The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged</td></tr><tr><td>b <input type="checkbox"/></td><td colspan="3">The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged</td></tr><tr><td>c <input type="checkbox"/></td><td colspan="3">The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged</td></tr><tr><td>d <input checked="" type="checkbox"/></td><td colspan="3">Other (describe in Section C)</td></tr><tr><td>23</td><td colspan="3">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?</td></tr><tr><td></td><td>23</td><td></td><td>No</td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td>24</td><td colspan="3">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?</td></tr><tr><td></td><td>24</td><td></td><td>No</td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td colspan="3">If "Yes," explain in Section C</td></tr></table> | 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 <input type="checkbox"/> Reporting to credit agency(ies) | | | | b <input type="checkbox"/> Selling an individual's debt to another party | | | | c <input type="checkbox"/> Actions that require a legal or judicial process | | | | d <input type="checkbox"/> Other similar actions (describe in Section C) | | | | 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | a <input checked="" type="checkbox"/> | Notified individuals of the financial assistance policy on admission | | | b <input type="checkbox"/> | Notified individuals of the financial assistance policy prior to discharge | | | c <input checked="" type="checkbox"/> | Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | d <input checked="" type="checkbox"/> | Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | e <input type="checkbox"/> | Other (describe in Section C) | | | f <input type="checkbox"/> | None of these efforts were made | | | Policy Relating to Emergency Medical Care | | | | 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | | | | 21 | Yes | | | | | | a <input type="checkbox"/> | The hospital facility did not provide care for any emergency medical conditions | | | b <input type="checkbox"/> | The hospital facility's policy was not in writing | | | c <input type="checkbox"/> | The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | d <input type="checkbox"/> | Other (describe in Section C) | | | 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 <input type="checkbox"/> | The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | b <input type="checkbox"/> | The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | c <input type="checkbox"/> | The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | d <input checked="" type="checkbox"/> | 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 | | | | | 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 | | |
| 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 <input type="checkbox"/> Reporting to credit agency(ies) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a <input checked="" type="checkbox"/> | Notified individuals of the financial assistance policy on admission | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input type="checkbox"/> | Notified individuals of the financial assistance policy prior to discharge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input checked="" type="checkbox"/> | Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input checked="" type="checkbox"/> | Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e <input type="checkbox"/> | Other (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f <input type="checkbox"/> | None of these efforts were made | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy Relating to Emergency Medical Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21 | Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| a <input type="checkbox"/> | The hospital facility did not provide care for any emergency medical conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input type="checkbox"/> | The hospital facility's policy was not in writing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input type="checkbox"/> | The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input type="checkbox"/> | Other (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 <input type="checkbox"/> | The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input type="checkbox"/> | The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input type="checkbox"/> | The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input checked="" type="checkbox"/> | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | 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)

ST ANTHONY NORTH HOSPITAL

Name of hospital facility or letter of facility reporting group

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

6

| | | 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 |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | No |
| 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 | <input checked="" type="checkbox"/> Hospital facility's website (list url) http //www stanthonynorthhealthcampus org/shc/community/community-benefit/ | | |
| b | <input checked="" type="checkbox"/> Other website (list url) https //www centura org/community-benefits/ | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a | https //www stanthonynorthhealthcampus org/SHC/Community/Community- If "Yes" (list url) Benefit/ | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

ST ANTHONY NORTH HOSPITAL

| | 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? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input checked="" type="checkbox"/> Asset level | | |
| d <input checked="" type="checkbox"/> Medical indigency | | |
| e <input checked="" type="checkbox"/> Insurance status | | |
| f <input checked="" type="checkbox"/> Underinsurance discount | | |
| g <input type="checkbox"/> Residency | | |
| h <input type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>http //www stanthonynorthhealthcampus org/financial-help/</u> | | |
| <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) | | |
| b <u>http //www stanthonynorthhealthcampus org/financial</u> <u>-help/</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>http //www stanthonynorthhealthcampus org/financial-help/</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input type="checkbox"/> 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 <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

ST ANTHONY NORTH HOSPITAL

| | | | | |
|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|----|
| 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? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| 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 | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d | <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

ST ANTHONY SUMMIT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

7

| | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | 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 <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | No |
| 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 <input checked="" type="checkbox"/> Hospital facility's website (list url) https //www.summitmedicalcenter.org/SMC/Community/Community-Benefit/ | | |
| b <input checked="" type="checkbox"/> Other website (list url) https //www.summitmedicalcenter.org/SMC/Community/Community-Benefit/ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a If "Yes" (list url) https //www.summitmedicalcenter.org/SMC/Community/Community-Benefit/ | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

ST ANTHONY SUMMIT MEDICAL CENTER

| | 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? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input checked="" type="checkbox"/> Asset level | | |
| d <input checked="" type="checkbox"/> Medical indigency | | |
| e <input checked="" type="checkbox"/> Insurance status | | |
| f <input checked="" type="checkbox"/> Underinsurance discount | | |
| g <input type="checkbox"/> Residency | | |
| h <input type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 Explained the method for applying for financial assistance? | 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 <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 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 <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https //www summitmedicalcenter org/Financial-Help/</u> | | |
| <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) | | |
| b <u>https //www summitmedicalcenter org/Financial-Help/</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https //www summitmedicalcenter org/Financial-Help/</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input type="checkbox"/> 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 <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

ST ANTHONY SUMMIT 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? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| 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 | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d | <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

ST THOMAS MORE HOSPITAL

Name of hospital facility or letter of facility reporting group

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

8

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

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

ST THOMAS MORE HOSPITAL

| | | Yes | No |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? | 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 | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | 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 | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https //www stmhospital org/financial-help/</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>https //www stmhospital org/financial-help/</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https //www stmhospital org/financial-help/</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> 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 | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

ST THOMAS MORE HOSPITAL

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? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| f | <input type="checkbox"/> None of these efforts were made | | |

Policy Relating to Emergency Medical Care

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

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 | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d | <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

OrthoColorado Hospital

Name of hospital facility or letter of facility reporting group

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

9

| | | Yes | No |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Community Health Needs Assessment | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | 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 |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 12 | | |
| 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 | No |
| 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) | | |
| | <input checked="" type="checkbox"/> Hospital facility's website (list url) | | |
| a | https //www.orthocolorado.org/uploadedFiles/orthocolorado/Content/O%20CO/Community/O%20CHNA%202012%20 | | |
| b | <input type="checkbox"/> Other website (list url) | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 12 | | |
| 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 | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 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)

Name of hospital facility or letter of facility reporting group

OrthoColorado Hospital

| | | Yes | No |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 | Yes |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1 0</u> % and FPG family income limit for eligibility for discounted care of <u>4 0</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? | 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 | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | 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 | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>https://www.centura.org/for-patients-and-families/billing-and-financial-services/financial-help/</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>https://www.centura.org/for-patients-and-families/billing-and-financial-services/financial-help/</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>https://www.centura.org/for-patients-and-families/billing-and-financial-services/financial-help/</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> 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 | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V

Facility Information (continued)

OrthoColorado Hospital

| | | | | |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|----|
| 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? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission b <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made | 19 | | No |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C) | 21 | Yes | |
| 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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged d <input checked="" type="checkbox"/> 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? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 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? **0**

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

Part VI

Supplemental Information

Provide the following information

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

| Form and Line Reference | Explanation |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part I, Line 3c Eligibility Criteria | CHI COLORADO HAS AN ESTABLISHED CHARITY CARE POLICY BASED ON THE FEDERAL POVERTY LEVEL CHARITY IS PROVIDED TO PATIENTS BASED ON A SLIDING SCALE THAT CONSIDERS THE PATIENT'S FAMILY SIZE AND INCOME LEVEL THE CHARITY PROVIDED RANGES FROM 100% OF THE PATIENT'S BILL FOR INDIVIDUALS WHOSE HOUSEHOLD INCOME IS AT 100%OR LESS OF THE FEDERAL POVERTY LEVEL, TO A 60% DEDUCTION FOR INDIVIDUALS WHOSE INCOME IS AT 400% OF THE FEDERAL POVERTY LEVEL CHI COLORADO TAKES INTO ACCOUNT SPECIFIC FACTS AND CIRCUMSTANCES IN GRANTING CHARITY IN SITUATIONS SUCH AS A CATASTROPHIC ILLNESS WHERE THE PATIENT DOES NOT HAVE LIQUID ASSETS |

| Form and Line Reference | Explanation |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 16a St Anthony Hospital | http //www stanthonyhosp org/sah/for-patients-and-families/billing-and-financial-services/financial-help/ |

| Form and Line Reference | Explanation |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 16a St Anthony North Hospital | https://www.stanthonyhosp.org/SAH/For-Patients-and-Families/Billing-and-Financial-Services/Financial-Help/ |

| Form and Line Reference | Explanation |
|---------------------------------------------------------------------------------------------|----------------------------|
| Schedule H, Part I, Line 6a Community benefit report prepared by related organization | Centura Health Corporation |

| Form and Line Reference | Explanation |
|-----------------------------------------------------------|-----------------------------------------------------------------------|
| Schedule H, Part I, Line 7g Subsidized Health Services | There are no physician clinics included in subsidized health services |

| Form and Line Reference | Explanation |
|--------------------------------------------------------------------------------------------|-------------|
| Schedule H, Part I, Line 7 Bad Debt Expense excluded from financial assistance calculation | 49314457 |

| Form and Line Reference | Explanation |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part I, Line 7 Costing Methodology used to calculate financial assistance | Catholic Health Initiatives COLORADO DOES NOT USE A COST ACCOUNTING SYSTEM TO DETERMINE THE COST OF CHARITY CARE PROVIDED THE ESTIMATED COST OF CARE IS CALCULATED BY APPLYING THE RATIO OF EACH FACILITY'S TOTAL EXPENSES TO TOTAL GROSS REVENUE WORKSHEET 2 WAS NOT USED TO DEVELOP THE COST TO CHARGE RATIO |

| Form and Line Reference | Explanation |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part III, Line 2 Bad debt expense - methodology used to estimate amount | Catholic Health Initiatives Colorado uses the overall cost to gross charge ratio applicable to each facility to determine the costs in Part III, Lines 2 and 3 Catholic Health Initiatives Colorado automatically discounts all self-pay patient accounts by 30% and also offers a prompt pay discount This allowance is not included in the calculation of the cost of bad debts in instances where a patient does not pay his or her bill |

| Form and Line Reference | Explanation |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Schedule H, Part III, Line 3 Bad Debt Expense Methodology | Catholic Health Initiatives Colorado does not include any portion of bad debt as community benefit |

| Form and Line Reference | Explanation |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part III, Line 4 Bad debt expense - financial statement footnote | Catholic Health Initiatives Colorado (CHIC) does not issue separate company audited financial statements. However, the organization is included in the consolidated financial statements of Catholic Health Initiatives (CHI). The consolidated footnote reads as follows: "The provision for bad debts is based upon management's assessment of historical and expected net collections, taking into consideration historical business and economic conditions, trends in health care coverage, and other collection indicators. Management routinely assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category. The results of these reviews are used to modify, as necessary, the provision for bad debts and to establish appropriate allowances for uncollectible net patient accounts receivable. After satisfaction of amounts due from insurance, CHI follows established guidelines for placing certain balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by each facility. The provision for bad debts is presented on the consolidated statements of operations as a deduction from patient services revenues (net of contractual allowances and discounts) since CHI accepts and treats substantially all patients without regard to the ability to pay." |

| Form and Line Reference | Explanation |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part III, Line 8 Community benefit & methodology for determining medicare costs | Cost for each hospital's cost report is pulled from year end trial balances. The cost is then evaluated and all non-allowable cost is removed via adjustments. The remaining allowable cost is then allocated to appropriate patient care and non-patient care cost centers based on Medicare allocation principles. Catholic Health Initiatives Colorado (CHIC) does not treat Medicare shortfalls as community benefit. CHIC's position is consistent with that of Catholic Health Initiatives (CHI), its Sponsor. Medicare is not a differentiating feature of tax-exempt health care organizations, for-profit hospitals treat and attempt to attract Medicare beneficiaries. |

| Form and Line Reference | Explanation |
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| Schedule H, Part III, Line 9b Collection practices for patients eligible for financial assistance | Catholic Health Initiatives Colorado's debt collection policy provides for the performance of a reasonable review of each patient's account prior to turning an account over to a third-party collection agent and prior to instituting any legal action for non-payment. The review of patient accounts is done to assure that the patient or their guarantor is not eligible for assistance through Catholic Health Initiatives Colorado's charity care policy, uninsured discount policy, or another financial assistance program (i.e. Medicaid). Catholic Health Initiatives Colorado requires the following of its third-party collection agencies: * Neither Catholic Health Initiatives Colorado hospitals or their collection agencies will request bench or arrest warrants as a result of non-payment, * Neither Catholic Health Initiatives Colorado hospitals or their collection agencies will seek liens that would require the sale or foreclosure of a primary residence, and * No Catholic Health Initiatives Colorado collection agency may seek court action without hospital approval. |

| Form and Line Reference | Explanation |
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| Schedule H, Part V, Section B, Line 16a FAP website | - PENROSE HOSPITAL Line 16a URL https://www.penrosetfrancis.org/financial-help/ , - ST ANTHONY HOSPITAL Line 16a URL See Supplemental Narrative, - MERCY REGIONAL MEDICAL CENTER Line 16a URL https://www.mercydurango.org/Financial-Help/ , - ST MARY-CORWIN MEDICAL CENTER Line 16a URL http://www.stmarycorwin.org/Financial-Help/ , - ST FRANCIS MEDICAL CENTER Line 16a URL https://www.penrosetfrancis.org/financial-help/ , - ST ANTHONY NORTH HOSPITAL Line 16a URL http://www.stanthonynorthhealthcampus.org/financial-help/ , - ST ANTHONY SUMMIT MEDICAL CENTER Line 16a URL https://www.summitmedicalcenter.org/Financial-Help/ , - ST THOMAS MORE HOSPITAL Line 16a URL https://www.stmhospital.org/financial-help/ , - OrthoColorado Hospital Line 16a URL https://www.centura.org/for-patients-and-families/billing-and-financial-services/financial-help/ , |

| Form and Line Reference | Explanation |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 16b FAP Application website | - PENROSE HOSPITAL Line 16b URL HTTPS //WWW PENROSESTFRANCIS ORG/FINANCIAL-HELP/ , - ST ANTHONY HOSPITAL Line 16b URL See Supplemental Narrative, - MERCY REGIONAL MEDICAL CENTER Line 16b URL http //www mercydurango org/financial-help/ , - ST MARY-CORWIN MEDICAL CENTER Line 16b URL http //www stmarycorwin org/Financial-Help/ , - ST FRANCIS MEDICAL CENTER Line 16b URL https //www penrosetfrancis org/financial-help/ , - ST ANTHONY NORTH HOSPITAL Line 16b URL http //www stanthonynorthhealthcampus org/financial-help/ , - ST ANTHONY SUMMIT MEDICAL CENTER Line 16b URL https //www summitmedicalcenter org/Financial-Help/ , - ST THOMAS MORE HOSPITAL Line 16b URL https //www stmhospital org/financial-help/ , - OrthoColorado Hospital Line 16b URL https //www centura org/for-patients-and-families/billing-and-financial-services/financial-help/ , |

| Form and Line Reference | Explanation |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 16c FAP plain language summary website | - PENROSE HOSPITAL Line 16c URL HTTPS //WWW PENROSESTFRANCIS ORG/FINANCIAL-HELP/ , - ST ANTHONY HOSPITAL Line 16c URL See Supplemental Narrative, - MERCY REGIONAL MEDICAL CENTER Line 16c URL http //www mercydurango org/financial-help/ , - ST MARY-CORWIN MEDICAL CENTER Line 16c URL http //www stmarycorwin org/Financial-Help/ , - ST FRANCIS MEDICAL CENTER Line 16c URL https //www penrosetfrancis org/financial-help/ , - ST ANTHONY NORTH HOSPITAL Line 16c URL http //www stanthonynorthhealthcampus org/financial-help/ , - ST ANTHONY SUMMIT MEDICAL CENTER Line 16c URL https //www summitmedicalcenter org/Financial-Help/ , - ST THOMAS MORE HOSPITAL Line 16c URL http //www stmhospital org/financial-help/ , - OrthoColorado Hospital Line 16c URL https //www centura org/for-patients-and-families/billing-and-financial-services/financial-help/ , |

| Form and Line Reference | Explanation |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part VI, Line 2 Needs assessment | The Catholic Health Initiatives Colorado related hospitals provides several services and resources to the communities it serves beyond the prioritized needs specifically identified in the Community Health Needs Assessment. It sponsors wellness events such as breast feeding education, asthma screenings, and financially supports wellness initiatives of cities and public schools. It also provides transportation for low income patients and housing at no cost or very low cost for the families of low income patients of the hospital that are far from their residence. It also supports, financially and through volunteerism, initiatives such as soup kitchens and meals on wheels to provide food and nutrition education to address hunger issues. Hospital staff also volunteer to serve as preceptors for students of local health professional programs and serve on boards of local community organizations that provide social services to populations in need. |

| Form and Line Reference | Explanation |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part VI, Line 3 Patient education of eligibility for assistance | Catholic Health Initiatives Colorado (CHIC) is operated as part of Centura Health Corporation (Centura) Information concerning financial assistance is included on Centura's website The website not only lists phone numbers for patients to call to discuss financial assistance, but also includes Centura's policy for charity care and its policies related to uninsured patients In addition, at the time of registration, uninsured patients are screened to determine if the patients qualify for any Federal, State or County programs Uninsured patients are also sent a letter requesting that the patient call to determine eligibility for various assistance programs, including charity |

| Form and Line Reference | Explanation |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part VI, Line 4 Community information | Catholic Health Initiatives Colorado hospitals provides healthcare services to the direct and surrounding communities where they are located. In addition, due to some of the specialized healthcare services available at these hospital facilities, a number of our patients come from what would be considered outside the immediate geographic area. Many of Catholic Health Initiatives Colorado related hospitals serve the Front Range communities, which have diverse populations, including serving our elderly and younger populations, low and improvished economic population groups, caring for all of their healthcare service needs. |

| Form and Line Reference | Explanation |
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| Schedule H, Part VI, Line 5 Promotion of community health | Catholic Health Initiatives Colorado hospitals implements a number of efforts and initiatives to promote the health of the community. It provides financial and volunteer support to clinics that provide care to low income patients. Staff volunteer on the boards of community based organizations that provide essential services to disadvantaged patients. Furthermore, the hospitals provides donations to the initiatives of community based organizations, cities and public schools to support events that promote health and wellness. |

| Form and Line Reference | Explanation |
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| Schedule H, Part VI, Line 6 Affiliated health care system | Catholic Health Initiatives Colorado (CHIC) is operated as part of Centura Health Corporation (Centura) Centura and its affiliated organizations are dedicated to extending the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities Specifically, Centura has launched a system-wide strategic plan to improve the quality, consistency, availability, and affordability of healthcare to communities throughout Colorado The three main components of this strategy are (1) to continue investing in technology advancements that improve the quality, costs, and coordination of care including the establishment of electronic health records linking our physicians, clinics, hospitals, long-term facilities and home care services, (2) providing wellness care, thereby potentially reducing health care costs by helping patients to maintain good health, growing the level of support and outreach provided to rural communities, and increasing access, affordability and quality of health care, and (3) coordinate and develop systems of care, looking to each facility and entity in Centura to share best practices and improve overall efficiency and communication system-wide from birth to home care |

| Form and Line Reference | Explanation |
|-------------------------------------------------------------------------|-------------|
| Schedule H, Part VI, Line 7 State filing of community benefit report | CO |

