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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

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

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

Department of the Treasury
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 07-01-2016 , and ending 06-30-2017

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final

☐ Return/terminated

☐ Amended return

☐ Application pending

C Name of organization

ST JUDE HOSPITAL INC

% BARBARA LAUPER

Doing business as

ST JUDE MEDICAL CENTER

Number and street (or P O box if mail is not delivered to street address)

101 EAST VALENCIA MESA DRIVE

Room/suite

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

FULLERTON, CA 92385

F Name and address of principal officer

Brian Helleland

101 EAST VALENCIA MESA DRIVE

FULLERTON, CA 92385

H(a) Is this a group return for subordinates?

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number

0928

D Employer identification number

95-1643325

E Telephone number

(714) 446-7200

G Gross receipts \$

558,844,767

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) () (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: WWW.STJUDEMEDICALCENTER.ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other

L Year of formation

1942

M State of legal domicile

CA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

SEE SCHEDULE O

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

3 Number of voting members of the governing body (Part VI, line 1a)

14

4 Number of independent voting members of the governing body (Part VI, line 1b)

13

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

2,769

6 Total number of volunteers (estimate if necessary)

693

7a Total unrelated business revenue from Part VIII, column (C), line 12

0

7b Net unrelated business taxable income from Form 990-T, line 34

0

Revenue

8 Contributions and grants (Part VIII, line 1h)

10,839,222

Prior Year

Current Year

9 Program service revenue (Part VIII, line 2g)

499,616,892

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

15,054,114

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

-51,725

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

525,458,503

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

5,703,119

14 Benefits paid to or for members (Part IX, column (A), line 4)

0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

213,961,404

16a Professional fundraising fees (Part IX, column (A), line 11e)

53,238

b Total fundraising expenses (Part IX, column (D), line 25) ▶1,337,555

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

277,692,176

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

497,409,937

19 Revenue less expenses Subtract line 18 from line 12

28,048,566

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

967,076,877

Beginning of Current Year

End of Year

21 Total liabilities (Part X, line 26)

427,534,503

22 Net assets or fund balances Subtract line 21 from line 20

539,542,374

Part II Signature Block

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

Sign Here

Signature of officer

2018-05-10

Date

BRIAN LEE HELLELAND CHIEF EXECUTIVE

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

KARA ADAMS

Preparer's signature

KARA ADAMS

Date

Check ☐ if self-employed

PTIN

P00023315

Firm's name

▶ ERNST & YOUNG US LLP

Firm's EIN

Firm's address

▶ 18101 VON KARMAN AVE STE 1700

IRVINE, CA 92612

Phone no

(949) 794-2300

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2016)

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission

SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

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

| | | | | |
|---------------------|---------|--------------------------|----------------------------------|---------------------------|
| 4a | (Code) | (Expenses \$ 492,618,758 | including grants of \$ 5,049,379 | (Revenue \$ 538,191,182) |
| See Additional Data | | | | |






















| | | | | |
|-----------|---------|--------------|------------------------|---------------|
| 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 ▶ | 492,618,758 |
|-----------|-----------------------------------------|-------------|

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

| | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----|
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b Yes | |
| 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II | 21 Yes | |
| 22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III | 22 Yes | |
| 23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J | 23 Yes | |
| 24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a | 24a | 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? If "Yes," complete Schedule L, Part I | 25a | No |
| b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I | 25b | No |
| 26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II | 26 | No |
| 27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III | 27 | No |
| 28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV | 28a | No |
| b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV | 28b | No |
| c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV | 28c | No |
| 29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M | 29 Yes | |
| 30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M | 30 Yes | |
| 31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I | 31 | No |
| 32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II | 32 | No |
| 33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I | 33 | No |
| 34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 | 34 Yes | |
| 35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a Yes | |
| b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 | 35b Yes | |
| 36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 | 36 | No |
| 37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI | 37 | No |
| 38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O | 38 Yes | |