Additional Data

Software ID: 14000329
Software Version: 2014v1.0
EIN: 84-0405257
Name: Catholic Health Initiatives Colorado

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

| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form and Line Reference | Explanation |
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - Penrose Hospital Focus groups made up of community leaders met and responded to a consistent set of questions Invitees were chosen based upon the area of expertise or interest in relationship to community health The focus groups were asked to 1) review compilation of existing data, and 2) to help translate that data to their own experience as a leader in the community and to provide their perspectives on the predominant health issues in their communities There were three focus groups meetings that took place in April 2012 and each meeting lasted several hours |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------|
| Schedule H, Part V, Section B, Line 6a Facility , 1 | Facility , 1 - PENROSE HOSPITAL St Francis Medical Center |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - Penrose Hospital The Focus Groups which were made up of community leaders met, identified and prioritized seven significant needs in the community These needs were as follows Children in Crisis Due to Violence, Failure to Meet the Needs of the Mentally/Behavioral Ill, Lack of Access into the Healthcare System, Lack of Systems Approach to Preventative Care, Obesity Rate in the Community - Lack of Systems Approach, Oral Health, and High Incidences of Melanoma Several strong community groups were already successfully working on these issues Instead of utilizing resources to create a new strategy, Penrose decided to support and partner with successful groups already working in the community To have the greatest impact on the needs that we did identify community benefit resources that were carefully planned and allocated towards targeted evidence based strategies known to directly impact and improve the identified needs All needs listed received support and were addressed either directly or indirectly with the community group resources Penrose directly contributed and patriciate in the following activities in support of the CHNA by staffing six neighborhood nurse centers which provided health assessments, education, referrals and pharmaceutical assistance to more than 4,200 individuals, donated annual rent monies to the Sisters of St Francis who provided counseling for mental health services to the poor and underserved population, provided 28,677 healthy meals to elderly and impoverished patients and community members, provided medication to 432 indigent patients, trained 904 students, residents & interns with hands0on experience, supervision and mentoring by hospital professionals, and over 274,000 people were impacted through community benefits outreach programs, events, services and donations from Penrose hospital Several needs which need continue support are the oral health, preventative care programs, melanoma and teen pregnancy issues |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - Penrose Hospital Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
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| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - ST ANTHONY HOSPITAL COMMUNITY MEMBERS WERE INTERVIEWED FOR THEIR PERSPECTIVES ON THE PREDOMINANT HEALTH ISSUES IN THEIR COMMUNITIES THEY WERE INTERVIEWED IN EITHER A ONE-ON-ONE INTERVIEW FORMAT OR A FOCUS GROUP THE INTERVIEWEES WERE COMPRISED OF REPRESENTATIVES FROM THE FOLLOWING GROUPS - Jefferson County Public Health Department - Health Consulting - Law Enforcement - Jefferson County School District - Federally Qualified Community Health Center - Senior Health Services/Jewish Family Services - Home Health/Hospice - Ministerial Associations - Emergency Medical Service - Low Income Population Representatives (Metro Community Provider Network and the Action Center) - Senior-aged Health Fair Participants - American Lung Association - American Cancer Society - Donor Alliance, tissue and organ recovery organization for colorado and wyoming |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 6a Facility , 1 | Facility , 1 - ST ANTHONY HOSPITAL OrthoColorado Hospital Exempla Lutheran Medical Center |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Anthony Hospital St Anthony Hospital community members were interviewed on their perspectives on the predominant health issues in their community, and surveys were taken at various events too In addition, the Colorado Department of Public Health and Environment (CDPHE) data was also evaluated and was included for prioritizing which community health needs ranked highest The needs were identified as follows Access, Cancer, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Communicable Disease/Overall Health Status, Oral Health, Sexual Health & HIV/Aids, Substance Abuse and Tobacco After doing an assessment of existing capacity and community efforts, St Anthony hospital decided to focus on obesity and injury prevention The needs not directly addressed by St Anthony Hospital were already being addressed by strong community organizations, and hospital resources were better used towards creating targeted strategies to impact the prioritized needs The direct efforts by St Anthony Hospital included 30,672 patient cases by providing some level of support with medical financial assistance, success of providing training for 501 students in Nursing, Radiology, Chaplaincy, EMT & Pharmacy areas, providing supportive therapies for 22,357 patients with healing focused in mind, body and spirit, offering over 1,700 flu shots for the prevention of getting or spreading the flu, engaged 98 older adults in fall prevention programming, established farmers market in the Lakewood community, actively participated in summer food programs, food drives and had employees serve on 50 community based committees and boards |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Anthony Hospital Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - Mercy Regional Medical Center Data was collected from a series of two community stakeholder meetings in each county during January 2012 - April 2012 Two meetings each in La Plata County and Archuleta County were well publicized through newspaper notices, individual mailings, and personal contacts Attendees included a broad cross-section of the public including local and regional public health representatives, Southern Ute Indian Health and Community Action Program, a variety of low-income consumer advocates, non-profit organizations, academic experts, local government officials, community-based organizations such as Citizens Healthcare Alliance, and health care providers including those focusing on patients with chronic disease and private businesses |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|----------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 6a Facility , 1 | Facility , 1 - MERCY REGIONAL MEDICAL CENTER Pagosa Springs Medical Center |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - Mercy Regional Medical Center Mercy Regional Medical Center performed an assessment community health needs by collecting data from a series of two community stakeholder meetings in two counties, and using data from the Colorado Department of Public Health and Environment The community health needs identified included Access to Healthcare, Cancer, Communicable Disease, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Oral Health, and Sexual Health Access to health care was prioritized as the highest priority and was considered number one due to it was strongly linked to an overall improved health status for the community The other community needs were also supported, but the following are the direct contributions of how Mercy Regional Medical Center addressed their community health needs Invested almost \$20,000 to recruit new physicians to the community, served 16,665 people at the local community health forums by providing education and health wellness, donated over \$124,000 to local non-profits which promoted health and wellness programs, provided a new program, "Gray matters", which donated fitted helmets for the prevention of traumatic brain injuries, donated \$11,803 and over 97 staff hours to serve the homeless at the local soup kitchens |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - Mercy Regional Medical Center Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted rates |

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

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| Form and Line Reference | Explanation |
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| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - St Mary-Corwin Medical Center Community members were interviewed in either a one-on-one interview format, focus group, or as part of a Committee for their perspectives on the predominant health issues in their communities Data was collected over the period from March to April 2012 Three hundred and eighty-two (382) community residents, all patients of St Mary-Corwin Medical Center or patients of Touchstone Health, an affiliated primary care clinic of St Mary-Corwin, filled out a Health Issue Ranking survey Eileen Aire, Associate Director, and Erika Henry, Research Assistant for the Center for Health Administration at the University of Colorado-Denver Business School and Health Science Center, compiled results of the survey and verified the validity and relevance of the survey results St Mary-Corwin Medical Center developed a Community Health Needs assessment Ranking Questionnaire to collect additional data Those surveyed were asked to rank 34 health issues using a scale of 1 to 5, with 1 meaning "not a critical issue" and 5 meaning a "very critical issue " The questionnaires were disseminated to a variety of internal and community groups Data was collected in March and April of 2012 The goal was to reach the broadest number of constituents possible in Pueblo County The questionnaires were targeted to reach specific constituent groups including, under or uninsured, faith-based, business, non-profit community organizations, seniors, students, primary care physicians, first responders, and hospital leadership, including Community Board members Surveys were distributed to individuals through the following organizations * Southern Colorado Family Medicine Clinic * Touchstone Health * Pueblo County United Way * Greater Pueblo Chamber of Commerce * Centura Health at Home * Long Term Care Ombudsman * Senior Resource Development Agency * St Mary-Corwin Medical Center Employed Physician Group * Colorado State University (Pueblo) Social Work Students * Wilz Trauma Symposium * Diocese of Pueblo Finance Council * St Mary-Corwin Medical Center Community Board * Pueblo Step-Up * Patient Family Advisory Council at St Mary-Corwin Medical Center * Diabetes Education Classes at St Mary-Corwin Medical Center * Catholic Charities Family Outreach |

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

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| Form and Line Reference | Explanation |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Mary Corwin Medical Center St Mary-Corwin Medical Center utilized data already available from the Colorado Department of Public Health and Environment (CDPHE) and interviewed and collected various data and surveys from local community members on their perspectives for the predominant health issues in their community The needs were identified as follows access to health services/insurance coverage, Diabetes, Obesity, unintended pregnancies, and substance abuse St Mary-Corwin Medical Center choose the two most important issues for them to address was Obesity and Teen and Unintended Pregnancies St Mary-Corwin Medical Center provided direct support for the following programs and community benefits held the annual Bessemer Healthy Block party to educate members of the community on healthy behaviors, provided "Mindful Living" class to patients, educated older adults in fall prevention, provided advance directive education to 280 patients and their families, donated to local organizations to provide support for their community benefit programs, and supported weekly summer farm stand which served hundreds of local community members |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Mary-Corwin Medical Center Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted rates |

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

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| Form and Line Reference | Explanation |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - St Francis Medical Center Focus groups made up of community leaders met and responded to a consistent set of questions Invitees were chosen based upon their areas of expertise or interest in relationship to community health The focus groups were asked to 1) review compilation of existing data, and 2) help translate that data to their own experience as a leader in the community and provide their perspectives on the predominant health issues in their communities There were three focus groups meetings that took place in April 2012 and each meeting lasted several hours |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------|
| Schedule H, Part V, Section B, Line 6a Facility , 1 | Facility , 1 - ST FRANCIS MEDICAL CENTER Penrose Hospital |

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 |
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| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Francis Medical Center St Francis Medical Center utilized data already available from the Colorado Department of Public Health and Environment (CDPHE), interviewed and collected various data and surveys from local community members on their perspectives for the predominant health issues in their community Children in Crisis Due to Violence, Failure to Meet the Needs of the Mentally/Behavioral Ill, Lack of Access into the Healthcare System, Lack of Systems Approach to Preventative Care, Obesity Rate in the Community - Lack of Systems Approach, Oral Health, and High Incidences of Melanoma Several strong community groups were already successfully working on these issues Instead of utilizing resources to create a new strategy, St Francis Medical Center decided to support and partner with successful groups already working in the community To have the greatest impact on the needs that we did identify community benefit resources that were carefully planned and allocated towards targeted evidence based strategies known to directly impact and improve the identified needs All needs listed received support and were addressed either directly or indirectly with the community group resources St Francis Medical Center directly contributed and participated in the following activities in support of the CHNA by staffing six neighborhood nurse centers which provided health assessments, education, referrals and pharmaceutical assistance to more than 4,200 individuals, donated annual rent monies to the Sisters of St Francis who provided counseling for mental health services to the poor and underserved population, provided 28,677 healthy meals to elderly and impoverished patients and community members, provided medication to 432 indigent patients, trained 904 students, residents & interns with hands0on experience, supervision and mentoring by hospital professionals, and over 274,000 people were impacted through community benefits outreach programs, events, services and donations from Penrose hospital Several needs which need continue support are the oral health, preventative care programs, melanoma and teen pregnancy issues |

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| Form and Line Reference | Explanation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Francis Medical Center Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - St Anthony North Hospital St Anthony Hospital community members were interviewed on their perspectives on the predominant health issues in their community, and surveys were also taken at health fair screenings too In addition, the Colorado Department of Public Health and Environment (CDPHE) data was also evaluated and was included for prioritizing which community health needs ranked highest The needs were identified as follows Access to Healthcare, Cancer, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Communicable Disease/Overall Health Status, Oral Health, Sexual Health & HIV/Aids, Substance Abuse and Tobacco After doing a capacity assessment and literature review of evidence based strategies, St Anthony North determined they would have the greatest impact addressing access to care and mental health/substance abuse issues The direct efforts by St Anthony North Hospital included 31,261 patient cases by providing some level of support with medical financial assistance, invested \$225,103 in training lab techs, nursing students, radiology students, chaplains and respiratory therapy students for workforce development, pastoral RN-nurses provided education and preventive care for 10,953 low-income patients, served 704 people with needed healthcare screenings, doula program provided 662 Spanish speaking women with lay birth coaches, and provided support to 832 patients through Alcoholic Anonymous groups |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Anthony North Hospital St Anthony Hospital community members were interviewed on their perspectives on the predominant health issues in their community, and surveys were also taken at health fair screenings too In addition, the Colorado Department of Public Health and Environment (CDPHE) data was also evaluated and was included for prioritizing which community health needs ranked highest The needs were identified as follows Access to Healthcare, Cancer, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Communicable Disease/Overall Health Status, Oral Health, Sexual Health & HIV/Aids, Substance Abuse and Tobacco After doing a capacity assessment and literature review of evidence based strategies, St Anthony North determined they would have the greatest impact addressing access to care and mental health/substance abuse issues The direct efforts by St Anthony North Hospital included 31,261 patient cases by providing some level of support with medical financial assistance, invested \$225,103 in training lab techs, nursing students, radiology students, chaplains and respiratory therapy students for workforce development, pastoral RN-nurses provided education and preventive care for 10,953 low-income patients, served 704 people with needed healthcare screenings, doula program provided 662 Spanish speaking women with lay birth coaches, and provided support to 832 patients through Alcoholic Anonymous groups |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Anthony North Hospital Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - St Anthony Summit Medical Center St Anthony Summit Medical Center retained Corona Insights Research Company to conduct three focus groups in June of 2012 Two focus group sessions were conducted with members of the general public while one focus group was conducted with Spanish-speaking residents The focus groups reviewed data relevant to the county and their opinions helped the hospital to identify whether there were significant differences in the opinion, perceptions, or experience of the residents on health needs The Summit County Public Health Director, physicians, Board members, City officials, subject matter experts, and the Community Health Needs Assessment Steering Committee were asked to rank several health issues using a scale of 1 to 5, with 1 meaning "not a critical issue" and 5 meaning a "very critical issue " The results of the surveys were averaged to provide a quantitative measure that was used in the prioritization process |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Anthony Summit Medical Center Key health needs for St Anthony Summit Hospital were identified as access to health services, injury prevention, substance abuse/mental health, cancer, flu shot/pneumonia vaccination, oral health, and sexual health and HIV/AIDS After doing an assessment of existing capacity and community efforts, OrthoColorado Hospital decided to focus on access to care and injury prevention St Anthony Summit Medical Center directly provided the following services and support to address the community health needs provided medical financial assistance to 3,735 patients cases, served 13,301 community members through injury prevention education and donated sports and provided fittings, served 900 people with needed health screenings, provided discounted or free radiology services and mammograms to 158 low income patients, donated 2,159 hours to provide first aid at the ski slopes, invested in training 68 nursing students, provided health education and outreach to 450 local children and their families through the Teddy Bear clinics |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Anthony Summit Medical Center Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - St Thomas More Hospital St Thomas More Hospital conducted COMMUNITY LEADER INTERVIEWS with Carla Dionne, Director, Fremont County Public Health and James Berg, Colorado Medical Assistance Program, State of Colorado The Hospital also developed a Health Needs Ranking Questionnaire Those surveyed were asked to rank 34 health issues using a scale of 1 to 5, with 1 meaning "not a critical issue" and 5 meaning a "very critical issue " The questionnaires were disseminated to a variety of internal and community groups The goal was to reach the broadest number of constituents possible Surveys were distributed to individuals between January 2012 and May 2012 through several community organizations |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - St Thomas More Hospital St Thomas More Hospital convened a task force to identify and prioritize Canon City community health needs assessment The task force was comprised of management from the hospital, local physicians and local community members Data was gathered thru the use of surveys, the Colorado Department of Public Health and Environment (CDPHE) and input from the task force committee The top health priorities were ranked as Cancer, Tobacco use, Heart Disease and Cerebrovascular disease, Obesity, Nutrition and Physical activity, and Oral Health St Thomas More directly supported these efforts to address the health needs they identified Donated over 400 employee hours to provide free and low-cost health screenings and education to 860 members of the community, engaged 300 members of the community at the Child Health Safety Data by donating and providing free bike helmet and car seat giveaways, provided free 13-week Tobacco Cessation classes, RNs donated 60 hours of home visits and phone calls to 167 patients to ensure continuity of care, hospital leadership participated in a Boys and Girls Club event and spoke to hundreds of participants about wellness, nutrition, finance and safety |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - St Thomas More Hospital Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted 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 |
|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 5 Facility , 1 | Facility , 1 - OrthoColorado Hospital OrthoColorado Hospital community members were interviewed on their perspectives on the predominant health issues in their community, and surveys were taken at various events too In addition, the Colorado Department of Public Health and Environment (CDPHE) data was also evaluated and was included for prioritizing which community health needs ranked highest The needs were identified as follows Access, Cancer, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Communicable Disease/Overall Health Status, Oral Health, Sexual Health & HIV/Aids, Substance Abuse and Tobacco After doing an assessment of existing capacity and community efforts, OrthoColorado Hospital decided to focus on obesity and injury prevention The needs not directly addressed by OrthoColorado were already being addressed by strong community organizations, and hospital resources were better used towards creating targeted strategies to impact the prioritized needs The direct and indirect efforts by OrthoColorado Hospital included 30,672 patient cases by providing some level of support with medical financial assistance, success of providing training for 501 students in Nursing, Radiology, Chaplaincy, EMT & Pharmacy areas, providing supportive therapies for 22,357 patients with healing focused in mind, body and spirit, offering over 1,700 flu shots for the prevention of getting or spreading the flu, engaged 98 older adults in fall prevention programming, established farmers market in the Lakewood community, actively participated in summer food programs, food drives and had employees serve on 50 community based committees and boards |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|-----------------------------------------------------------|
| Schedule H, Part V, Section B, Line 6a Facility , 1 | Facility , 1 - OrthoColorado Hospital St Anthony Hospital |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 11 Facility , 1 | Facility , 1 - OrthoColorado Hospital OrthoColorado Hospital community members were interviewed on their perspectives on the predominant health issues in their community, and surveys were taken at various events too In addition, the Colorado Department of Public Health and Environment (CDPHE) data was also evaluated and was included for prioritizing which community health needs ranked highest The needs were identified as follows Access, Cancer, Diabetes, Heart Disease and Cerebrovascular Disease, Injury, Mental Health, Obesity, Nutrition & Physical Activity, Communicable Disease/Overall Health Status, Oral Health, Sexual Health & HIV/Aids, Substance Abuse and Tobacco After doing an assessment of existing capacity and community efforts, OrthoColorado Hospital decided to focus on obesity and injury prevention The needs not directly addressed by OrthoColorado were already being addressed by strong community organizations, and hospital resources were better used towards creating targeted strategies to impact the prioritized needs The direct and indirect efforts by OrthoColorado Hospital included 30,672 patient cases by providing some level of support with medical financial assistance, success of providing training for 501 students in Nursing, Radiology, Chaplaincy, EMT & Pharmacy areas, providing supportive therapies for 22,357 patients with healing focused in mind, body and spirit, offering over 1,700 flu shots for the prevention of getting or spreading the flu, engaged 98 older adults in fall prevention programming, established farmers market in the Lakewood community, actively participated in summer food programs, food drives and had employees serve on 50 community based committees and boards |

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

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

| Form and Line Reference | Explanation |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule H, Part V, Section B, Line 22 Facility , 1 | Facility , 1 - OrthoColorado Hospital Catholic Health Initiatives Colorado (CHIC) automatically discounts all self-pay patient accounts by 30% and also offers a 10% prompt pay discount The total discount of 40% approximates CHIC's contracted rates |

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) |
|-----------------------------------------------------------------------------------------------------|-----------------------------|
| Synergy Orthopedics 8510 Bryant St Suite 320 Westminster, CO 80031 | Physician clinic |
| VILLAS AT SUNNY ACRES 2501 EAST 104TH AVE THORNTON, CO 80233 | Physician clinic |
| SMC GASTROENTEROLOGY 1925 E ORMAN PUEBLO, CO 81004 | Physician clinic |
| WOMEN'S HEALTH SPECIALISTS 13691 Colorado Blvd Suite 106 thornton, CO 80602 | Physician clinic |
| DURANGO URGENT CARE AT DMR 1 SKIER PLACE DURANGO, CO 81301 | Physician clinic |
| PSF Primary Care Health Care Services 2960 N Circle Dr Suite 100 Colorado Springs, CO 80909 | Physician clinic |
| GARDENS AT ST ELIZABETH 2835 WEST 32ND AVE DENVER, CO 80211 | Physician clinic |
| North Metro Internal Medicine 8300 Alcott St Suite 302 Westminster, CO 80031 | Physician clinic |
| SUMMIT CARDIOLOGY 360 PEAK ONE DR Suite 390 FRISCO, CO 80443 | Physician clinic |
| PENROSE HOME CARE 7015 TALL OAKS DRIVE COLORADO SPRINGS, CO 80919 | Physician clinic |
| SMC SURGICAL PHYSICIANS 1925 E ORMAN PUEBLO, CO 81004 | Physician clinic |
| Dimension Pain Management 400 W 144th Suite 240 Westminster, CO 80031 | Physician clinic |
| PENROSE COMMUNITY HOSPITAL 3205 N CASCADE AVE COLORADO SPRINGS, CO 80917 | Physician clinic |
| SURGERY SERVICES & THE MEDICAL HOME 1339 PHAY AVE CANON CITY, CO 81212 | Physician clinic |
| Vascular & Endovascular Specialist of Colorado 11700 W 2nd Place Suite 210 Lakewood, CO 80228 | Physician clinic |

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

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

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

| Name and address | Type of Facility (describe) |
|--------------------------------------------------------------------------------------------------------------|-----------------------------|
| SMC Physician Partners-Rehab 1925 E ORMAN PUEBLO,CO 81004 | Physician clinic |
| BRECKENRIDGE MEDICAL CLINIC 555 S PARK AVE PLAZA II PO BOX 6909 BRECKENRIDGE,CO 80424 | Physician clinic |
| TOUCHSTONE PUEBLO WEST CLINIC 141 S PURCELL BLVD Suite 106 PUEBLO WEST,CO 81007 | Physician clinic |
| PSYCHIATRIC SERVICES 11600 W 2nd Place Lakewood,CO 80228 | Physician clinic |
| MEDALION RETIREMENT COMMUNITY 1719 EAST BIJOU ST COLORADO SPRINGS,CO 80909 | Physician clinic |
| ST ANTHONY HEALTH CENTER EVERGREEN 1520 EVERGREEN PKWY EVERGREEN,CO 80439 | Physician clinic |
| MERCY HEALTH SERVICES CLINIC 1800 E THIRD AVE DURANGO,CO 81301 | Physician clinic |
| Centura Health Urgent Care Canon City 3245 E US Hwy 50 Canon City,CO 81212 | Physician clinic |
| Rocky Mountain Sports and Family Medicine 1315 Fortino Blvd W Pueblo,CO 81008 | Physician clinic |
| AZTEC DIAGNOSTIC LAB 604 S RIO GRANDE AZTEC,NM 87410 | Physician clinic |
| MERCY HOME HEALTH ONE MERCADO STREET suite 270 DURANGO,CO 81301 | Physician clinic |
| SENIOR HEALTH CENTER WEST 11700 W 2nd Place Lakewood,CO 80228 | Physician clinic |
| Endocrinology Diabetes & Thyroid Specialists of Colorado 11700 W 2nd Place Suite 210 Lakewood,CO 80228 | Physician clinic |
| PHYSICIAN PARTNERS ORTHOPAEDIC SURGERY 4112 OUTLOOK BLVD PUEBLO,CO 81008 | Physician clinic |
| ASSOCIATED SURGEONS 11700 W 2nd Place Suite 210 Lakewood,CO 80228 | Physician clinic |

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

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

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

| Name and address | Type of Facility (describe) |
|----------------------------------------------------------------------------------------------------------|-----------------------------|
| Southern Colorado Gynecology Oncology 2222 N Nevada Ave Suite 2025 Colorado Springs, CO 80907 | Physician clinic |
| PENROSE URGENT CARE AT CRIPPLE CREEK 1101 TELLER COUNTY ROAD 1 CRIPPLE CREEK, CO 80813 | Physician clinic |
| MERCY DIAGNOSTIC LAB 2577 N MAIN AVE DURANGO, CO 81301 | Physician clinic |
| CENTURA HOME OXYGEN-PUEBLO 4025 CLUB MANOR DRIVE PUEBLO, CO 81008 | Physician clinic |
| PSF Primary Care Health Care Services 6011 E Woodmen Suite 100 Colorado Springs, CO 80923 | Physician clinic |
| Southern Colorado Breast Care Specialists 2312 N Nevada Ave Suite 235 Colorado Springs, CO 80907 | Physician clinic |
| PROGRESSIVE CARE CENTER 1338 PHAY AVE CANON CITY, CO 81212 | Physician clinic |
| ST ANTHONY HOSPICE 1391 SPEER BLVD Suite 600 DENVER, CO 80204 | Physician clinic |
| NAMASTE ALZHEIMER CENTER 2 PENROSE BOULEVARD COLORADO SPRINGS, CO 80906 | Physician clinic |
| SENIOR HEALTH CENTER NORTH 8510 BRYANT ST SUITE 250 WESTMINSTER, CO 80031 | Physician clinic |
| VILLA PUEBLO SENIOR LIVING COMMUNITY 1111 BONFORTE BLVD PUEBLO, CO 81001 | Physician clinic |
| Cardiac and Thoracic Surgery Associates PC 2222 N Nevada Ave Suite 5011 Colorado Springs, CO 80907 | Physician clinic |
| CHAMBERS SPECIALTY SURGICAL CARE 11700 W 2nd Place Suite 210 Lakewood, CO 80228 | Physician clinic |
| ST ANTHONY KEYSTONE MEDICAL CLINIC 1252 COUNTY ROAD 8 KEYSTONE, CO 80435 | Physician clinic |
| NORTH RIDGE MEDICAL PRACTICE 13691 COLORADO BLVD SUITE 106 THORNTON, CO 80602 | Physician clinic |

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

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

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

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

| Name and address | Type of Facility (describe) |
|----------------------------------------------------------------------------------------------------------------|-----------------------------|
| CENTURA HOME OXYGEN-COLORADO SPRINGS 4260 BUCKINGHAM DR suite 100 COLORADO SPRINGS,CO 80907 | Physician clinic |
| TOUCHSTONE 1925 E ORMAN PUEBLO,CO 81004 | Physician clinic |
| INTERNAL MEDICINE 614 YALE CANON CITY,CO 81212 | Physician clinic |
| Southern Colorado Vascular Surgery 2222 N Nevada Ave Suite 5011 Colorado Springs,CO 80907 | Physician clinic |
| INTERMOUNTAIN NEURO PHYSICIANS 11750 W 2nd Place Suite 255 Lakewood,CO 80228 | Physician clinic |
| REHABILITATIONCCOM 1338 PHAY AVE CANON CITY,CO 81212 | Physician clinic |
| FAMILY MEDICINE CLINIC NORTH 8510 BRYANT ST SUITE 210 WESTMINSTER,CO 80031 | Physician clinic |
| Centura Family Care Center 916 Indiana Ave Pueblo,CO 81004 | Physician clinic |
| PENROSE MOUNTAIN URGENT CARE CLINIC 41 STATE HIGHWAY 67 WOODLAND PARK,CO 80863 | Physician clinic |
| Advanced Care in Endocrinology and Diabetes 3207 North Academy Blvd Suite 1300 Colorado Springs,CO 80917 | Physician clinic |
| SOUTHERN COLORADO FAMILY MEDICINE 1008 MINNEQUA AVE PUEBLO,CO 81004 | Physician clinic |
| HOSPICE OF MERCY ONE MERCADO STREET suite 270 DURANGO,CO 81301 | Physician clinic |
| Mercy Cardiology Associates 1 Mercado Street Durango,CO 81301 | Physician clinic |
| CHPG Westminster Internal & Family Medicine 400 W 144th Suite 260A Westminster,CO 80023 | Physician clinic |
| Aspen Ridge ENT 11700 2nd Place Suite 210 Lakewood,CO 80228 | Physician clinic |

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) |
|--------------------------------------------------------------------------------|-----------------------------|
| ST MARY CORWIN HOME SERVICES 4025 CLUB MANOR DRIVE PUEBLO,CO 81003 | Physician clinic |
| PRIMARY CARE SERVICES 4231 W 16TH AVE DENVER,CO 80204 | Physician clinic |
| CENTURA HOME OXYGEN-DENVER 2590 W 2ND AVE SUITE 5 DENVER,CO 80219 | Physician clinic |
| ST ANTHONY COPPER MOUNTAIN CLINIC 860 COPPER RD COPPER MOUNTAIN,CO 80443 | Physician clinic |
| Urgent Care of Golden 1030 Johnson Rd Suite 200 Golden,CO 80401 | Physician clinic |
| OBGYN SERVICES 1335 PHAY AVE SUITE B CANON CITY,CO 81212 | Physician clinic |
| SASMC AMBULATORY SURGERY CENTER 340 PEAK ONE DRIVE FRISCO,CO 80443 | Physician clinic |
| Durango Cancer Center 1 Mercado Street Suite 100 Durango,CO 81301 | Physician clinic |

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
Catholic Health Initiatives Colorado

Employer identification number
84-0405257

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 |
|----------------------------------------------------|---------|-------------------------------|--------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------|------------------------------------|
| See Additional Data Table | | | | | | | |

2

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

19

3

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

8

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 |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule I, Part I, Line 2 Description Of Procedure For Monitoring Use Of Grant Funds | GRANTS ARE GIVEN AT THE DISCRETION OF THE CATHOLIC HEALTH INITIATIVES COLORADO CEO THE CEO MAKES REQUESTS FOR FUNDING, WHICH IS PAID OUT IN THE FORM OF A DONATION TO THE ENTITY OR USED TO REIMBURSE AN INVOICE SUBMITTED FOR AN EXPENSE FOR A SPECIFIC PURPOSE THE MAJORITY OF THE DONEES ARE 501(C)(3) ORGANIZATIONS THAT ASSUME RESPONSIBILITY FOR ENSURING THAT THE FUNDS ARE USED IN FURTHERANCE OF THE PURPOSE OF THE GRANT |
| Schedule I, Part I, Line 2 Procedures for monitoring use of grant funds | GRANTS ARE GIVEN AT THE DISCRETION OF THE CATHOLIC HEALTH INITIATIVES COLORADO CEO THE CEO MAKES REQUESTS FOR FUNDING, WHICH IS PAID OUT IN THE FORM OF A DONATION TO THE ENTITY OR USED TO REIMBURSE AN INVOICE SUBMITTED FOR AN EXPENSE FOR A SPECIFIC PURPOSE THE MAJORITY OF THE DONEES ARE 501(C)(3) ORGANIZATIONS THAT ASSUME RESPONSIBILITY FOR ENSURING THAT THE FUNDS ARE USED IN FURTHERANCE OF THE PURPOSE OF THE GRANT |

Additional Data

Software ID: 14000329
Software Version: 2014v1.0
EIN: 84-0405257
Name: Catholic Health Initiatives Colorado

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-----------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------|------------------------------------|
| PROJECT CURE10377 E GEDDAS AVE CENTENNIAL,CO 80112 | 84-1568566 | 501(c)(3) | | 138,494 | BOOK | EXPIRED SUPPLIES | HEALTHCARE |
| ARRUPE JESUIT HIGH SCHOOL4343 UTICA STREET DENVER,CO 80204 | 02-0628872 | 501(c)(3) | 24,000 | | | | SPONSORSHIP |
| ST ANTHONY HEALTH FOUNDATION11600 W 2ND PLACE LAKEWOOD,CO 80228 | 84-0902211 | 501(c)(3) | 24,000 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| THE CHATEAUS LLC720 E SPRINGMONT DRIVE PUEBLO WEST,CO 81007 | 20-5039821 | | 30,000 | | | | SPONSORSHIP |
| COMPANEROUS FOUR CORNERSRIO 309 DURANGO,CO 81301 | 64-0959974 | 501(c)(3) | 10,000 | | | | SPONSORSHIP |
| DURANGO DEVO INC10 TOWN PLAZA DURANGO,CO 81301 | 64-0959974 | 501(c)(3) | 7,000 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| DURANGO DIALYSIS CENTER LLCPO BOX 8500-16074 PHILADELPHIA,PA 19178 | 20-1557928 | | 10,315 | | | | SPONSORSHIP |
| FOUR CORNERS HEALTH CARE CENTER2911 JUNCTION STREET DURANGO,CO 81301 | 20-1420109 | | 38,919 | | | | SPONSORSHIP |
| LA PLATA ECONOMIC DEV 1211 MAIN AVE DURANGO,CO 81301 | 84-1533334 | 501(c)(3) | 7,500 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-----------------------------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| MERCY HEALTH FOUNDATION1010 THREE SPRINGS BLVD DURANGO,CO 81301 | 84-0902211 | 501(c)(3) | 12,260 | | | | SPONSORSHIP |
| ST THOMAS MORE FOUNDATION1338 PHAY AVE CANON CITY,CO 81212 | 84-0902211 | 501(c)(3) | 60,808 | | | | SPONSORSHIP |
| CATHOLIC HEALTH INITIATIVES COLORADO FOUNDATION6385 CORPORATE DRIVE COLORADO SPRINGS,CO 80919 | 84-0902211 | 501(c)(3) | 170,000 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-------------------------------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| CATHOLIC CHARITIES OF COLORADO 29 W KIOWA STREET COLORADO SPRINGS, CO 80903 | 84-0586169 | 501(c)(3) | 16,500 | | | | SPONSORSHIP |
| MOORE PROMOTIONAL PRODUCTS AND APPARAL 734 E PLATTE AVE COLORADO SPRINGS, CO 80903 | 52-3399142 | | 35,080 | | | | PARTNERSHIP OPPORTUNITY |
| RONALD MCDONALD HOUSE CHARITIES OF SOUTHERN COLORADO 311 NORTH LOGAN COLORADO SPRINGS, CO 80909 | 84-1013843 | 501(c)(3) | 11,000 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|-------------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| FIRST & MAIN TOWN CENTER111 SOUTH TEJON STREET COLORADO SPRINGS,CO 80903 | 84-1526427 | | 13,500 | | | | SPONSORSHIP |
| IMG COLLEGE LLC (AIR FORCE FOOTBALL)BOX 16533 PALATINE,IL 60055 | 27-3646546 | | 60,000 | | | | SPONSORSHIP |
| POLICE FOUNDATION OF COLORADO SPRINGS10 LAKE CIRCLE COLORADO SPRINGS,CO 80906 | 27-0926740 | 501(c)(3) | 7,500 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV , appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--------------------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| AMERICAN HEART ASSOCIATIONSO CENTRAL AFFILIATE10900-B STONELAKE BLVD AUSTIN,TX 78759 | 13-5613797 | 501(c)(3) | 22,500 | | | | SPONSORSHIP |
| YMCA OF THE PIKES PEAK REGION17250 JACKSON CREEK PARKWAY MONUMENT,CO 80133 | 84-0404266 | 501(c)(3) | 5,250 | | | | SPONSORSHIP |
| ROCKY MOUNTAIN WOMEN'S FILM FESTIVAL 421 STEJON STREET COLORADO SPRINGS,CO 80903 | 84-1097818 | 501(c)(3) | 11,247 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|----------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------|------------------------------------|
| PIKES PEAK COMMUNITY FOUNDATION730 N NEVADA AVE COLORADO SPRINGS, CO 80903 | 84-1339670 | 501(c)(3) | 6,000 | | | | SPONSORSHIP |
| MEDICAL VOYCE SCIENCE & MULTIMEDIAPO BOX 2942 MONUMENT, CO 80132 | 20-3168222 | | 5,970 | | | | SPONSORSHIP |
| SPREE RACING738 E CACHE LA POUDRE COLORADO SPRINGS, CO 80930 | 45-5525583 | | 15,282 | | | | SPONSORSHIP |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|--------------------------------------------------------------------------------|------------|------------------------------------|--------------------------|-----------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------|
| CROSSROADS TURNING POINTS509 E 13TH STREET PUEBLO,CO 81001 | 84-0810723 | 501(c)(3) | 24,000 | | | | DETOX BEDS |
| YOUNG WOMENS CHRISTIAN ASSOCIATION OF PUEBLO801 N SANTA FE AVE PUEBLO,CO 81003 | 84-0402720 | 501(c)(3) | 7,500 | | | | SPONSORSHIP |
| ST MARY-CORWIN FOUNDATION1008 MINNEQUA AVE PUEBLO,CO 81004 | 84-0902211 | 501(c)(3) | 13,431 | | | | CONTRIBUTION |

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
Catholic Health Initiatives Colorado

Employer identification number
84-0405257

Part I

Questions Regarding Compensation

| | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <div><div>1a</div><div>Check the appropriate 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.</div><div><div><div><input type="checkbox"/> First-class or charter travel</div><div><input checked="" type="checkbox"/> Travel for companions</div><div><input checked="" type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div></div><div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input checked="" type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div></div></div> | | |
| <div><div>b</div><div>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.</div></div> | Yes | |
| <div><div>2</div><div>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?</div></div> | Yes | |
| <div><div>3</div><div>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.</div><div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div></div> | | |
| <div><div>4</div><div>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:</div></div> | | |
| <div><div>a</div><div>Receive a severance payment or change-of-control payment?</div></div> | | No |
| <div><div>b</div><div>Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div></div> | Yes | |
| <div><div>c</div><div>Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> <div>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</div> | | No |
| <div><div></div><div>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</div></div> | | |
| <div><div>5</div><div>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:</div></div> | | |
| <div><div>a</div><div>The organization?</div></div> | | No |
| <div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 5a or 5b, describe in Part III.</div> | | No |
| <div><div>6</div><div>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:</div></div> | | |
| <div><div>a</div><div>The organization?</div></div> | | No |
| <div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 6a or 6b, describe in Part III.</div> | | No |
| <div><div>7</div><div>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.</div></div> | Yes | |
| <div><div>8</div><div>Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.</div></div> | | No |
| <div><div>9</div><div>If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</div></div> | | |