Part V

Statements Regarding Other IRS Filings and Tax Compliance

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

☒

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------|
| | | Yes | No |
| 1a | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable | 1a | 0 |
| b | Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable | 1b | 0 |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | Yes |
| 2a | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return | 2a | 2,769 |
| 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 | No |
| b | If "Yes," has it filed a Form 990-T for this year?If "No" to line 3b, provide an explanation in Schedule O | 3b | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | 4a | No |
| b | If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | 5a | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5b | No |
| c | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | 5c | |
| 6a | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | 6a | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | 6b | |
| 7 Organizations that may receive deductible contributions under section 170(c). | | | |
| a | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | 7a | Yes |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | Yes |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year | 7d | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | 7e | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | 7f | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | 7g | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | 7h | |
| 8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | | 8 | |
| 9a | Did the sponsoring organization make any taxable distributions under section 4966? | 9a | |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | 9b | |
| 10 Section 501(c)(7) organizations. Enter | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12 | 10a | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | 10b | |
| 11 Section 501(c)(12) organizations. Enter | | | |
| a | Gross income from members or shareholders | 11a | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) | 11b | |
| 12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | | 12a | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | 12b | |
| 13 Section 501(c)(29) qualified nonprofit health insurance issuers. | | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O | 13a | |
| b | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans | 13b | |
| c | Enter the amount of reserves on hand | 13c | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | No |
| b | If "Yes," has it filed a Form 720 to report these payments?If "No," provide an explanation in Schedule O | 14b | |

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

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

Section A. Governing Body and Management

| | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| 1a | Enter the number of voting members of the governing body at the end of the tax year | 14 | |
| If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 13 | |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | No |
| 6 | Did the organization have members or stockholders? | 6 | Yes |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | Yes |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | |
| a | The governing body? | 8a | Yes |
| b | Each committee with authority to act on behalf of the governing body? | 8b | Yes |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | No |

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

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

Section C. Disclosure

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

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.
 ►BARBARA LAUPER 101 E VALENCIA MESA DRIVE FULLERTON, CA 92385 (714) 446-7200

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

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

Form **990** (2016)

[illegible]

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 ▶ 596

Section B. Independent Contractors

| (A) Name and business address | (B) Description of services | (C) Compensation |
|-------------------------------------------------------------------------------------|--------------------------------|---------------------|
| REPUBLIC BUSINESS CREDIT LLC, PO BOX 203152 DALLAS, TX 75320 | NURSING SERVICES | 1,643,192 |
| PROCARE NURSES LLC, FILE 57074 LOS ANGELES, CA 90074 | NURSING SERVICES | 1,168,865 |
| APPROVED NURSING SOLUTIONS LLC, 211 E IMPERIAL HWY FULLERTON, CA 92835 | NURSING SERVICES | 997,352 |
| CAREERSTAFF UNLIMITED ORANGE COUNTY, PO BOX 301076 DALLAS, TX 75303 | NURSING SERVICES | 923,240 |
| ALLIED ANESTHESIA MEDICAL GROUP INC, 400 N TUSTIN STE 400 SANTA ANA, CA 92705 | MEDICAL SERVICES | 915,761 |

Form 990 (2016)

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☐

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------|----------------------------------------------------|-----------------------------------------|------------------------------------------------------------------|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns . . . | 1a | | | | |
| | b Membership dues . . . | 1b | | | | |
| | c Fundraising events . . . | 1c | 488,171 | | | |
| | d Related organizations | 1d | 3,134,811 | | | |
| | e Government grants (contributions) | 1e | 5,550 | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 6,709,075 | | | |
| | g Noncash contributions included in lines 1a-1f \$ _____ | | 239,904 | | | |
| | h Total. Add lines 1a-1f | | 10,337,607 | | | |
| Program Service Revenue | | Business Code | | | | |
| | 2a NET PATIENT REVENUE | 622110 | 527,560,536 | 527,560,536 | 0 | 0 |
| | b MOB RENTAL REVENUE | 531120 | 4,623,833 | 4,623,833 | 0 | 0 |
| | c CAFETERIA | 722310 | 2,213,155 | 2,213,155 | 0 | 0 |
| | d HOSPITAL FEE | 900099 | 1,370,745 | 1,370,745 | 0 | 0 |
| | e PARKING REVENUE | 900099 | 1,041,084 | 1,041,084 | 0 | 0 |
| | f All other program service revenue | | 1,381,829 | 1,381,829 | 0 | 0 |
| | g Total. Add lines 2a-2f | | 538,191,182 | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | -39,866 | | | -39,866 |
| | 4 Income from investment of tax-exempt bond proceeds | | 0 | | | |
| | 5 Royalties | | 0 | | | |
| | 6a Gross rents | (i) Real (ii) Personal | | | | |
| | b Less rental expenses | | | | | |
| | c Rental income or (loss) | 0 0 | | | | |
| | d Net rental income or (loss) | | 0 | | | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities (ii) Other | | | | |
| | b Less cost or other basis and sales expenses | | | | | |
| | c Gain or (loss) | 9,286,639 | | | | |
| | d Net gain or (loss) | | 9,286,639 | | | 9,286,639 |
| | 8a Gross income from fundraising events (not including \$ 488,171 of contributions reported on line 1c) See Part IV, line 18 | a 200,912 | | | | |
| | b Less direct expenses | b 212,310 | | | | |
| | c Net income or (loss) from fundraising events | | -11,398 | | | -11,398 |
| | 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 | | | |
| | 10a Gross sales of inventory, less returns and allowances | a 0 | | | | |
| | b Less cost of goods sold | b 0 | | | | |
| | c Net income or (loss) from sales of inventory | | 0 | | | |
| Miscellaneous Revenue | Business Code | | | | | |
| 11a | | | | | | |
| b | | | | | | |
| c | | | | | | |
| d All other revenue | | | | | | |
| e Total. Add lines 11a-11d | | 0 | | | | |
| 12 Total revenue. See Instructions | | 557,764,164 | 538,191,182 | 0 | 9,235,375 | |

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. | 5,040,196 | 5,040,196 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22. | 9,183 | 9,183 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16. | 0 | 0 | | |
| 4 Benefits paid to or for members. | 0 | 0 | | |
| 5 Compensation of current officers, directors, trustees, and key employees. | 1,704,740 | 1,255,529 | 449,211 | 0 |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). | 0 | 0 | 0 | 0 |
| 7 Other salaries and wages. | 169,716,973 | 158,647,618 | 10,296,010 | 773,345 |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions). | 10,036,827 | 9,388,711 | 566,905 | 81,211 |
| 9 Other employee benefits. | 46,196,279 | 43,990,616 | 2,054,463 | 151,200 |
| 10 Payroll taxes. | 13,174,648 | 12,323,911 | 744,137 | 106,600 |
| 11 Fees for services (non-employees). | | | | |
| a Management. | 56,430,768 | 44,580,307 | 11,850,461 | |
| b Legal. | 3,893,843 | 0 | 3,893,843 | 0 |
| c Accounting. | 0 | 0 | 0 | 0 |
| d Lobbying. | 41,207 | 41,207 | 0 | 0 |
| e Professional fundraising services. See Part IV, line 17. | 114,736 | | | 114,736 |
| f Investment management fees. | 2,364 | 2,364 | 0 | 0 |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). | 33,347,744 | 26,713,105 | 6,634,639 | 0 |
| 12 Advertising and promotion. | 0 | 0 | 0 | 0 |
| 13 Office expenses. | 5,099,134 | 3,947,807 | 1,149,674 | 1,653 |
| 14 Information technology. | 0 | 0 | 0 | 0 |
| 15 Royalties. | 0 | 0 | 0 | 0 |
| 16 Occupancy. | 8,649,249 | 7,372,942 | 1,169,163 | 107,144 |
| 17 Travel. | 289,739 | 219,198 | 70,541 | 0 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials. | 0 | 0 | 0 | 0 |
| 19 Conferences, conventions, and meetings. | 271,508 | 205,421 | 66,087 | |
| 20 Interest. | 15,421,395 | 13,910,098 | 1,511,297 | 0 |
| 21 Payments to affiliates. | 0 | 0 | 0 | 0 |
| 22 Depreciation, depletion, and amortization. | 35,793,099 | 33,858,606 | 1,932,827 | 1,666 |
| 23 Insurance. | 2,924,112 | 1,836,348 | 1,087,764 | 0 |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a MEDICAL SUPPLIES | 85,817,211 | 85,817,211 | 0 | 0 |
| b HOSPITAL FEE | 18,753,875 | 18,753,875 | 0 | 0 |
| c EQUIPMENT MAINTENANCE | 11,377,903 | 4,714,725 | 6,663,178 | 0 |
| d DEBT EXTINGUISHMENT | 12,789,403 | 12,789,403 | 0 | 0 |
| e All other expenses | 7,200,377 | 7,200,377 | | |
| 25 Total functional expenses. Add lines 1 through 24e. | 544,096,513 | 492,618,758 | 50,140,200 | 1,337,555 |
| 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). | 0 | | | |