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 |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule J, Part II REPORTABLE INDIVIDUALS COMPENSATED BY UNRELATED ORGANIZATIONS | ALL KEY EMPLOYEES AND HOSPITAL CEOS ARE COMPENSATED BY CENTURA HEALTH CORPORATION, WHO MANAGES THE DAILY ACTIVITIES OF THE CATHOLIC HEALTH INITIATIVES-COLORADO (CHIC) HOSPITALS UNDER A JOINT OPERATING AGREEMENT DATED DECEMBER 8, 1995 BETWEEN THE ADVENTIST HEALTHCARE SYSTEM AND CATHOLIC HEALTH INITIATIVES AS SUCH, THEIR SALARIES ARE PAID TO THEM BY CENTURA, AN UNRELATED ORGANIZATION, FOR SERVICES RENDERED IN THEIR CAPACITY AS KEY EMPLOYEES OR OFFICERS OF CHIC ALL OF THEIR REPORTABLE COMPENSATION IS DISCLOSED ON FORM 990, SCHEDULE J, PART II, ROW (I) AND 990, PART VII, COLUMN (D) AS REPORTING ORGANIZATION COMPENSATION IN ADDITION, THE CEO AND CFO OF CHIC WERE APPOINTED AS SUCH BY THE CHIC BOARD OF DIRECTORS WHILE THEY ARE OFFICERS OF THESE ENTITIES, A VERY SMALL PORTION OF THEIR TIME IS DIRECTLY RELATED TO THE OPERATIONS OF CHIC THEY ARE COMPENSATED BY CENTURA, WHICH IS CHARGED WITH MANAGING THE FACILITIES THEIR RESPECTIVE COMPENSATION IS NOT REPORTED ON THE FILING ORGANIZATION'S 990 BUT IN FACT IS REPORTED IN FULL ON PART VII AND SCHEDULE J OF CENTURA HEALTH CORPORATION'S FORM 990 |
| Schedule J, Part I, Line 3 METHODS USED TO ESTABLISH CEO COMPENSATION | CATHOLIC HEALTH INITIATIVES-COLORADO'S CEO IS PAID BY CENTURA HEALTH CORPORATION (CENTURA) OUTSIDE CONSULTANTS ARE ENGAGED TO PROVIDE RECOMMENDATIONS TO CENTURA'S COMPENSATION COMMITTEE REGARDING THE COMPENSATION OF FACILITY CEOS THE CONSULTANT'S RECOMMENDATIONS ARE THEN PRESENTED TO AND APPROVED BY THE COMPENSATION COMMITTEE |
| Schedule J, Part I, Line 1a Travel for companions | SENIOR VICE PRESIDENTS AND HOSPITAL CEOS ARE PAID THROUGH CENTURA HEALTH CORPORATION AND ARE ELIGIBLE FOR THE FOLLOWING BENEFITS TRAVEL FOR COMPANIONS, HEALTH OR SOCIAL CLUB DUES, AND REIMBURSEMENT UP TO \$10,000 FOR PERSONAL SERVICES SUCH AS TAX, FINANCIAL, AND ESTATE PLANNING SERVICES, ALONG WITH TAX GROSS-UP PAYMENTS FOR ANY REIMBURSEMENTS INCLUDED IN TAXABLE COMPENSATION ALL BENEFITS ARE PROVIDED PURSUANT TO A WRITTEN POLICY GOVERNING PAYMENT AND REIMBURSEMENT, SUBSTANTIATION IS REQUIRED FOR ALL EXPENSES SUBMITTED FOR REIMBURSEMENT, AND REIMBURSEMENTS ARE INCLUDED IN TAXABLE COMPENSATION WHERE APPROPRIATE |
| Schedule J, Part I, Line 1a Tax indemnification and gross-up payments | See Schedule J, Part I, Line 1a - Travel for Companions Disclosure |
| Schedule J, Part I, Line 1a Personal services | See Schedule J, Part I, Line 1a - Travel for Companions Disclosure |
| Schedule J, Part I, Line 4b Supplemental nonqualified retirement plan | 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 individuals were eligible to participate in that plan Michael Rowan, James Swindle, and Patricia Webb During 2014 the following contributions were made by CHI to the deferred compensation plan Michael Rowan \$0 James Swindle \$209,039 Patricia Webb \$119,218 During 2014 the following distributions were made by CHI to the deferred compensation plan Michael Rowan \$224,413 James Swindle \$121,664 Patricia Webb \$72,038 Due to the "super" vesting rules under the CHI deferred compensation plan, participants who have met certain requirements such as termination, age, or years of service are eligible to receive their 2014 contributions in cash These cash payouts are included in the participant's reportable compensation in column (iii) Other Reportable Compensation on Schedule J Part II During 2014, the following contributions that would have been made by CHI to the deferred compensation plan were paid in cash Michael Rowan \$266,409 IN ADDITION, CENTURA OFFERS A NON-QUALIFIED RETIREMENT PLAN IN WHICH SENIOR EXECUTIVES (SENIOR VPS AND ABOVE) ARE PROVIDED A 10% OF SALARY ALLOWANCE TO PURCHASE INSURANCE PRODUCTS OR CONTRIBUTE INTO THE DEFERRED COMPENSATION PLAN IN ADDITION, A PENSION RESTORATION BENEFIT IS PROVIDED WHICH CREDITS PARTICIPANTS WITH A BENEFIT WHICH IS CALCULATED BASED ON THE EXCESS OF THE PARTICIPANT'S COMPENSATION OVER THE MAXIMUM ALLOWED FOR PENSION CONTRIBUTIONS AMOUNTS DEFERRED ARE NOT REPORTED AS TAXABLE INCOME UNTIL/UNLESS A TRIGGERING EVENT OCCURS THIS DEFERRED COMPENSATION PLAN HAS A SUBSTANTIAL RISK OF FORFEITURE PROVISION AND AN ELECTED VESTING SCHEDULE THE FOLLOWING INDIVIDUALS WERE ELIGIBLE TO PARTICIPATE IN AND RECEIVED CONTRIBUTIONS TO THE SUPPLEMENTAL NON-QUALIFIED DEFERRED COMPENSATION PLAN DURING THE CALENDAR YEAR 2014 Margaret Sabin \$133,860 Jeffrey Brickman \$149,218 DURING THE CALENDAR YEAR 2014 THE FOLLOWING DISTRIBUTIONS WERE MADE BY CENTURA FROM THE DEFERRED COMPENSATION PLAN Jeffrey Brickman \$65,646 Margaret Sabin \$116,223 |
| Schedule J, Part I, Line 7 Non-fixed payments | PARTICIPANTS IN CENTURA'S INCENTIVE COMPENSATION PLANS INCLUDE DIRECTORS AND ABOVE PAYOUTS ARE BASED ON METRICS ESTABLISHED AND APPROVED BY CENTURA'S COMPENSATION COMMITTEE THE METRICS INCLUDE QUANTIFIABLE MEASURES PERTAINING TO FINANCIAL PERFORMANCE, SAFETY AND QUALITY AND ASSOCIATE SATISFACTION WITH EACH METRIC WEIGHTED IN DETERMINING THE OVERALL SCORE THE INCENTIVE COMPENSATION PAYOUT IS CALCULATED BASED ON THE CUMULATIVE SCORE FOR ALL METRICS AND THE PAYOUT IS BASED ON A COMBINATION OF THE SCORE, THE INDIVIDUAL'S BASE COMPENSATION AMOUNT AND POSITION (E G DIRECTOR, VICE PRESIDENT) |

Additional Data

Software ID: 14000329

Software Version: 2014v1.0

EIN: 84-0405257

Name: Catholic Health Initiatives Colorado

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

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred in prior Form 990 |
|---------------------------------------------------|----------------------------------------------------|-------------------------------------|-------------------------------------|------------------------------------------------|-------------------------|---------------------------------|-----------------------------------------------------------------------|
| | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| MICHAEL ROWAN FACHE BOARD MEMBER/EVP CHI COO | (i) (ii)0 1,195,620 | 0 788,897 | 0 515,926 | 0 32,602 | 0 21,054 | 0 2,554,099 | 0 224,413 |
| DEAN SWINDLE CPA BOARD MEMBER/EVP CHI CFO | (i) (ii)0 982,534 | 0 628,162 | 0 144,996 | 0 238,041 | 0 21,310 | 0 2,015,043 | 0 121,664 |
| PATRICIA WEBB BOARD MEMBER | (i) (ii)0 642,302 | 0 252,031 | 0 103,902 | 0 149,270 | 0 14,996 | 0 1,162,501 | 0 72,038 |
| Jeffrey Brickman Group Chief Executive Officer | (i) (ii)0 608,571 | 0 347,354 | 0 9,574 | 0 164,818 | 0 16,859 | 0 1,147,176 | 0 65,646 |
| Janiece McNichols CFO-St Anthony North | (i) (ii)0 173,978 | 0 53,339 | 0 341 | 0 13,639 | 0 10,601 | 0 251,898 | 0 0 |
| DANIEL REEVES CFO - PENROSE ST FRANCIS | (i) (ii)0 255,120 | 0 79,095 | 0 1,270 | 0 15,600 | 0 19,202 | 0 370,287 | 0 0 |
| MARGARET SABIN CEO - PENROSE ST FRANCIS | (i) (ii)0 581,307 | 0 290,781 | 0 90,623 | 0 149,460 | 0 21,405 | 0 1,133,576 | 0 116,223 |
| DAVID THOMPSON CFO - ST ANTHONY | (i) (ii)0 308,392 | 0 108,841 | 0 2,035 | 0 15,600 | 0 6,798 | 0 441,666 | 0 0 |
| Camille Azar Physician | (i) (ii)0 738,395 | 0 0 | 0 3,765 | 0 15,600 | 0 21,526 | 0 779,286 | 0 0 |
| Michael Drewek Physician | (i) (ii)0 772,645 | 0 239 | 0 1,381 | 0 15,600 | 0 22,186 | 0 812,051 | 0 0 |
| Alexander Fraley Physician | (i) (ii)0 677,728 | 0 6,575 | 0 822 | 0 15,600 | 0 22,011 | 0 722,736 | 0 0 |
| A STEWART LEVY PHYSICIAN | (i) (ii)0 793,651 | 0 819 | 0 3,203 | 0 15,600 | 0 21,987 | 0 835,260 | 0 0 |
| Mark ROBINSON Physician | (i) (ii)0 715,720 | 0 80 | 0 1,253 | 0 14,300 | 0 21,634 | 0 752,987 | 0 0 |

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
Catholic Health Initiatives Colorado**Employer identification number**

84-0405257

Return Reference**Explanation**Form 990, Part VI,
Line 16b EVAL OF
PARTICIPATION IN JV
ARRANGEMENTS

CATHOLIC HEALTH INITIATIVES-COLORADO HAS NOT FORMALLY ADOPTED A WRITTEN POLICY OR WRITTEN PROCEDURE REGARDING JOINT VENTURES. HOWEVER, CATHOLIC HEALTH INITIATIVES' ("CHI") SYSTEM-WIDE JOINT VENTURE MODEL OPERATING AGREEMENT INCORPORATES CONTROLS OVER THE VENTURE SUFFICIENT TO ENSURE THAT (1) THE EXEMPT ORGANIZATION AT ALL TIMES RETAINS CONTROL OVER THE VENTURE SUFFICIENT TO ENSURE THAT THE PARTNERSHIP FURTHERS THE EXEMPT PURPOSE OF THE ORGANIZATION, (2) IN ANY PARTNERSHIP IN WHICH THE EXEMPT ORGANIZATION IS A PARTNER, ACHIEVEMENT OF EXEMPT PURPOSES IS PRIORITIZED OVER MAXIMIZATION OF PROFITS FOR THE PARTNERS, (3) THE PARTNERSHIP DOES NOT ENGAGE IN ANY ACTIVITIES THAT WOULD JEOPARDIZE THE EXEMPT ORGANIZATION'S EXEMPTION, (4) RETURNS OF CAPITAL, ALLOCATIONS, AND DISTRIBUTIONS MUST BE MADE IN PROPORTION TO THE PARTNERS' RESPECTIVE OWNERSHIP INTERESTS, AND (5) ALL CONTRACTS ENTERED INTO BY THE PARTNERSHIP WITH THE EXEMPT ORGANIZATION MUST BE AT ARM'S-LENGTH, WITH PRICES SET AT FAIR MARKET VALUE. ANY JOINT VENTURE AGREEMENTS THAT DO NOT CONFORM TO THE MODEL AGREEMENT ARE GENERALLY REVIEWED BY COUNSEL.

| Return Reference | Explanation |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VI, Line 15 PROCESS USED TO ESTABLISH COMP | THE ORGANIZATION'S CEO AND OFFICERS ARE EMPLOYED BY CENTURA HEALTH CORPORATION ("CENTURA") OUTSIDE CONSULTANTS ARE ENGAGED TO PROVIDE RECOMMENDATIONS TO CENTURA'S COMPENSATION COMMITTEE REGARDING THE COMPENSATION OF FACILITY CEOS AND CENTURA SENIOR EXECUTIVES THE CONSULTANT'S RECOMMENDATIONS ARE THEN PRESENTED TO AND APPROVED BY THE COMPENSATION COMMITTEE CENTURA'S HUMAN RESOURCES DEPARTMENT PERFORMS ANALYSES OF THE MARKET TO DETERMINE COMPENSATION RANGES FOR THE REMAINDER OF CENTURA EXECUTIVES WHICH ARE REVIEWED AND APPROVED BY CENTURA'S SENIOR LEADERSHIP FOR THOSE REPORTABLE INDIVIDUALS (I.E. BOARD MEMBERS) WHOSE COMPENSATION IS PAID BY CATHOLIC HEALTH INITIATIVES ("CHI"), THEIR COMPENSATION WAS SET BY A COMPENSATION COMMITTEE UTILIZING AN INDEPENDENT CONSULTANT AND COMPARABILITY STUDIES TO DETERMINE COMPENSATION AMOUNTS THAT WERE BOARD APPROVED AND PAID TO THEM IN ACCORDANCE WITH A WRITTEN CONTRACT |

| Return Reference | Explanation |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VI, Line 6 Classes of members or stockholders | ACCORDING TO THE BYLAWS OF CATHOLIC HEALTH INITIATIVES-COLORADO, THE ENTITY'S SOLE MEMBER IS CATHOLIC HEALTH INITIATIVES, A COLORADO NONPROFIT CORPORATION |

| Return Reference | Explanation |
|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VI, Line 7a Members or stockholders electing members of governing body | THE SOLE CORPORATE MEMBER HAS THE POWER TO APPOINT, REPLACE OR REMOVE THE MEMBERS OF THE BOARD OF DIRECTORS. ACCORDING TO THE ORGANIZATION'S BYLAWS, THE SOLE MEMBER SHALL FILL ALL VACANCIES ON THE BOARD OF TRUSTEES CREATED BY REMOVAL, RESIGNATION, OR DEATH |

| Return Reference | Explanation |
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| Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders | <p>CATHOLIC HEALTH INITIATIVES-COLORADO'S ("CHIC") CORPORATE MEMBER IS CATHOLIC HEALTH INITIATIVES ("CHI") PURSUANT TO SECTION 5 4 1 OF THE ORGANIZATION'S BYLAWS, THE CORPORATE MEMBER SHALL HAVE THE SPECIFIC RIGHTS SET FORTH IN THE GOVERNANCE MATRIX EXCEPT TO THE EXTENT OTHERWISE PROVIDED IN ORGANIZATION'S ARTICLES AND BYLAWS PURSUANT TO THE GOVERNANCE MATRIX THE FOLLOWING RIGHTS ARE HELD BY THE CHIC BOARD - APPROVE MEMBERS OF THE CHIC BOARD - AMENDMENT OF THE CORPORATE DOCUMENTS OF CHIC - APPROVE REMOVAL OF A MEMBER OF THE GOVERNING BODY OF CHIC - ADOPTION OF LONG RANGE AND STRATEGIC PLANS FOR CHIC - SUBSTANTIAL CHANGE IN THE MISSION OR PHILOSOPHY OF CHIC The following rights are reserved to the CHI Board directly or through powers delegated to the CHI Chief Executive Officer - REMOVAL OF A MEMBER OF THE GOVERNING BODY OF CHIC - APPROVAL OF ISSUANCE OF DEBT BY CHIC - APPROVAL OF PARTICIPATION OF CHIC IN A JOINT VENTURE - APPROVAL OF FORMATION OF A NEW CORPORATION BY CHIC - APPROVAL OF A MERGER INVOLVING CHIC - APPROVAL OF THE SALE OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF CHIC - TO REQUIRE THE TRANSFER OF ASSETS BY CHIC TO CHI TO ACCOMPLISH CHI'S GOALS AND OBJECTIVES, AND TO SATISFY CHI DEBTS PURSUANT TO SECTION 5 5 2 OF THE ORGANIZATION'S BYLAWS, CHI MAY, IN EXERCISE OF ITS APPROVAL POWERS, GRANT OR WITHHOLD APPROVAL IN WHOLE OR IN PART, OR MAY, IN ITS COMPLETE DISCRETION, AFTER CONSULTATION WITH THE BOARD AND THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE ORGANIZATION, RECOMMEND SUCH OTHER OR DIFFERENT ACTIONS AS IT DEEMS APPROPRIATE IN ADDITION, PURSUANT TO THE AFFILIATION AGREEMENT BETWEEN CHI, CHIC, CENTURA HEALTH CORPORATION, AND PORTERCARE ADVENTIST HEALTH SYSTEM, CERTAIN MATTERS AFFECTING CHIC MUST BE APPROVED BY BOTH PORTERCARE AND CHI THOSE ITEMS INCLUDE - THE TRANSFER OF ASSETS VALUED AT OVER \$1,000,000 - THE ISSUANCE OF A DEBT INSTRUMENT IN EXCESS OF \$250,000 - THE AMENDMENT OF THE ORGANIZING DOCUMENTS - THE ADMISSION OF A NEW SPONSOR - A MERGER OR DISSOLUTION OR REORGANIZATION - SETTLEMENT OF LEGAL PROCEEDINGS IN EXCESS OF \$2,000,000 - CAPITAL EXPENDITURES IN EXCESS OF \$2,000,000</p> |

| Return Reference | Explanation |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VI, Line 11b Review of form 990 by governing body | ONCE THE RETURN IS PREPARED, A DRAFT OF THE FORM 990 IS PROVIDED TO MANAGEMENT, INCLUDING THE CFO, FOR REVIEW. THE RETURN IS E-MAILED TO THE ENTIRE BOARD FOR REVIEW PRIOR TO FILING. SUBSEQUENT TO THE RETURN BEING PROVIDED TO THE BOARD, THE TAX DEPARTMENT FILES THE RETURN WITH THE APPROPRIATE FEDERAL AND STATE AGENCIES, MAKING ANY NON-SUBSTANTIVE CHANGES NECESSARY TO EFFECT E-FILING. ANY SUCH CHANGES ARE NOT RE-SUBMITTED TO THE BOARD. |