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

| | | | | (A) Beginning of year | | (B) End of year |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------------|-------------|--------------------|
| Assets | 1 | Cash—non-interest-bearing | | 8,871 | 1 | 9,900 |
| | 2 | Savings and temporary cash investments | | 3,576,787 | 2 | 3,560,903 |
| | 3 | Pledges and grants receivable, net | | 2,666,006 | 3 | 5,099,943 |
| | 4 | Accounts receivable, net | | 46,544,551 | 4 | 52,665,276 |
| | 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 | 0 |
| | 7 | Notes and loans receivable, net | | 1,561 | 7 | 0 |
| | 8 | Inventories for sale or use | | 5,121,453 | 8 | 6,253,738 |
| | 9 | Prepaid expenses and deferred charges | | 997,613 | 9 | 953,935 |
| | 10a | Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D. | 10a | 1,002,550,166 | | |
| | b | Less: accumulated depreciation | 10b | 383,878,987 | | |
| | | | | 630,253,675 | 10c | 618,671,179 |
| | 11 | Investments—publicly traded securities | | 255,853,668 | 11 | 237,144,139 |
| | 12 | Investments—other securities. See Part IV, line 11 | | 0 | 12 | 0 |
| | 13 | Investments—program-related. See Part IV, line 11 | | 0 | 13 | 0 |
| | 14 | Intangible assets | | 0 | 14 | 0 |
| 15 | Other assets. See Part IV, line 11 | | 22,052,692 | 15 | 21,666,968 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 967,076,877 | 16 | 946,025,981 | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 44,437,825 | 17 | 43,417,332 |
| | 18 | Grants payable | | 0 | 18 | 0 |
| | 19 | Deferred revenue | | 0 | 19 | 0 |
| | 20 | Tax-exempt bond liabilities | | 0 | 20 | 0 |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D. | | 0 | 21 | 0 |
| | 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 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 0 | 23 | 0 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 0 | 24 | 0 |
| | 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. | | 383,096,678 | 25 | 387,918,969 |
| | 26 | Total liabilities. Add lines 17 through 25 | | 427,534,503 | 26 | 431,336,301 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | | |
| | 27 | Unrestricted net assets | | 880,494,070 | 27 | 532,594,753 |
| | 28 | Temporarily restricted net assets | | -340,976,696 | 28 | -17,930,073 |
| | 29 | Permanently restricted net assets | | 25,000 | 29 | 25,000 |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> 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 | | 539,542,374 | 33 | 514,689,680 |
| 34 | Total liabilities and net assets/fund balances | | 967,076,877 | 34 | 946,025,981 | |

Part XI Reconciliation of Net AssetsCheck 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 | 557,764,164 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 544,096,513 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 13,667,651 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 539,542,374 |
| 5 | Net unrealized gains (losses) on investments | 5 | 15,305,707 |
| 6 | Donated services and use of facilities | 6 | 0 |
| 7 | Investment expenses | 7 | 0 |
| 8 | Prior period adjustments | 8 | 0 |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -53,826,052 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 514,689,680 |

Part XII Financial Statements and ReportingCheck 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 | | No |
| b Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | | No |
| c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O | | |
| 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | Yes | |
| b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits | Yes | |

Additional Data

Software ID:

Software Version:

EIN: 95-1643325

Name: ST JUDE HOSPITAL INC

Form 990 (2016)

Form 990, Part III, Line 4a:

SEE SCHEDULE O

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|---------|--------------|------------------------------|--------|-----------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| SISTER JANE DE LISLE CSJ VICE CHAIR | 4 0 0 0 | X | | | | | | 0 | 0 | 0 |
| SISTER JUDITH FERGUS CSJ TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| AMANDA FERRARI TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| SISTER MARIE GAILLAC TRUSTEE (PART YEAR) | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| TIMOTHY GRECO MD TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| BRIAN LEE HELLELAND TRUSTEE/CHIEF EXECUTIVE | 50 0 0 0 | X | | X | | | | 0 | 685,689 | 51,420 |
| JOE LINS TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| SISTER EILEEN MCNERNEY CSJ TRUSTEE | 2 0 2 0 | X | | | | | | 0 | 0 | 0 |
| CHRIS MEYER TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| MARIA MINON MD TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |

| (A) Name and Title | (B) Average hours per week (list any hours spent on the organization) | (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 | (E) Reportable compensation from related organizations |
|-----------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------|
|-----------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------|