| Return Reference | Explanation | |
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| | Form 990, Part VI, Line 12c Conflict of interest policy | <p>PROCEDURE 1 PROCEDURE FOR CONFLICT OF INTEREST REPORTING 1 1 THE CATHOLIC HEALTH INITIA TIVES-COLORADO ("CHIC") COMPLIANCE DEPARTMENT ADMINISTERS AN ANNUAL CONFLICT OF INTEREST P ROCESS (USUALLY STARTING IN NOVEMBER) COLLECTING AND ASSESSING ANY POTENTIAL CONFLICTS BOA RD MEMBERS AND RELATED BOARD COMMITTEE MEMBERS, MATERIALS MANAGEMENT/SUPPLY CHAIN AS WELL AS CHIC MANAGEMENT MAY HAVE. THE FOLLOWING PROCESS IS FOLLOWED 1 1 1 A COVER LETTER ALON G WITH THE CONFLICTS OF INTEREST POLICY AND THE CONFLICTS OF INTEREST DISCLOSURE STATEMENT ARE AUTOMATICALLY GENERATED AND DISTRIBUTED VIA EMAIL UTILIZING THE COMPLY TRACK SURVEY M ANAGER TOOL. FOR THOSE WITHOUT EMAIL ADDRESSES, THE DOCUMENTS ARE SENT VIA US MAIL 1 1 2 A REQUEST IS MADE TO COMPLETE THE DISCLOSURE STATEMENT FROM ONLINE AND SUBMIT AN ELECTRON IC SIGNATURE USING THE SURVEY TOOL. FOR THOSE WITHOUT AN EMAIL ADDRESS, A REQUEST IS MADE TO FAX OR MAIL ORIGINALS TO THE COMPLIANCE DEPARTMENT 1 1 3 A REPORT IS COMPILED IDENTIF YING ALL REPORTED POTENTIAL CONFLICTS, NO RESPONSES AND NO NOTED CONFLICTS 1 1 4 THE REP ORT IS REVIEWED FOR POTENTIAL CONFLICTS AND CATEGORIZED BY TYPE OF CONFLICT 1 1 5 A MEMO IS DISTRIBUTED TO EACH FACILITY CEO AND CFO ALONG WITH REPORTED CONFLICTS FOR PROCESSING AND RELEVANT ACTION OR FOLLOW UP. THE CEO OR CFO, ON BEHALF OF THE CEO, WILL DISTRIBUTE IN FORMATION ABOUT SPECIFIC CONFLICTS TO RELEVANT DEPARTMENT MANAGEMENT FOR CONSIDERATION IN FUTURE BUSINESS DEALINGS/NEGOTIATIONS 1 1 6 THE REPORT IS SHARED WITH THE CHIC BOARD FOR INFORMATION, DISCUSSION, AND POSSIBLE ACTION RELATIVE TO SPECIFIC CONFLICTIVE SITUATIONS 2 PROCEDURE FOR DISCLOSURE 2 1 WHENEVER ANY MATTER COMES BEFORE A MEETING OF THE BOARD, A BOARD COMMITTEE MANAGEMENT OR MATERIALS MANAGEMENT/SUPPLY CHAIN THAT GIVES RISE TO A PO TENTIAL CONFLICT OF INTEREST, THE FOLLOWING PROCEDURES SHALL APPLY 2 1 1 AN INTERESTED P ERSON MAY MAKE A PRESENTATION AT THE BOARD, COMMITTEE MEETING OR MANAGEMENT MEETING BUT AF TER SUCH PRESENTATION, HE/SHE SHALL, IF REQUESTED BY THE BOARD OR COMMITTEE, LEAVE THE MEE TING DURING THE DISCUSSION OF, AND THE VOTE ON, THE TRANSACTION OR ARRANGEMENT THAT RESULT S IN THE CONFLICT OF INTEREST 2 1 2 THE CHAIRPERSON OF THE BOARD OR COMMITTEE SHALL, IF APPROPRIATE, APPOINT A DISINTERESTED PERSON OR COMMITTEE TO INVESTIGATE ALTERNATIVES TO TH E PROPOSED TRANSACTION OR ARRANGEMENT 2 1 3 AFTER EXERCISING DUE DILIGENCE, THE BOARD OR COMMITTEE SHALL DETERMINE WHETHER CHIC CAN OBTAIN A MORE ADVANTAGEOUS TRANSACTION OR ARR ANGEMENT WITH REASONABLE EFFORTS FROM A PERSON OR ENTITY THAT WOULD NOT GIVE RISE TO A CONF LICT OF INTEREST 2 1 4 IF A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT IS NOT REASONAB LY ATTAINABLE UNDER CIRCUMSTANCES THAT WOULD NOT GIVE RISE TO A CONFLICT OF INTEREST, THE BOARD OR COMMITTEE SHALL DETERMINE, BY A MAJORITY VOTE OF THE DISINTERESTED MEMBERS, WHETH ER THE TRANSACTION OR ARRANGEMENT IS IN CHIC'S BEST INTEREST AND FOR ITS OWN BENEFIT AND W HETHER THE TRANSACTION IS FAIR AND REASONABLE TO CHIC AND SHALL MAKE ITS DECISION AS TO WH ETHER TO ENTER INTO THE TRANSACTION OR ARRANGEMENT IN CONFORMITY WITH SUCH DETERMINATION 2 1 5 FOR TRANSACTIONS THAT ARE NEGOTIATED BY CHIC MANAGEMENT AND MATERIALS MANAGEMENT/SU PPLY CHAIN AND WHICH ARE NOT REQUIRED TO BE REPORTED TO THE BOARD, EACH MANAGER WILL TAKE PRECAUTIONS TO ENSURE THERE IS NO CONFLICT OR THE APPEARANCE OF A CONFLICT RELATIVE TO THE BUSINESS NEGOTIATIONS AND TRANSACTION. IF A CONFLICT, OR THE APPEARANCE OF A CONFLICT EXI STS, THE INTERESTED PERSON WILL REMOVE HIMSELF/HERSELF OR OTHER INTERESTED PARTY FROM THE NEGOTIATION/TRANSACTION 3 VIOLATIONS OF THE CONFLICTS OF INTEREST POLICY 3 1 IF THE BOA RD, COMMITTEE OR CHIC MANAGEMENT HAS REASONABLE CAUSE TO BELIEVE THAT AN INTERESTED PERSON HAS FAILED TO DISCLOSE ACTUAL OR POSSIBLE CONFLICTS OF INTEREST, IT SHALL INFORM THE INTE RESTED PERSON TO DISCLOSE 3 2 IF, AFTER HEARING THE RESPONSE OF THE INTERESTED PERSON AND MAKING SUCH FURTHER INVESTIGATION AS MAY BE WARRANTED IN THE CIRCUMSTANCES, THE BOARD, C OMMITTEE OR CHIC MANAGEMENT DETERMINES THAT THE INTERESTED PERSON HAS IN FACT FAILED TO DI SCLOSE AN ACTUAL OR POSSIBLE CONFLICT OF INTEREST, IT SHALL TAKE APPROPRIATE DISCIPLINARY AND CORRECTIVE ACTION 4 RECORDS OF PROCEEDINGS 4 1 THE MINUTES OF THE BOARD AND ANY COM MITTEES WITH BOARD DELEGATED POWERS SHALL CONTAIN 4 1 1 THE NAMES OF THE PERSONS WHO DIS CLOSED OR OTHERWISE WERE FOUND TO HAVE AN ACTUAL OR POSSIBLE CONFLICT OF INTEREST, THE NAT URE OF THE CONFLICT, ANY ACTION TAKEN TO DETERMINE WHETHER A CONFLICT OF INTEREST WAS PRES ENT, AND THE BOARD OR COMMITTEE'S DECISION AS TO WHETHER A CONFLICT OF INTEREST, IN FACT, EXISTED 4 1 2 THE NAMES OF THE PERSONS WHO WERE PRESENT FOR DISCUSSIONS RELATING TO THE TRANSACTION OR ARRANGEMENT, THE CONTENT OF THE DISCUSSION, INCLUDING ANY ALTERNATIVES TO T HE PROPOSED TRANSACTION OR ARRANGEMENT, A RECORD OF ANY VOTES TAKEN IN CONNECTION THEREWIT H AND A RECORD THAT THE PERSON(S) WITH A CONFLICT</p> |

| Return Reference | Explanation | |
|------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Form 990, Part VI, Line 12c Conflict of interest policy | <p>OF INTEREST DID NOT PARTICIPATE IN THE VOTE 4 1 3 FOR BUSINESS TRANSACTIONS BEING NEGOTIATED OUTSIDE OF THOSE REQUIRED TO BE REPORTED TO THE BOARD AND ANY COMMITTEES, THE COMPLIANCE DEPARTMENT SHALL MAINTAIN DOCUMENTATION AS TO THE RESOLUTION AND APPROPRIATENESS OF ANY POTENTIAL CONFLICT RELATIVE TO MANAGEMENT AND MATERIALS MANAGEMENT/SUPPLY CHAIN ASSOCIATES CONDUCTING BUSINESS ON BEHALF OF CHIC 5 COMPENSATION 5 1 A VOTING MEMBER OF A BOARD OR A BOARD COMMITTEE WHO RECEIVES COMPENSATION, DIRECTLY OR INDIRECTLY, FROM CHIC FOR SERVICES IS PRECLUDED FROM VOTING ON MATTERS PERTAINING TO THAT MEMBER'S COMPENSATION 5 2 A PHYSICIAN WHO IS A VOTING MEMBER OF A BOARD OR BOARD COMMITTEE AND RECEIVES COMPENSATION, DIRECTLY OR INDIRECTLY, FROM CHIC FOR SERVICES IS PRECLUDED FROM DISCUSSING AND VOTING ON MATTERS PERTAINING TO THAT MEMBER AND OTHER PHYSICIANS' COMPENSATION NO PHYSICIAN OR PHYSICIAN BOARD MEMBER OR COMMITTEE MEMBER, EITHER INDIVIDUALLY OR COLLECTIVELY, IS PROHIBITED FROM PROVIDING INFORMATION TO THE BOARD OR BOARD COMMITTEE REGARDING PHYSICIAN COMPENSATION 6 ANNUAL STATEMENTS 6 1 ALL INTERESTED PERSONS MUST COMPLETE A DISCLOSURE STATEMENT ANNUALLY THIS DISCLOSURE STATEMENT MAY BE MODIFIED FROM TIME TO TIME AS DEEMED APPROPRIATE THE VICE PRESIDENT OF CHIC COMPLIANCE IS RESPONSIBLE FOR CIRCULATING, ENSURING COMPLETION OF THE DISCLOSURE STATEMENT BY ALL INTERESTED PERSONS OF CHIC, AND REPORTING THE RESULTS TO THE CHIC HEALTH BOARD 7 PERIODIC REVIEWS 7 1 ANNUALLY, INTERNAL AUDIT WILL REVIEW COMPENSATION AND FINANCIAL ARRANGEMENTS FOR POTENTIAL CONFLICTS OF INTEREST</p> |

| Return Reference | Explanation |
|----------------------------------------------------------------------------------|-------------|
| Form 990, Part VI, Line 15b Process to establish compensation of other employees | SEE ABOVE |

| Return Reference | Explanation |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VI, Line 19 Required documents available to the public | THE ORGANIZATION'S GOVERNING DOCUMENTS ARE AVAILABLE ON THE COLORADO SECRETARY OF STATE'S WEBSITE. THE ORGANIZATION'S FINANCIAL STATEMENTS ARE INCLUDED IN THE CATHOLIC HEALTH INITIATIVES CONSOLIDATED AUDITED FINANCIAL STATEMENTS THAT ARE AVAILABLE AT WWW.CATHOLICHEALTHINIT.ORG OR AT WWW.DACBOND.COM . THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS NOT PUBLICLY AVAILABLE. |

| Return Reference | Explanation |
|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part VIII, Line 11d Other Miscellaneous Revenue | Other Miscellaneous Revenue - Total Revenue 8138316, Related or Exempt Function Revenue , Unrelated Business Revenue 28574, Revenue Excluded from Tax Under Sections 512, 513, or 514 8109742, |

| Return Reference | Explanation |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Form 990, Part IX, Line 11g Other Fees | Other Fees for Services - Total Expense 401522947, Program Service Expense 327250506, Management and General Expenses 74272441, Fundraising Expenses , |

| Return Reference | Explanation |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Form 990, Part XI, Line 9 Other changes in net assets or fund balances | Minority Interest - -8322035, Capital Resource Pool Contributions - -13336818, |

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
Catholic Health Initiatives Colorado

Employer identification number
84-0405257

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 | 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) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|----------------------------------------------------------|-------------------------|--------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------|-----------------------------------------|----|----------------------------------------------------------------------------|-------------------------------------------|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| 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.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|----|
| Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule | | Yes | No |
| 1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV? | | | |
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | 1a | | 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 | Yes | |
| 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 | | No |
| l Performance of services or membership or fundraising solicitations for related organization(s) | 1l | Yes | |
| m Performance of services or membership or fundraising solicitations by related organization(s) | 1m | Yes | |
| n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | 1n | | No |
| o Sharing of paid employees with related organization(s) | 1o | | No |
| p Reimbursement paid to related organization(s) for expenses | 1p | Yes | |
| q Reimbursement paid by related organization(s) for expenses | 1q | 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 | Yes | |

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

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|-----------------------------------------------------|----------------------------------|------------------------|----------------------------------------------|
| (1) Catholic Health Initiatives Colorado Foundation | B | 170,000 | FMV |

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) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|-----------------------------------------|-------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------|----|------------------------------|------------------------------------|--------------------------------------|----|----------------------------------------------------------------|-------------------------------------|----|-----------------------------|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

Part VII

Supplemental Information

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

| Return Reference | Explanation |
|------------------|-------------|
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Additional Data

Software ID: 14000329

Software Version: 2014v1.0

EIN: 84-0405257

Name: Catholic Health Initiatives Colorado

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) ALEAGENT CREIGHTON CLINIC 12809 W DODGE RD OMAHA, NE 68154 47-0765154 | HEALTHCARE | NE | 501(c)(3) | 3 | ACH | Yes | |
| (1) ALEAGENT CREIGHTON HEALTH 12809 W DODGE RD OMAHA, NE 68154 47-0757164 | HEALTHCARE | NE | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (2) ALEAGENT CREIGHTON HEALTH FOUNDATION 12809 W DODGE RD OMAHA, NE 68154 47-0648586 | FUNDRAISING | NE | 501(c)(3) | 7 | ACH | Yes | |
| (3) ALEAGENT HEALTH - BERGAN MERCY HEALTH SYSTEM 7500 MERCY RD OMAHA, NE 68124 47-0484764 | HEALTHCARE | NE | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (4) ALEAGENT HEALTH - COMMUNITY MEMORIAL HOSPITAL OF MISSOURI VALLEY IA 631 N 8TH ST MISSOURI VALLEY, IA 51555 42-0776568 | HEALTHCARE | IA | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (5) ALEAGENT HEALTH - IMMANUEL MEDICAL CENTER 6901 N 72ND ST OMAHA, NE 68122 47-0376615 | HEALTHCARE | NE | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (6) ALEAGENT HEALTH - MEMORIAL HOSPITAL SCHUYLER 104 W 17TH ST SCHUYLER, NE 68661 47-0399853 | HEALTHCARE | NE | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (7) ALEAGENT HEALTH - MERCY HOSPITAL CORNING IOWA PO BOX 368 CORNING, IA 50841 42-0782518 | HEALTHCARE | IA | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (8) ALVERNA APARTMENTS 300 SE 8TH AVE LITTLE FALLS, MN 56345 41-1351177 | LTERM CARE | MN | 501(c)(3) | 9 | CHI | Yes | |
| (9) APPLETREE COURT 601 OAK ST BRECKENRIDGE, MN 56520 41-1850500 | SENIOR LIVING | MN | 501(c)(3) | 9 | SFH | Yes | |
| (10) BELLEVILLE ST JOSEPH HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 27-4005511 | HEALTHCARE | TX | 501(c)(3) | 3 | SHSC | Yes | |
| (11) BISHOP DRUMM RETIREMENT CENTER 1111 6TH AVE DES MOINES, IA 50314 42-0725196 | LTERM CARE | IA | 501(c)(3) | 9 | CHI-IA CORP | Yes | |
| (12) BORNEMANN HEALTHCARE CORPORATION 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-2187242 | HEALTHCARE | PA | 501(c)(3) | Type I | CHI | Yes | |
| (13) BURLESON ST JOSEPH HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2759890 | HEALTHCARE | TX | 501(c)(3) | 3 | SJSC | Yes | |
| (14) BURLESON ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2913931 | HEALTHCARE | TX | 501(c)(3) | 9 | SJSC | Yes | |
| (15) CARRINGTON HEALTH CENTER 800 N 4TH ST CARRINGTON, ND 58421 45-0227311 | HEALTHCARE | ND | 501(c)(3) | 3 | CHI | Yes | |
| (16) CATHOLIC HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 47-0617373 | HEALTHCARE | CO | 501(c)(3) | Type I | NA | Yes | |
| (17) CATHOLIC HEALTH INITIATIVES - COLORADO 188 INVERNESS DRIVE WEST STE 500 ENGLEWOOD, CO 80112 84-0405257 | HEALTHCARE | CO | 501(c)(3) | 3 | CHI | Yes | |
| (18) CATHOLIC HEALTH INITIATIVES - IOWA CORP 1111 6TH AVE DES MOINES, IA 50314 42-0680448 | HEALTHCARE | IA | 501(c)(3) | 3 | CHI | Yes | |
| (19) CATHOLIC HEALTH INITIATIVES COLORADO FOUNDATION 6385 CORPORATE DR STE 301 COLORADO SPRINGS, CO 80919 84-0902211 | FUNDRAISING | CO | 501(c)(3) | 7 | CHIC | 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) CATHOLIC HEALTH INITIATIVES NATIONAL FOUNDATION 6385 CORPORATE DR COLORADO SPRINGS, CO 80919 27-0930004 | FUNDRAISING | CO | 501(c)(3 | Type I | CHI | Yes | |
| (1) CATHOLIC HEALTH INITIATIVES VIRTUAL HEALTH SERVICES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-0992796 | HEALTHCARE | CO | 501(c)(3 | Type I | CHINS | Yes | |
| (2) CENTENNIAL MEDICAL GROUP INC 2700 STEWART PKWY ROSEBURG, OR 97471 26-3946191 | PHYSICIANS | OR | 501(c)(3 | 9 | MMC | Yes | |
| (3) CENTRAL KANSAS MEDICAL CENTER 3515 BROADWAY GREAT BEND, KS 67530 48-0543724 | SURGERY CENTER | KS | 501(c)(3 | 3 | CHI | Yes | |
| (4) CHI HEALTH CONNECT AT HOME - FARGO 4816 AMBER VALLEY PKWY S FARGO, ND 58104 27-1966847 | HEALTHCARE | MN | 501(c)(3 | 9 | CHI | Yes | |
| (5) CHI INSTITUTE FOR RESEARCH AND INNOVATION 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 27-1050565 | HEALTHCARE | CO | 501(c)(3 | Type I | CHI | Yes | |
| (6) CHI KENTUCKY INC 3900 OLYMPIC BLVD STE 400 ERLANGER, KY 41018 20-2741651 | HEALTHCARE | KY | 501(c)(3 | Type I | CHI | Yes | |
| (7) CHI NATIONAL HOME CARE 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-1261716 | HEALTHCARE | CO | 501(c)(3 | 9 | CHI NS | Yes | |
| (8) CHI NATIONAL SERVICES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 45-2532084 | HEALTHCARE | CO | 501(c)(3 | Type I | CHI | Yes | |
| (9) CHI NEBRASKA 6940 O ST STE 200 LINCOLN, NE 68510 36-3233121 | HEALTHCARE | NE | 501(c)(3 | Type I | CHI | Yes | |
| (10) CHI ST JOSEPH'S CHILDREN 1516 5TH ST NW ALBUQUERQUE, NM 87102 71-0897107 | COMMUNITY | NM | 501(c)(3 | Type I | CHI | Yes | |
| (11) CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE MEDICAL CENTER 6624 FANNIN ST HOUSTON, TX 77030 74-1161938 | HEALTHCARE | TX | 501(c)(3 | 3 | SLHS | Yes | |
| (12) CHI ST VINCENT HOSPITAL HOT SPRINGS 300 WERNER ST HOT SPRINGS, AR 71913 71-0236913 | HEALTHCARE | AR | 501(c)(3 | 3 | CHISVHS | Yes | |
| (13) CHI ST VINCENT HOT SPRINGS 300 WERNER ST HOT SPRINGS, AR 71913 26-1125064 | HOLDING CO | AR | 501(c)(3 | Type II | SVIMC | Yes | |
| (14) CHI ST VINCENT MEDICAL GROUP HOT SPRINGS 1 MERCY LANE STE 201 HOT SPRINGS, AR 71913 26-1125131 | HEALTHCARE | AR | 501(c)(3 | 3 | CHISVHS | Yes | |
| (15) COMMUNITY LIMITED CARE DIALYSIS CENTER 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 23-7419853 | HOLDING CO | OH | 501(c)(2 | | GSH | Yes | |
| (16) COMMUNITY MEMORIAL HOSPITAL MEDICAL SERVICE FOUNDATION 631 N 8TH ST MISSOURI VALLEY, IA 51555 42-1294399 | FUNDRAISING | IA | 501(c)(3 | Type I | AH-CMHMV | Yes | |
| (17) CONTINUING CARE HOSPITAL 150 NORTH EAGLE CREEK DR LEXINGTON, KY 40509 61-1400619 | LT ACH | KY | 501(c)(3 | 3 | SJHS | Yes | |
| (18) COVENANT HOME CARE 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 23-2028429 | HOME HEALTH | PA | 501(c)(3 | Type II | CHI NHC | Yes | |
| (19) ENUMCLAW REGIONAL HOSPITAL ASSOCIATION 1450 BATTERSBY AVE ENUMCLAW, WA 98022 91-0715805 | HEALTHCARE | WA | 501(c)(3 | 3 | FHS | Yes | |

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

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|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (41) FLAGET HEALTHCARE INC 4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 61-1345363 | HEALTHCARE | KY | 501(c)(3 | 3 | KOH | Yes | |
| (1) FLAGET MEMORIAL HOSPITAL FOUNDATION INC 4305 NEW SHEPHERDSVILLE RD BARDSTOWN, KY 40004 56-2351341 | FUNDRAISING | KY | 501(c)(3 | Type I | FH | Yes | |
| (2) FRANCISCAN CARE CENTER 4111 N HOLLAND-SYLVANIA RD TOLEDO, OH 43623 34-1931806 | HEALTHCARE | OH | 501(c)(3 | 9 | FLC | Yes | |
| (3) FRANCISCAN FOUNDATION 1717 SOUTH J ST TACOMA, WA 98405 91-1145592 | FUNDRAISING | WA | 501(c)(3 | 9 | FHS | Yes | |
| (4) FRANCISCAN HEALTH SYSTEM 1717 SOUTH J ST TACOMA, WA 98405 91-0564491 | HEALTHCARE | WA | 501(c)(3 | 3 | CHI | Yes | |
| (5) FRANCISCAN HEALTH VENTURES FKA SJMGROUP TACOMA FNC CTR BLDG 1145 BROADWAY TACOMA, WA 98402 43-1882377 | PHYSICIANS | MO | 501(c)(3 | 9 | CHI | Yes | |
| (6) FRANCISCAN LIVING COMMUNITIES 5942 RENAISSANCE PLACE STE A TOLEDO, OH 43623 34-1892096 | HEALTHCARE | OH | 501(c)(3 | Type I | SFH | Yes | |
| (7) FRANCISCAN MEDICAL GROUP 1313 BROADWAY STE 200 TACOMA, WA 98402 91-1939739 | HEALTHCARE | WA | 501(c)(3 | 9 | FHS | Yes | |
| (8) FRANCISCAN VILLA OF SOUTH MILWAUKEE INC 3601 S CHICAGO AVE SOUTH MILWAUKEE, WI 53172 39-1093829 | HEALTHCARE | WI | 501(c)(3 | 9 | CHI | Yes | |
| (9) GARRISON MEMORIAL HOSPITAL 407 THIRD AVENUE SOUTHEAST GARRISON, ND 58540 45-0227752 | HEALTHCARE | ND | 501(c)(3 | 3 | SAMC | Yes | |
| (10) GLOBAL HEALTH INITIATIVES 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 20-1536108 | MINISTRIES | CO | 501(c)(3 | Type I | CHI | Yes | |
| (11) GOOD SAMARITAN COLLEGE OF NURSING & HEALTH SCIENCE 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-1778403 | EDUCATION | OH | 501(c)(3 | 2 | GSH | Yes | |
| (12) GOOD SAMARITAN FOUNDATION OF CINCINNATI INC 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-1206047 | FUNDRAISING | OH | 501(c)(3 | Type I | GSH | Yes | |
| (13) GOOD SAMARITAN HOSPITAL PO BOX 1990 KEARNEY, NE 68848 47-0379755 | HEALTHCARE | NE | 501(c)(3 | 3 | CHI NEBRASKA | Yes | |
| (14) GOOD SAMARITAN HOSPITAL FOUNDATION 111 W 31ST ST KEARNEY, NE 68847 47-0659443 | FUNDRAISING | NE | 501(c)(3 | 7 | GSH | Yes | |
| (15) GOOD SAMARITAN HOSPITAL FOUNDATION - DAYTON 110 N MAIN ST STE 500 DAYTON, OH 45402 23-7296923 | FUNDRAISING | OH | 501(c)(3 | 7 | SHP | Yes | |
| (16) HARRISON MEDICAL CENTER 2520 CHERRY AVE BREMERTON, WA 98310 91-0565546 | HEALTHCARE | WA | 501(c)(3 | 3 | FHS | Yes | |
| (17) HARRISON MEDICAL CENTER FOUNDATION 2520 CHERRY AVE BREMERTON, WA 98310 91-1197626 | FUNDRAISING | WA | 501(c)(3 | 7 | HMC | Yes | |
| (18) HEALTH SET 2420 W 26TH AVE STE 460D DENVER, CO 80211 84-1102943 | LOW INC CARE | CO | 501(c)(3 | 7 | CHIC | Yes | |
| (19) HEALTHCARE AND WELLNESS FOUNDATION 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 76-0761782 | FUNDRAISING | MN | 501(c)(3 | Type I | SFMC | Yes | |

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|-----------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (61) HIGHLINE MEDICAL CENTER 16251 SYLVESTER RD SW BURIEN, WA 98166 91-0712166 | HEALTHCARE | WA | 501(c)(3) | 3 | FHS | Yes | |
| (1) HOUSE OF MERCY 1111 6TH AVE DES MOINES, IA 50314 42-1323808 | SHELTER | IA | 501(c)(3) | 7 | CHI-IA CORP | Yes | |
| (2) JEWISH HOSPITAL AND ST MARY'S HEALTHCARE INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1029768 | HEALTHCARE | KY | 501(c)(3) | 3 | KOH | Yes | |
| (3) KENTUCKYONE HEALTH MEDICAL GROUP INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1352729 | HEALTHCARE | KY | 501(c)(3) | 9 | JHSMH | Yes | |
| (4) KENTUCKYONE HEALTH INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1029769 | HEALTHCARE | KY | 501(c)(3) | 9 | CHI | Yes | |
| (5) LAKEWOOD HEALTH CENTER 600 MAIN AVE S BAUDETTE, MN 56623 41-0758434 | HEALTHCARE | MN | 501(c)(3) | 3 | CHI | Yes | |
| (6) LAKEWOOD REGIONAL HEALTHCARE FOUNDATION 600 MAIN AVE S BAUDETTE, MN 56623 41-1893795 | FUNDRAISING | ND | 501(c)(3) | 7 | LHC | Yes | |
| (7) LINUS OAKES INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-0821381 | SENIOR LIVING | OR | 501(c)(3) | 9 | MMC | Yes | |
| (8) LISBON AREA HEALTH SERVICES 905 MAIN ST LISBON, ND 58054 82-0558836 | HEALTHCARE | ND | 501(c)(3) | 3 | CHI | Yes | |
| (9) LUFKIN VISION ACQUISITIONS PO BOX 1447 LUFKIN, TX 75901 82-0563768 | PROPERTY MGMT | TX | 501(c)(3) | Type III-FI | MHSET | Yes | |
| (10) MADISON ST JOSEPH HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2761145 | HEALTHCARE | TX | 501(c)(3) | 3 | SJSC | Yes | |
| (11) MADONNA MANOR INC 2344 AMSTERDAM ROAD VILLA HILLS, KY 51017 61-0654635 | LIVING ASSIST | KY | 501(c)(3) | 1 | FLC | Yes | |
| (12) MEMORIAL HEALTH CARE SYSTEM FOUNDATION INC 2525 DE SALES AVE CHATTANOOGA, TN 37404 62-1839548 | FUNDRAISING | TN | 501(c)(3) | 7 | MHCS | Yes | |
| (13) MEMORIAL HEALTH CARE SYSTEM INC 2525 DE SALES AVE CHATTANOOGA, TN 37404 62-0532345 | HEALTHCARE | TN | 501(c)(3) | 3 | CHI | Yes | |
| (14) MEMORIAL HEALTH PARTNERS FOUNDATION INC 5600 BRAINERD RD STE 500 CHATTANOOGA, TN 37411 03-0417049 | HEALTHCARE | TN | 501(c)(3) | 9 | MHCS | Yes | |
| (15) MEMORIAL HEALTH SYSTEM OF EAST TEXAS PO BOX 1447 LUFKIN, TX 75902 75-0755367 | HEALTHCARE | TX | 501(c)(3) | 3 | CHI | Yes | |
| (16) MEMORIAL MEDICAL CENTER - LIVINGSTON PO BOX 1447 LUFKIN, TX 75902 76-0436439 | HEALTHCARE | TX | 501(c)(3) | 3 | MHSET | Yes | |
| (17) MEMORIAL MEDICAL CENTER - SAN AUGUSTINE PO BOX 1447 LUFKIN, TX 75902 75-2663904 | HEALTHCARE | TX | 501(c)(3) | 3 | MHSET | Yes | |
| (18) MEMORIAL MULTISPECIALTY ASSOCIATES 1201 FRANK AVE LUFKIN, TX 95904 75-2721155 | PHYSICIANS | TX | 501(c)(3) | Type III-FI | MHSET | Yes | |
| (19) MEMORIAL SPECIALTY HOSPITAL PO BOX 1447 LUFKIN, TX 95902 75-2492741 | HEALTHCARE | TX | 501(c)(3) | 3 | MHSET | Yes | |

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|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (81) MERCY AUXILIARY OF CENTRAL IOWA 1111 6TH AVE DES MOINES, IA 50314 42-6076069 | AUXILIARY | IA | 501(c)(3 | Type I | MF-DM IA | Yes | |
| (1) MERCY CLINICS INC 1111 6TH AVE DES MOINES, IA 50314 42-1193699 | PHYSICIANS | IA | 501(c)(3 | 9 | CHI-IA CORP | Yes | |
| (2) MERCY COLLEGE OF HEALTH SCIENCES 1111 6TH AVE DES MOINES, IA 50314 42-1511682 | EDUCATION | IA | 501(c)(3 | 2 | CHI-IA CORP | Yes | |
| (3) MERCY FOUNDATION OF DES MOINES IA 1111 6TH AVE DES MOINES, IA 50314 23-7358794 | FUNDRAISING | IA | 501(c)(3 | 7 | CHI-IA CORP | Yes | |
| (4) MERCY FOUNDATION INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-6088946 | FUNDRAISING | OR | 501(c)(3 | 7 | MMC | Yes | |
| (5) MERCY HEALTH CARE FOUNDATION PO BOX 368 CORNING, IA 50841 42-1461064 | FUNDRAISING | IA | 501(c)(3 | Type I | AHMH-Corning | Yes | |
| (6) MERCY HEALTHCARE FOUNDATION 570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0435338 | FUNDRAISING | ND | 501(c)(3 | Type I | MHVC | Yes | |
| (7) MERCY HOSPITAL FOUNDATION COUNCIL BLUFFS 800 MERCY DR COUNCIL BLUFFS, IA 51503 42-1178204 | FUNDRAISING | IA | 501(c)(3 | Type I | AHBMHS | Yes | |
| (8) MERCY HOSPITAL OF DEVILS LAKE 1031 7TH ST NE DEVILS LAKE, ND 58301 45-0227012 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (9) MERCY HOSPITAL OF DEVILS LAKE FOUNDATION 1031 7TH ST NE DEVILS LAKE, ND 58301 35-2367360 | FUNDRAISING | ND | 501(c)(3 | 7 | MHDL | Yes | |
| (10) MERCY HOSPITAL OF VALLEY CITY 570 CHAUTAUQUA BLVD VALLEY CITY, ND 58072 45-0226553 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (11) MERCY MEDICAL CENTER 1301 15TH AVE WEST WILLISTON, ND 58801 45-0231183 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (12) MERCY MEDICAL CENTER - CENTERVILLE ONE ST JOSEPHS DRIVE CENTERVILLE, IA 52544 42-0680308 | HEALTHCARE | IA | 501(c)(3 | 3 | CHI-IA CORP | Yes | |
| (13) MERCY MEDICAL CENTER INC 2700 STEWART PKWY ROSEBURG, OR 97471 93-0386868 | HEALTHCARE | OR | 501(c)(3 | 3 | CHI | Yes | |
| (14) MERCY MEDICAL FOUNDATION 1301 15TH AVE WEST WILLISTON, ND 58801 45-0381803 | FUNDRAISING | ND | 501(c)(3 | Type I | MMC | Yes | |
| (15) MERCY PROFESSIONAL PRACTICE ASSOCIATES INC 1111 6TH AVE DES MOINES, IA 50314 42-1470935 | PHYSICIANS | IA | 501(c)(3 | 9 | CHI-IA CORP | Yes | |
| (16) NEBRASKA HEART HOSPITAL 7500 S 91ST ST LINCOLN, NE 68526 39-2031968 | HEALTHCARE | NE | 501(c)(3 | 3 | CHI NEBRASKA | Yes | |
| (17) NORTH CENTRAL HEALTH CARE ALLIANCE DBA PRIMECARE HEALTH GROUP 401 N 9th St BISMARCK, ND 585014507 45-0439894 | HEALTHCARE | ND | 501(c)(3 | 9 | NHCA | Yes | |
| (18) OAKES COMMUNITY HOSPITAL 1200 N 7TH ST OAKES, ND 58474 45-0231675 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (19) OAKES COMMUNITY HOSPITAL FOUNDATION 1200 N 7TH ST OAKES, ND 58474 71-0966606 | FUNDRAISING | ND | 501(c)(3 | Type I | OCH | Yes | |

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|----------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (101) PINEYWOODS MEDICAL DEVELOPMENT CORP PO BOX 1447 LUFKIN, TX 75902 75-2493116 | PROPERTY MGMT | TX | 501(c)(3 | Type III-FI | MHSET | Yes | |
| (1) PROVIDENCE CARE CENTER 2025 HAYES AVENUE SANDUSKY, OH 44870 34-1658625 | HEALTHCARE | OH | 501(c)(3 | 9 | FLC | Yes | |
| (2) PROVIDENCE CARE CENTERS 2025 HAYES AVENUE SANDUSKY, OH 44870 34-1826099 | HOLDING CO | OH | 501(c)(3 | Type II | FLC | Yes | |
| (3) PROVIDENCE RESIDENTIAL COMMUNITY CORPORATION 5055 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1896807 | LIVING COMM | OH | 501(c)(3 | 9 | FLC | Yes | |
| (4) PUEBLO STEPUP 1925 E ORMAN AVE STE G52 PUEBLO, CO 81004 84-1234295 | COMMUNITY | CO | 501(c)(3 | 7 | CHIC | Yes | |
| (5) REGIONAL HOSPITAL FOR RESPIRATORY AND COMPLEX CARE 12844 MILITARY RD S TUKWILA, WA 98168 91-1170040 | HEALTHCARE | WA | 501(c)(3 | 3 | FHS | Yes | |
| (6) SET OF COLORADO SPRINGS INC 2864 S CIRCLE DR STE 450 COLORADO SPRINGS, CO 80906 84-1183335 | LTERM CARE | CO | 501(c)(3 | 7 | CHIC | Yes | |
| (7) SAINT CLARE'S COMMUNITY CARE INC 25 POCONO RD DENVER, NJ 07834 22-2876836 | HEALTHCARE | NJ | 501(c)(3 | Type II | SCHS | Yes | |
| (8) SAINT CLARE'S FOUNDATION INC 25 POCONO RD DENVER, NJ 07834 22-2502997 | FUNDRAISING | NJ | 501(c)(3 | 7 | SCHS | Yes | |
| (9) SAINT CLARE'S HEALTH SERVICES INC 25 POCONO RD DENVER, NJ 07834 22-3639733 | MANAGEMENT | NJ | 501(c)(3 | Type II | CHI | Yes | |
| (10) SAINT CLARE'S HOSPITAL INC 25 POCONO RD DENVER, NJ 07834 22-3319886 | HEALTHCARE | NJ | 501(c)(3 | 3 | SCHS | Yes | |
| (11) SAINT ELIZABETH FOUNDATION 555 S 70TH ST LINCOLN, NE 68510 47-0625523 | FUNDRAISING | NE | 501(c)(3 | 7 | SERMC | Yes | |
| (12) SAINT ELIZABETH HEALTH SERVICES 555 S 70TH ST LINCOLN, NE 68510 36-3233120 | HEALTHCARE | NE | 501(c)(3 | 3 | SERMC | Yes | |
| (13) SAINT ELIZABETH REGIONAL MEDICAL CENTER 555 S 70TH ST LINCOLN, NE 68510 47-0379836 | HEALTHCARE | NE | 501(c)(3 | 3 | CHI NEBRASKA | Yes | |
| (14) SAINT FRANCIS MEDICAL CENTER 2620 W FAIDLEY GRAND ISLAND, NE 68803 47-0376601 | HEALTHCARE | NE | 501(c)(3 | 3 | CHI NEBRASKA | Yes | |
| (15) SAINT FRANCIS MEDICAL CENTER FOUNDATION PO BOX 9804 GRAND ISLAND, NE 68802 47-0630267 | FUNDRAISING | NE | 501(c)(3 | 7 | SFMC | Yes | |
| (16) SAINT JOSEPH BEREА HOSPITAL FOUNDATION INC 305 ESTILL ST BEREA, KY 40403 26-0152877 | FUNDRAISING | KY | 501(c)(3 | 7 | SJHS | Yes | |
| (17) SAINT JOSEPH HEALTH SYSTEM INC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 61-1334601 | HEALTHCARE | KY | 501(c)(3 | 3 | KOH | Yes | |
| (18) SAINT JOSEPH HOSPITAL FOUNDATION INC ONE SAINT JOSEPH DRIVE LEXINGTON, KY 40504 61-1159649 | FUNDRAISING | KY | 501(c)(3 | Type I | SJHS | Yes | |
| (19) SAINT JOSEPH LONDON FOUNDATION INC 1001 SAINT JOSEPH LANE LONDON, KY 40741 26-0438748 | FUNDRAISING | KY | 501(c)(3 | 7 | SJHS | Yes | |