| (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 | | | |
| SAMUEL CHUCK NIXON MD TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| LEE PENROSE PRES & CEO (PART YEAR) | 50 0 0 0 | X | | X | | | | 0 | 1,236,215 | 45,944 |
| SISTER MARY ROGERS CSJ TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| CHARLES ROONEY CHAIR | 5 0 0 0 | X | | | | | | 0 | 0 | 0 |
| SISTER MICHELLE TOCHTROP TRUSTEE (PART YEAR) | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| MIKE HERNANDEZ TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| DONALD BITTNER MD TRUSTEE | 2 0 0 0 | X | | | | | | 0 | 0 | 0 |
| PANAGIOTIS BOUGAS MD TRUSTEE/CHIEF OF STAFF (PT YR) | 2 0 0 0 | X | | | | | | 100,438 | 0 | 0 |
| MELINDA BOWLES TRUSTEE (PART YEAR) | 2 0 50 0 | X | | | | | | 0 | 528,536 | 48,488 |
| MARK JABLONSKI VP MISSION INTEGRATION | 50 0 0 0 | | | X | | | | 416,768 | 0 | 40,592 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|---------|--------------|------------------------------|--------|-----------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| SAJEN MATTHEWS MD CHIEF OF STAFF | 50 0 0 0 | | | X | | | | 49,500 | 0 | 0 |
| EDUARDO SALVADOR CHIEF FINANCIAL OFFICER | 50 0 0 0 | | | X | | | | 448,763 | 0 | 38,055 |
| THERESA PANE SECRETARY | 50 0 0 0 | | | X | | | | 131,826 | 0 | 18,694 |
| KAREN CANNIZZARO VP OPERATIONS | 50 0 0 0 | | | | X | | | 349,474 | 0 | 36,425 |
| LAURA RAMOS VP NURSING SERVICES | 50 0 0 0 | | | | X | | | 362,714 | 0 | 32,091 |
| TERESA FREY VP CLINICAL EXCELLENCE | 50 0 0 0 | | | | X | | | 323,075 | 0 | 20,400 |
| KATAYOUN MOSTAFAIE MEDICAL DIRECTOR | 50 0 0 0 | | | | X | | | 288,102 | 0 | 32,829 |
| RIAD ABDELKARIM CHIEF MEDICAL OFFICER (PT YR) | 50 0 0 0 | | | | X | | | 389,247 | 0 | 25,223 |
| GRACE POON REGISTERED NURSE III | 50 0 0 0 | | | | | X | | 323,327 | 0 | 40,536 |
| BARRY ROSS VP HEALTHY COMMUNITIES | 50 0 0 0 | | | | | X | | 344,054 | 0 | 43,860 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|---------|--------------|------------------------------|--------|-----------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| SUSAN SMITH VP PHILANTHROPY | 50 0 0 0 | | | | | X | | 355,675 | 0 | 36,642 |
| DRU ANN COPPING VP MKTG PUBLIC AFFAIRS | 50 0 0 0 | | | | | X | | 290,177 | 0 | 15,121 |
| DON MILLER DIRECTOR OF PHARMACY | 50 0 0 0 | | | | | X | | 235,674 | 0 | 41,710 |
| KEVIN MURPHY FORMER OFFICER | 0 0 52 0 | | | | | | X | 0 | 272,153 | 26,282 |
| MICHAEL MORINO MD VP - MED AFFAIRS (FMR KEY EMP) | 0 0 52 0 | | | | | | X | 0 | 692,796 | 16,087 |

| | | |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| SCHEDULE A (Form 990 or 990-EZ) | 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 |
| | | 2016 Open to Public Inspection |
| Department of the Treasury Internal Revenue Service Name of the organization ST JUDE HOSPITAL INC | Employer identification number 95-1643325 | |

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.
The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10

☐

An organization that normally receives (1) more than 33¹/₃% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33¹/₃% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

Enter the number of supported organizations _____
- g

Provide the following information about the supported organization(s) _____

| (i)Name of supported organization | (ii)EIN | (iii) Type of organization (described on lines 1- 10 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (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, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------|---------|---------|-----------|----------|
| Section A. Public Support | | | | | | |
| <div>Calendar year (or fiscal year beginning in) ▶</div> | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (f)Total |
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public support. Subtract line 5 from line 4 | | | | | | |
| Section B. Total Support | | | | | | |
| <div>Calendar year (or fiscal year beginning in) ▶</div> | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (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 ▶ <input type="checkbox"/> | | | | | | |
| Section C. Computation of Public Support Percentage | | | | | | |
| 14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)) | | | | | 14 | |
| 15 Public support percentage for 2015 Schedule A, Part II, line 14 | | | | | 15 | |
| 16a 33 1/3% support test—2016. 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 ▶ <input type="checkbox"/> | | | | | | |
| b 33 1/3% support test—2015. 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 ▶ <input type="checkbox"/> | | | | | | |
| 17a 10%-facts-and-circumstances test—2016. 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 ▶ <input type="checkbox"/> | | | | | | |
| b 10%-facts-and-circumstances test—2015. 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 ▶ <input type="checkbox"/> | | | | | | |
| 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 ▶ <input type="checkbox"/> | | | | | | |