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|-----------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (121) SAINT JOSEPH MOUNT STERLING FOUNDATION INC 225 FALCON DR MOUNT STERLING, KY 40353 27-2884584 | FUNDRAISING | KY | 501(c)(3 | 7 | SJHS | Yes | |
| (1) SAINT JOSEPH'S HOSPITAL FOUNDATION 30 WEST 7TH ST DICKINSON, ND 58601 36-3418207 | FUNDRAISING | ND | 501(c)(3 | Type I | SJHHC | Yes | |
| (2) SAMARITAN BEHAVIORAL HEALTH INC 601 S EDWIN C MOSES BLVD DAYTON, OH 45417 02-0633634 | HEALTHCARE | OH | 501(c)(3 | 7 | SHP | Yes | |
| (3) SAMARITAN HEALTH PARTNERS 110 N MAIN ST STE 500 DAYTON, OH 45402 31-1107411 | HEALTHCARE | OH | 501(c)(3 | Type I | CHI | Yes | |
| (4) SCHUYLER MEMORIAL HOSPITAL FOUNDATION INC 104 W 17TH ST SCHUYLER, NE 68661 36-3630014 | FUNDRAISING | NE | 501(c)(3 | Type I | AHMHS | Yes | |
| (5) SJRMC JOPLIN MISSOURI 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 44-0545809 | HEALTHCARE | MO | 501(c)(3 | 3 | CHI | Yes | |
| (6) SL AUGUSTA CORP PO BOX 20269 HOUSTON, TX 77225 76-0226623 | TITLE HOLDING | TX | 501(c)(2 | | SLPC | Yes | |
| (7) ST ALEXIUS MEDICAL CENTER 900 EAST BROADWAY AVENUE BISMARCK, ND 58501 45-0226711 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (8) ST ANTHONY HOSPITAL 1601 SE COURT AVE PENDLETON, OR 97801 93-0391614 | HEALTHCARE | OR | 501(c)(3 | 3 | CHI | Yes | |
| (9) ST ANTHONY HOSPITAL FOUNDATION 1601 SE COURT AVE PENDLETON, OR 97801 93-0992727 | FUNDRAISING | OR | 501(c)(3 | Type I | SAH | Yes | |
| (10) ST ANTHONY'S HOSPITAL ASSOCIATION FOUR HOSPITAL DR MORRILTON, AR 72110 71-0245507 | HEALTHCARE | AR | 501(c)(3 | 3 | SVIMC | Yes | |
| (11) ST CATHERINE HOSPITAL 401 EAST SPRUCE ST GARDEN CITY, KS 67846 48-0543721 | HEALTHCARE | KS | 501(c)(3 | 3 | CHI | Yes | |
| (12) ST CATHERINE HOSPITAL DEVELOPMENT FOUNDATION 401 EAST SPRUCE ST GARDEN CITY, KS 67846 20-0598702 | FUNDRAISING | KS | 501(c)(3 | Type I | SCH | Yes | |
| (13) ST CLARE COMMONS 5942 RENAISSANCE PLACE STE A TOLEDO, OH 43623 27-0163752 | LIVING COMM | OH | 501(c)(3 | 9 | FLC | Yes | |
| (14) ST DOMINIC OF ONTARIO OREGON 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 93-0433692 | HEALTHCARE | OR | 501(c)(4 | | CHI | Yes | |
| (15) ST FRANCIS HOME 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0729978 | LTERM CARE | MN | 501(c)(3 | 9 | CHI | Yes | |
| (16) ST FRANCIS LIFE CARE CORPORATION 19 POCONO RD DENVER, NJ 07834 22-2536017 | ELDERLY CARE | NJ | 501(c)(3 | 9 | SCHS | Yes | |
| (17) ST FRANCIS MEDICAL CENTER 2400 ST FRANCIS DR BRECKENRIDGE, MN 56520 41-0695598 | HEALTHCARE | MN | 501(c)(3 | 3 | CHI | Yes | |
| (18) ST FRANCIS OF BAKER CITY 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 93-0412495 | HEALTHCARE | OR | 501(c)(3 | 3 | CHI | Yes | |
| (19) ST JOSEPH FOUNDATION OF BRYAN TEXAS 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2351158 | FUNDRAISING | TX | 501(c)(3 | Type I | SJSC | Yes | |

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|------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|----|
| | | | | | | Yes | No |
| (141) ST JOSEPH HEALTH MINISTRIES 1929 LINCOLN HWY E STE 150 LANCASTER, PA 17602 23-2342997 | HEALTHCARE | PA | 501(c)(3 | Type I | CHI | Yes | |
| (1) ST JOSEPH MANOR 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2847594 | HEALTHCARE | TX | 501(c)(3 | 9 | SJSC | Yes | |
| (2) ST JOSEPH MEDICAL CENTER FOUNDATION 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-2649362 | FUNDRAISING | PA | 501(c)(3 | Type I | SJRHN | Yes | |
| (3) ST JOSEPH MEDICAL CENTER INC 201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-0591461 | HEALTHCARE | MD | 501(c)(3 | 3 | CHI | Yes | |
| (4) ST JOSEPH MEDICAL GROUP 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 20-8544021 | HEALTHCARE | PA | 501(c)(3 | 9 | BHC | Yes | |
| (5) ST JOSEPH PHYSICIAN ASSOCIATES 2801 FRANCISCAN DRIVE BRYAN, TX 77802 20-3159302 | HEALTHCARE | TX | 501(c)(3 | 3 | SJSC | Yes | |
| (6) ST JOSEPH PHYSICIAN ENTERPRISE INC 201 INTERNATIONAL CIRCLE STE 212 HUNT VALLEY, MD 21030 52-1311775 | PHYSICIANS | MD | 501(c)(3 | Type I | SJMC | Yes | |
| (7) ST JOSEPH REGIONAL HEALTH CENTER 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-1282696 | HEALTHCARE | TX | 501(c)(3 | 3 | SJSC | Yes | |
| (8) ST JOSEPH REGIONAL HEALTH NETWORK 2500 BERNVILLE RD PO BOX 316 READING, PA 19603 23-1352211 | HEALTHCARE | PA | 501(c)(3 | 3 | CHI | Yes | |
| (9) ST JOSEPH REGIONAL HEALTH PARTNERS 2801 FRANCISCAN DRIVE BRYAN, TX 77802 45-4088170 | HEALTHCARE | TX | 501(c)(3 | 3 | SJSC | Yes | |
| (10) ST JOSEPH REGIONAL HEALTH PARTNERS ACO 2801 FRANCISCAN DRIVE BRYAN, TX 77802 46-3265423 | HEALTHCARE | TX | 501(c)(3 | 3 | SJSC | Yes | |
| (11) ST JOSEPH SERVICES CORPORATION 2801 FRANCISCAN DRIVE BRYAN, TX 77802 74-2455161 | MANAGEMENT | TX | 501(c)(3 | Type I | SFH | Yes | |
| (12) ST JOSEPH'S AREA HEALTH SERVICES 600 PLEASANT AVE PARK RAPIDS, MN 56470 41-0695603 | HEALTHCARE | MN | 501(c)(3 | 3 | CHI | Yes | |
| (13) ST JOSEPH'S HOSPITAL AND HEALTH CENTER 30 WEST 7TH ST DICKINSON, ND 58601 45-0226429 | HEALTHCARE | ND | 501(c)(3 | 3 | CHI | Yes | |
| (14) ST LEONARD 8100 CLYO ROAD CENTERVILLE, OH 45458 34-1940863 | LIVING COMM | OH | 501(c)(3 | 9 | FLC | Yes | |
| (15) ST LEONARD FOUNDATION 8100 CLYO ROAD CENTERVILLE, OH 45458 32-0102715 | FUNDRAISING | OH | 501(c)(3 | 7 | SLEO | Yes | |
| (16) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-0274448 | MANAGEMENT | TX | 501(c)(3 | Type I | SLHS | Yes | |
| (17) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - PMC 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 27-3733278 | HEALTHCARE | TX | 501(c)(3 | 3 | SLCDC | Yes | |
| (18) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - SUGAR LAND 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-1947374 | HEALTHCARE | TX | 501(c)(3 | 3 | SLHS | Yes | |
| (19) ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION - THE WOODLANDS 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-0335902 | HEALTHCARE | TX | 501(c)(3 | 3 | SLCDC | 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) ST LUKE'S COMMUNITY HEALTH SERVICES 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0536234 | HEALTHCARE | TX | 501(c)(3) | 3 | SLHS | Yes | |
| (1) ST LUKE'S FOUNDATION 1213 HERMANN DRIVE STE 855 HOUSTON, TX 77004 45-3811485 | FUNDRAISING | TX | 501(c)(3) | 7 | SLHS | Yes | |
| (2) ST LUKE'S HEALTH SYSTEM CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0536232 | MANAGEMENT | TX | 501(c)(3) | Type I | CHI | Yes | |
| (3) ST LUKE'S HOSPITAL AT THE VINTAGE 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 26-3734606 | HEALTHCARE | TX | 501(c)(3) | 3 | SLHS | Yes | |
| (4) ST LUKE'S MEDICAL GROUP 6624 FANNIN ST HOUSTON, TX 77030 76-0458535 | PHYSICIANS | TX | 501(c)(3) | 3 | SLHS | Yes | |
| (5) ST LUKE'S MEDICAL TOWER CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0531713 | PROPERTY MGMT | TX | 501(c)(3) | Type I | CHI-SLH | Yes | |
| (6) ST LUKE'S PROPERTIES CORPORATION 6624 FANNIN ST STE 1100 HOUSTON, TX 77030 76-0531716 | PROPERTY MGMT | TX | 501(c)(3) | Type I | SLHS | Yes | |
| (7) ST LUKE'S SUGAR LAND PROPERTIES CORPORATION 6624 FANNIN ST STE 2505 HOUSTON, TX 77030 45-4120549 | PROPERTY MGMT | TX | 501(c)(3) | Type I | SLCDC-SL | Yes | |
| (8) ST MARY'S COMMUNITY HOSPITAL 1314 3RD AVE NEBRASKA CITY, NE 68410 47-0443636 | HEALTHCARE | NE | 501(c)(3) | 3 | CHI NEBRASKA | Yes | |
| (9) ST MARY'S HOSPITAL FOUNDATION 1314 3RD AVE NEBRASKA CITY, NE 68410 47-0707604 | FUNDRAISING | NE | 501(c)(3) | 7 | SMCH | Yes | |
| (10) ST VINCENT FOUNDATION TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 51-0169537 | FUNDRAISING | AR | 501(c)(3) | Type I | SVIMC | Yes | |
| (11) ST VINCENT INFIRMARY MEDICAL CENTER TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0236917 | HEALTHCARE | AR | 501(c)(3) | 3 | CHI | Yes | |
| (12) ST VINCENT MEDICAL GROUP TWO ST VINCENT CIRCLE LITTLE ROCK, AR 72205 71-0830696 | HEALTHCARE | AR | 501(c)(3) | 9 | SVIMC | Yes | |
| (13) SYLVANIA FRANCISCAN HEALTH 1715 INDIAN WOOD CIR 200 MAUMEE, OH 43537 34-1412964 | HEALTHCARE | OH | 501(c)(3) | Type I | CHI | Yes | |
| (14) SYLVANIA FRANCISCAN HEALTH FOUNDATION 1715 INDIAN WOOD CIR 200 MAUMEE, OH 43537 45-5357161 | FUNDRAISING | OH | 501(c)(3) | Type I | FLC | Yes | |
| (15) THE COMMONS OF PROVIDENCE 5000 PROVIDENCE DRIVE SANDUSKY, OH 44870 34-1826097 | ASSIST LIVING | OH | 501(c)(3) | 9 | FLC | Yes | |
| (16) THE GOOD SAMARITAN HOSPITAL OF CINCINNATI OH 619 OAK ST ACCOUNTING-3 W CINCINNATI, OH 45206 31-0537486 | HEALTHCARE | OH | 501(c)(3) | 3 | CHI | Yes | |
| (17) THE PHYSICIAN NETWORK 2000 Q ST STE 500 LINCOLN, NE 68503 47-0780857 | PHYSICIANS | NE | 501(c)(3) | Type I | CHI NEBRASKA | Yes | |
| (18) TOTAL HEALTHCARE 188 INVERNESS DRIVE WEST STE 500 ENGLEWOOD, CO 80112 84-0927232 | HEALTHCARE | CO | 501(c)(3) | 3 | CHIC | Yes | |
| (19) TRINITY HOSPITAL TWIN CITY 819 NORTH FIRST STREET DENNISON, OH 44621 27-5401105 | HEALTHCARE | OH | 501(c)(3) | 3 | SFH | 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) UNITY FAMILY HEALTHCARE 815 SE 2ND ST LITTLE FALLS, MN 56345 41-0721642 | HEALTHCARE | MN | 501(c)(3 | 3 | CHI | Yes | |
| (1) VILLA NAZARETH INC 801 PAGE DR FARGO, ND 58103 45-0226714 | LTERM CARE | ND | 501(c)(3 | 9 | CHI | Yes | |
| (2) VISITING NURSE ASSOCIATION OF ST CLARE'S INC 191 WOODPORT RD SPARTA, NJ 07871 22-1768334 | HOME HEALTH | NJ | 501(c)(3 | 9 | SCHS | Yes | |
| (3) WOODLANDS DOCTOR GROUP 17200 ST LUKES WAY STE 170 THE WOODLANDS, TX 77384 27-4499340 | PHYSICIANS | TX | 501(c)(3 | 9 | SLCHS | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | | (d) Direct Controlling Entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of- year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------|---------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|-----------------------------------------|----|----------------------------------------------------------------------------|----------------------------------------------|----|--------------------------------|
| | | | | | | | | Yes | No | | Yes | No | |
| CATHOLIC HEALTH INITIATIVES PHYSICIAN SERVICES LLC 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 46-2945938 | PRACTICE MGMT SRVC | DE | CHI | | Related | -572,398 | 4,681,573 | | No | 0 | Yes | | 80 % |
| CENTRAL NEBRASKA HOME CARE SERVICES PO BOX 1146 4502 N SECOND AVE KEARNEY, NE 68848 47-0692112 | HEALTHCARE SRVC | NE | na | | Related | -49,959 | 152,789 | | No | -22,980 | Yes | | 100 % |
| CENTRAL NEBRASKA REHABILITATION SERVICES LLC 3004 W FAIDLEY AVENUE GRAND ISLAND, NE 68803 81-0653461 | Physical Therapy | NE | SFMC | | Related | 2,441,607 | 3,412,341 | | No | 0 | | No | 51 % |
| CHI OPERATING INVESTMENT PROGRAM LP 198 INVERNESS DRIVE WEST ENGLEWOOD, CO 80112 47-0727942 | INVESTMENTS | CO | CHI | | Unrelated | 0 | 0 | | No | 0 | Yes | | 100 % |
| CHICAMSURG Surgery Centers LLC 188 INVERNESS DRIVE WEST 500 ENGLEWOOD, CO 80112 46-5683027 | SURGERY CENTER | CO | CHIC | | Related | 0 | 0 | | No | 0 | | No | 51 % |
| CHICLARKIN VENTURES LLC 188 INVERNESS DRIVE WEST 500 ENGLEWOOD, CO 80112 47-4210888 | URGENT CARE | CO | CHIC | | Related | 0 | 0 | | No | 0 | Yes | | 87 % |
| Colorado Springs CK Leasing LLC 8770 W Bryn Mawr Ste 1370 CHICAGO, IL 60631 26-2982714 | REAL ESTATE | CO | CHI | | Related | 120,659 | 1,039,682 | | No | 0 | Yes | | 66 % |
| HC SL VINTAGE I LLC 18000 W SARAH LANE STE 250 BROOKFIELD, WI 53045 27-0453767 | PROPERTY HOLDING | WI | SL HOSP- VINTAGE | | Related | 1,365,254 | 55,596,761 | | No | 0 | | No | 51 % |
| HEALTHCARE SUPPORT SERVICES LLC PO BOX 9804 GRAND ISLAND, NE 68802 72-1546196 | LAUNDRY | NE | na | | Related | 317,516 | 3,231,655 | | No | 98,557 | | No | 100 % |
| Heartland Oncology LLC 2337 E Crawford St Salina, KS 67401 46-4265403 | ONCOLOGY | KS | SCH | | Related | 0 | 0 | | No | 0 | | No | 51 % |
| HIGHLINE IMAGING LLC PO BOX 184 BRUSH PRAIRIE, WA 98606 20-0460005 | DIAGNOSTIC IMAGING | WA | HMC | | Related | 65,074 | 1,408,012 | | No | 0 | | No | 80 % |
| LAKESIDE AMBULATORY SURGICAL CENTER LLC 17031 LAKESIDE HILLS DR OMAHA, NE 68130 20-4267902 | AMBUL SURG CTR | NE | ACH | | Related | 3,533,817 | 1,380,299 | | No | 0 | | No | 53 93 % |
| LAKESIDE ENDOSCOPY CENTER LLC 17001 LAKESIDE HILLS PLZ STE 201 OMAHA, NE 68130 20-5544496 | ENDOSCOPY SRVC | NE | ACH | | Related | 1,590,148 | 895,940 | | No | 0 | | No | 50 96 % |
| LINCOLN CK LEASING LLC 6003 Old Cheney Rd Lincoln, NE 68516 26-2496856 | Real Estate | NE | SERMC | | Related | 488,450 | 230,998 | | No | 0 | | No | 53 76 % |
| NEBRASKA SPINE HOSPITAL LLC 6901 N 72ND ST OMAHA, NE 68122 27-0263191 | SPINE HOSPITAL | NE | ACH | | Related | 13,895,341 | 16,839,322 | | No | 0 | | No | 51 % |

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) Dispropportionate 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 | |
| NORTH RIVER SURGERY CENTER LLC 2209 WILDWOOD AVE SHERWOOD, AR 72120 71-0799771 | AMBUL SURG CTR | AR | SVIMC | Related | 141,898 | 0 | | No | 0 | | No | 57.45 % |
| ORTHOCOLORADO LLC 11650 WEST 2ND PLACE LAKEWOOD, CO 80255 37-1577105 | ORTHO HOSPITAL | CO | THC | Related | 9,103,000 | 2,202,895 | | No | 0 | | No | 60 % |
| PENINSULA RADIATION ONCOLOGY LLC 314 MLK JR WAY STE 11 TACOMA, WA 98405 87-0808610 | HEALTHCARE SRVC | WA | FHS | Related | 278,198 | 2,753,330 | | No | 0 | | No | 60 % |
| Penrad Imaging 1390 Kelly Johnson Blvd COLORADO SPRINGS, CO 80920 84-1072619 | Medical Imaging | CO | CHIC | Related | -9,742 | 2,091,440 | | No | 0 | | No | 70 % |
| PMC HOSPITAL LLC 3100 MAIN ST STE 500 HOUSTON, TX 77002 27-3280598 | HOSPITAL | TX | SL CDC-PMC | Related | 5,287,747 | 67,411,280 | | No | 0 | Yes | | 51 % |
| PRAIRIE HEALTH VENTURES LLC 421 S 9TH ST STE 102 LINCOLN, NE 68508 20-4962103 | TECH SRVC | NE | AH-IMC | Related | 0 | 0 | | No | 0 | Yes | | 65.75 % |
| Pueblo Ambulatory Surgery Center LLC 188 INVERNESS DRIVE WEST 500 ENGLEWOOD, CO 80112 62-1488737 | SURGERY CENTER | CO | CHIC | Related | 0 | 0 | | No | 0 | | No | 51 % |
| Saint JOSEPH - PAML LLC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 45-2116736 | MGMT SVCS | KY | SJHS | Related | 60,881 | 406,070 | | No | 0 | Yes | | 62.5 % |
| SAINT JOSEPH - SCA HOLDINGS LLC 1451 Harrodsburg RD LEXINGTON, KY 40503 45-3801157 | OP SURGERY | DE | SJHS | Related | 0 | 0 | | No | 0 | Yes | | 51 % |
| SAINT JOSEPH-ANC HOME CARE SERVICES 1700 EDISON DR MILFORD, OH 45150 26-3330545 | HOME HEALTH | KY | JHSMH | Related | 7,722,504 | 1,056,144 | | No | 0 | | No | 100 % |
| SCA Premier Surgery Center of Louisville LLC 200 Abraham Flexner Way LOUISVILLE, KY 40202 72-1386840 | SURGERY CENTER | KY | JHSMH | Related | -177,796 | 2,205,015 | | No | 0 | | No | 51 % |
| ST FRANCIS LAND COMPANY 5390 N ACADEMY BLVD STE 300 COLORADO SPRINGS, CO 80918 26-3134100 | REAL ESTATE | CO | CHIC | Related | -217,802 | 12,693,252 | | No | 0 | | No | 51 % |
| ST FRANCIS MEDICAL CENTER ASSOCIATES 1717 SOUTH J ST TACOMA, WA 98405 91-1352698 | MED OFFICE | WA | FHS | Related | 265,783 | 1,961,020 | | No | 0 | | No | 61.08 % |
| ST LUKE'S DIAGNOSTIC CATH LAB LLP 6624 FANNIN ST STE 800 HOUSTON, TX 77030 71-0959365 | DIAGNOSTICS | TX | SLHS HOLDINGS | Related | 611,532 | 1,117,217 | | No | 0 | | No | 61.45 % |
| ST LUKE'S LAKESIDE HOSPITAL LLC 6624 FANNIN STE 2505 HOUSTON, TX 77030 30-0427437 | HOSPITAL | TX | SL CDC-W | Related | 277,867 | 42,485,184 | | No | 0 | Yes | | 51 % |

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) Disproprrtionate 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 | |
| ST LUKE'S THE WOODLANDS SLEEP CENTER LLC 6624 FANNIN STE 800 HOUSTON, TX 77030 46-2795726 | DIAGNOSTICS | TX | SLHSH | Related | -76,879 | 1,171,971 | | No | 0 | Yes | | 51 % |
| Superior Medical Imaging LLC 5000 North 26th ST LINCOLN, NE 68521 26-2884555 | OP Diagnostics | NE | SERMC | Related | 0 | 0 | | No | 0 | Yes | | 51 % |
| SURGERY CENTER OF LEXINGTON LLC 200 ABRAHAM FLEXNER WAY LOUISVILLE, KY 40202 62-1179539 | SURGERY CENTER | KY | SJHS | Related | 187,315 | 2,777,419 | | No | 0 | Yes | | 51 % |
| SURGERY CENTER OF LOUISVILLE LLC 200 Abraham Flexner Way LOUISVILLE, KY 40202 62-1179537 | SURGERY CENTER | KY | JHSMH | Related | 11,207 | 803,899 | | No | 0 | Yes | | 51 % |
| ALEGENT HEALTH NORTHWEST IMAGING CENTER LLC 3606 N 156TH ST OMAHA, NE 68116 06-1786985 | OP DIAGNOSTICS | NE | ACH | Related | -147,872 | 429,431 | | No | | Yes | | 51 % |
| AUDUBON AMBULATORY SURGERY CENTER LLC 3030 NORTH CIRCLE DR COLORADO SPRINGS, CO 80909 84-1482638 | AMBUL SURG CTR | CO | CHIC | Related | 3,069,333 | 3,517,273 | | No | | Yes | | 56 1 % |
| AUDUBON LAND COMPANY LLC 5390 N ACADEMY BLVD STE 300 COLORADO SPRINGS, CO 80918 84-1513085 | REAL ESTATE | CO | CHIC | Related | 116,620 | 10,842,022 | | No | | | No | 69 4 % |
| AVANTAS LLC 11128 JOHN GALT BLVD STE 400 OMAHA, NE 68137 39-2045003 | STAFFING OF NURSES | NE | AHBMHS | Related | 270,464 | 4,883,491 | | No | -449,169 | | No | 95 % |
| BERGAN MERCY SURGERY CENTER LLC 7710 MERCY RD STE 200 OMAHA, NE 68124 20-8671994 | AMBUL SURG STR | NE | ACH | Related | 262,283 | 2,676,707 | | No | | | No | 63 57 % |
| BERYWOOD OFFICE PROPERTIES LLC 400 BERYWOOD TRAIL CLEVELAND, TN 37312 62-1875199 | PHYS OFFICE | TN | MHCS | Related | 77,646 | 976,529 | | No | | Yes | | 63 % |
| BLUEGRASS REGIONAL IMAGING CENTER 1218 SOUTH BROADWAY STE 310 LEXINGTON, KY 40504 61-1386736 | DIAGNOSTIC IMAGING | KY | SJHS | Related | 216,144 | 3,219,211 | | No | | | No | 65 % |

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 | | | | | | | | |
| Alegent HealthCreighton St Joseph Managed Care Services Inc 12809 West Dodge Rd Omaha, NE 68154 47-0802396 | Managed Care | NE | CHI Nebraska | C Corporation | -3,506,547 | 6,404,877 | 100 % | Yes | |
| All Saints Insurance Company SPC Ltd PO BOX 10073 APO Georgetown, GRAND CAYMAN KY11001 CJ | Insurance | CJ | CHI | C Corporation | 0 | 0 | 100 % | Yes | |
| ALLIANCE HEALTH PROVIDERS OF BRAZOS 2801 FRACNISCAN DRIVE BRYAN, TX 77802 74-2466914 | Healthcare | TX | SJSC | C Corporation | 204,115 | 535,165 | 100 % | Yes | |
| Alternative Insurance Management Service Inc 3900 OLYMPIC BLVD STE 400 Erlanger, KY 41018 84-1112049 | Management Services | CO | CHI | C Corporation | 7,902 | 6,274,993 | 100 % | Yes | |
| AMERICAN NURSING CARE Inc 1700 EDISON DR MILFORD, OH 45150 31-1085414 | HOME HEALTH | OH | CHS | C Corporation | 0 | 0 | 100 % | Yes | |
| AMERIMED INC 1700 EDISON DR MILFORD, OH 45150 31-1158699 | HOME HEALTH | OH | ANC | C Corporation | 0 | 0 | 100 % | Yes | |
| BC HOLDING COMPANY INC 1850 BLUEGRASS AVE LOUISVILLE, KY 40215 31-1542851 | Fitness Club | KY | JHSMH | C Corporation | 0 | 0 | 100 % | Yes | |
| Caduceus Medical Associates INC 5600 Brainerd Road Ste 500 Chattanooga, TN 37411 62-1570736 | Healthcare | TN | MHCS | C Corporation | 0 | 1,008 | 100 % | Yes | |
| Captive Management Initiatives Ltd PO BOX 10073 APO Georgetown, GRAND CAYMAN KY11001 CJ 98-0663022 | Captive Management | CJ | CHI | C Corporation | 38,500 | 164,455 | 100 % | Yes | |
| Carmona-DeSoto Building Horizontal Property Regime Inc 300 Werner St Hot Springs, AR 71913 71-0771076 | Healthcare | AR | CHI-SVHS | C Corporation | 0 | 0 | 100 % | Yes | |
| Catholic Health Initiatives Center for Translational Research 198 INVERNESS DRIVE WEST Englewood, CO 80112 27-2269511 | Research | CO | CIRI | Trust | 207 | 1,241,259 | 100 % | Yes | |
| CGH REALTY COMPANY INC 2500 Bernville Rd Reading, PA 19603 23-2326801 | Real Estate | PA | SJHM | C Corporation | 9,432 | 57,096 | 100 % | Yes | |
| CHI St Luke's Health Baylor College of Medicine Medical Center Condominium Assoc 6624 Fannin STE 1100 Houston, TX 77030 46-5079545 | Condo Assoc | TX | CHI-SLHBCM | C Corporation | 0 | 0 | 100 % | Yes | |
| ClearRiver Health 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-4495960 | Insurance | TN | PHPSI | C Corporation | 36,560 | 6,936,559 | 100 % | Yes | |
| Comcare Services Inc 5570 DTC Parkway Englewood, CO 80111 84-0904813 | Inactive | CO | CHIC | C Corporation | 0 | 0 | 100 % | 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 | | | | | | | | |
| CONSOLIDATED HEALTH SERVICES 1700 EDISON DR MILFORD, OH 45150 31-1378212 | HOME HEALTH | OH | CHI | C Corporation | 0 | 0 | 100 % | Yes | |
| Des Moines Medical Center Inc 1111 6TH AVE Des Moines, IA 50314 42-0837382 | Real Estate | IA | CHI-IA Corp | C Corporation | 66,600 | 1,084,162 | 92 98 % | Yes | |
| East Texas Clinical Services Inc 2801 Via Fortuna 500 Austin, TX 78746 45-4736213 | Healthcare | TX | MHSET | C Corporation | 0 | 16,782 | 100 % | Yes | |
| First Initiatives Insurance LTD PO BOX 10073 APO Georgetown, GRAND CAYMAN KY11001 CJ 98-0203038 | Insurance | CJ | CHI | C Corporation | 0 | 0 | 100 % | Yes | |
| Franciscan Services Inc 198 INVERNESS DRIVE WEST Englewood, CO 80112 23-2487967 | Healthcare | CO | CHI | C Corporation | 0 | 11,732,007 | 100 % | Yes | |
| Good Samaritan Outreach Services PO Box 1990 Kearney, NE 68848 47-0659440 | Medical Clinic | NE | CHI Nebraska | C Corporation | 0 | 0 | 100 % | Yes | |
| Health Systems Enterprises Inc 1700 EDISON DR MILFORD, OH 45150 47-0664558 | MGMT | NE | GSH | C Corporation | 117,378 | 1,101,845 | 100 % | Yes | |
| Healthcare MGMT Services Organization INC 1149 MARKET ST Tacoma, WA 98402 91-1865474 | Health Org | WA | FHS | C Corporation | 0 | 0 | 100 % | Yes | |
| HeartlandPlains Health 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-4368223 | Insurance | NE | PHPSI | C Corporation | 16,717 | 3,317,219 | 100 % | Yes | |
| Highline Medical Group 15811 AMBUAN Blvd SW STE A Burien, WA 98166 91-1407026 | Medical Services | WA | HMC | C Corporation | 4,004,636 | 7,896,793 | 100 % | Yes | |
| Medquest 1301 15TH AVENUE WEST Williston, ND 58801 45-0392137 | Sale of DME | ND | MMC Williston | C Corporation | 680,617 | 2,138,655 | 100 % | Yes | |
| Mercy Park Apartments LTD 1111 6th AVE Des Moines, IA 50314 42-1202422 | Housing | IA | CHI-IA Corp | C Corporation | 1,871,589 | 2,272,598 | 100 % | Yes | |
| Mercy Services Corp 2700 STEWART PARKWAY Roseburg, OR 97471 93-0824308 | Retail Sales | OR | MMC | C Corporation | 2,365,469 | 1,363,682 | 100 % | Yes | |
| MHI Clinical Services 1201 W Frank Ave Lufkin, TX 75904 46-1967952 | Healthcare | TX | MHSET | C Corporation | 0 | 0 | 100 % | Yes | |
| Mountain Management Services Inc 6028 Shallowford Rd Chattanooga, TN 37421 62-1570739 | MGMT SVC ORG | TN | MHCS | C Corporation | 30,454,753 | 7,395,265 | 100 % | Yes | |

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

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|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------|----------------------------------|-----------------------------------------------------|------------------------------|------------------------------------|-----------------------------|----------------------------------------------|--|
| Yes | No | | | | | | | | |
| Nazareth Assurance Company PO BOX 10073 APO Georgetown, GRAND CAYMAN KY11001 CJ 03-0304831 | Insurance | CJ | CHI | C Corporation | 0 | 0 | 100 % | Yes | |
| PATIENT TRANSPORT SERVICES INC 1700 EDISON DR MILFORD, OH 45150 31-1100798 | HOME HEALTH | OH | ANC | C Corporation | 0 | 0 | 100 % | Yes | |
| PhysicianHealth System Network 1149 MARKET ST Tacoma, WA 98402 91-1746721 | Health Org | WA | FHS | C Corporation | 0 | 0 | 100 % | Yes | |
| Prominence Health Plan Services Inc (fka CollabHealth Plan Services Inc) 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-1224037 | Admin Services | CO | PHI | C Corporation | 5,403,442 | 38,272,607 | 100 % | Yes | |
| Prominence Health Inc (fka CollabHealth Managed Solutions Inc) 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-1222808 | Holding Co | CO | CHI | C Corporation | 0 | 23,806,707 | 100 % | Yes | |
| QCA Health Plan Inc 12615 Chenal Parkway STE 300 Little Rock, AR 72211 71-0794605 | Insurance | AR | QCHI | C Corporation | 0 | 64,017,278 | 100 % | Yes | |
| QualChoice Holdings Inc 12615 Chenal Parkway STE 300 Little Rock, AR 72211 27-4075520 | Holding Co | AR | PHPS | C Corporation | 0 | 10,190 | 100 % | Yes | |
| QualChoice Life and Health Insurance Company Inc 12615 Chenal Parkway STE 300 Little Rock, AR 72211 71-0386640 | Insurance | AR | QCH | C Corporation | 0 | 7,484,480 | 100 % | Yes | |
| RiverLink Health 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-4380824 | Insurance | OH | PHPS | C Corporation | 18,330 | 3,418,330 | 100 % | Yes | |
| RiverLink Health of Kentucky Inc 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-4828332 | Insurance | KY | PHPS | C Corporation | 28,342 | 5,528,676 | 100 % | Yes | |
| Saint Clare's Primary Care Inc 66 FORD RD Denville, NJ 07834 22-2441202 | Billing Services | NJ | SCCC | C Corporation | 1,080,457 | 1,584,958 | 100 % | Yes | |
| SAMARITAN FAMILY CARE INC 40 W FOURTH ST STE 1700 Dayton, OH 45402 31-1299450 | Healthcare | OH | SHP | C Corporation | 0 | 0 | 100 % | Yes | |
| SFH ASSURANCE LTD PO BOX 10073 APO Georgetown, GRAND CAYMAN KY11001 CJ 98-1056892 | Insurance | CJ | SFH | C Corporation | 0 | 0 | 100 % | Yes | |
| SJH Services Corporation 198 INVERNESS DRIVE WEST Englewood, CO 80112 23-2307408 | Healthcare | CO | FSI | C Corporation | 0 | 0 | 100 % | Yes | |
| SJL PHYSICIAN MANAGEMENT SERVICES INC 200 Abraham Flexner Way Louisville, KY 40202 27-0164198 | Mgmt | KY | SJHS | C Corporation | 51,739 | 0 | 100 % | 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 | SLHS | C Corporation | 3,907,811 | 14,848,162 | 100 % | Yes | |
| SoundPath Health Inc 32129 Weyerhaeuser Way S STE 201 Federal Way, WA 98001 42-1720801 | Insurance | WA | PHPS | C Corporation | 152,264,069 | 31,407,675 | 100 % | Yes | |
| St Alexius Health Services Inc 900 East Broadway Avenue Bismarck, ND 58501 45-0402812 | Healthcare | ND | SAMC | C Corporation | 0 | 1,263 | 100 % | Yes | |
| St Anthony Development Company 1415 Southgate Pendleton, OR 97801 93-1216943 | Athletic Club | OR | SAH | C Corporation | 1,570,570 | 2,201,473 | 100 % | Yes | |
| St Joseph Development Company Inc 1717 SOUTH J ST Tacoma, WA 98405 91-1480569 | Rental | WA | FSI | C Corporation | 0 | 0 | 100 % | Yes | |
| ST JOSEPH OFFICE PARK ASSOCIATION 1451 HARRODSBURG RD STE D202 Lexington, KY 40504 61-1079899 | Mgmt | KY | SJHS | C Corporation | 0 | 0 | 85 % | Yes | |
| St Luke's 6620 Main Condominium Association 6624 Fannin STE 1100 Houston, TX 77030 30-0355517 | Condo Assoc | TX | SLPC | C Corporation | 0 | 0 | 100 % | Yes | |
| St Luke's Anesthesiology Associates 6624 Fannin STE 1100 Houston, TX 77030 46-1517163 | Medical Clinic | TX | CHI-SLH | C Corporation | 4,178,843 | 2,295,469 | 100 % | Yes | |
| St Luke's Episcopal Hospital Physician Hospital Organization Inc 6720 Bertner MC4-262 Houston, TX 77030 76-0377932 | PHO | TX | CHI-SLH | C Corporation | 550,615 | 0 | 60 % | Yes | |
| St Luke's Health System Holdings Inc (fka SLEHS Holdings Inc) 6624 Fannin STE 800 Houston, TX 77030 76-0637138 | Holding Co | TX | SLHS | C Corporation | 1,919,866 | 25,724,802 | 100 % | Yes | |
| St Luke's Medical Arts Center I Condominium Association 6624 Fannin STE 1100 Houston, TX 77030 30-0355518 | Condo Assoc | TX | SLPC | C Corporation | 0 | 0 | 100 % | Yes | |
| St Luke's Medical Tower Condominium Association 6624 Fannin STE 1100 Houston, TX 77030 76-0298751 | Condo Assoc | TX | SLMTC | C Corporation | 0 | 0 | 100 % | Yes | |
| St Vincent Community Health Services Inc TWO ST VINCENT CIRCLE Little Rock, AR 72205 71-0710785 | Healthcare | AR | SVIMC | C Corporation | 4,570,363 | 16,185,431 | 100 % | Yes | |
| StableView Health Inc 198 INVERNESS DRIVE WEST Englewood, CO 80112 46-4373713 | Insurance | KY | PHPS | C Corporation | 28,342 | 5,528,676 | 100 % | Yes | |
| Sugar Land Doctor Group 1317 Lake Point Parkway Sugar Land, TX 77478 45-4270163 | Medical Clinic | TX | SLCDC-SL | C Corporation | 788,883 | 991,134 | 100 % | 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 | | | | | | | |
| The Texas Heart Institute at St Luke's Episcopal Hospital Denton A Cooley Building Condominium Association 6624 Fannin STE 1100 Houston, TX 77030 90-0064009 | Condo Assoc | TX | CHI-SLH | C Corporation | 0 | 0 | 100 % | Yes |
| Towson Management Inc 7601 OSLER DR Towson, MD 21204 52-1710750 | Mgmt Services | MD | FSI | C Corporation | 0 | 0 | 100 % | Yes |