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (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)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (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 2016 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2015 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--------------------------------------------------------------------------------------------------------------|-----------|--|
| 17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2015 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2016. 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—2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

Section A - Adjusted Net Income

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

Section B - Minimum Asset Amount

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

Section C - Distributable Amount

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

Part V

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

| Section D - Distributions | Current Year |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2016 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-2016 | (iii) Distributable Amount for 2016 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------|-------------------------------------------|
| 1 Distributable amount for 2016 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2016 | | | |
| a | | | |
| b | | | |
| c From 2013. | | | |
| d From 2014. | | | |
| e From 2015. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2016 distributable amount | | | |
| i Carryover from 2011 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2016 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2016 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2017. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b Excess from 2013. | | | |
| c Excess from 2014. | | | |
| d Excess from 2015. | | | |
| e Excess from 2016. | | | |

Part VI **Supplemental Information.**

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

| |
|-------------------------------------|
| Facts And Circumstances Test |
| |

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

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

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

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

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

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

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

| | |
|--------------------------------------------------|----------------------------------------------|
| Name of the organization ST JUDE HOSPITAL INC | Employer identification number 95-1643325 |
|--------------------------------------------------|----------------------------------------------|

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- |
|----------|-------------|---------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| | | | | |
| | | | | |
| 2 | | | | |
| | | | | |
| 3 | | | | |
| | | | | |
| 4 | | | | |
| | | | | |
| 5 | | | | |
| | | | | |
| 6 | | | | |

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

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

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

Limits on Lobbying Expenditures
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing
organization's
totals**(b)** Affiliated
group totals

1a Total lobbying expenditures to influence public opinion (grass roots lobbying)

b Total lobbying expenditures to influence a legislative body (direct lobbying)

c Total lobbying expenditures (add lines 1a and 1b)

d Other exempt purpose expenditures

e Total exempt purpose expenditures (add lines 1c and 1d)

f Lobbying nontaxable amount Enter the amount from the following table in both columns

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

g Grassroots nontaxable amount (enter 25% of line 1f)

h Subtract line 1g from line 1a If zero or less, enter -0-

i Subtract line 1f from line 1c If zero or less, enter -0-

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

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

Lobbying Expenditures During 4-Year Averaging Period

| Calendar year (or fiscal year beginning in) | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) Total |
|---------------------------------------------------------------------|----------|----------|----------|----------|-----------|
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

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

| | | (a) | | (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 | 0 |
| d | Mailings to members, legislators, or the public? | | No | 0 |
| e | Publications, or published or broadcast statements? | | No | 0 |
| f | Grants to other organizations for lobbying purposes? | | No | 0 |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | 0 |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | 0 |
| i | Other activities? | Yes | | 41,207 |
| j | Total. Add lines 1c through 1i | | | 41,207 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

Part IV Supplemental Information

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

| Return Reference | Explanation |
|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE C, PART II-B, LINE 11 | LOBBYING ACTIVITIES DURING THE YEAR, ST JOSEPH HEALTH SYSTEM CONDUCTED ADVOCACY EFFORTS WHICH INCLUDED SOME LOBBYING ACTIVITIES. THESE ACTIVITIES INCLUDED MEETING WITH LOCAL, STATE AND FEDERAL LEGISLATORS, THEIR STAFF AND OTHER GOVERNMENTAL OFFICIALS, AS WELL AS COMMUNICATION TO LEGISLATORS ADVOCATING POSITIONS ON LEGISLATION. THE LOBBYING EXPENDITURES REPORTED REPRESENTS THE PORTION OF DUES ALLOCATED TO ST JUDE MEDICAL CENTER. |

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|----------------------------------------------------------------------------------|
| efile GRAPHIC print - DO NOT PROCESS | | As Filed Data - | | DLN: 93493131050608 | |
| <div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div> | | <div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div> | | | <div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div> |
| Name of the organization ST JUDE HOSPITAL INC | | | | Employer identification number 95-1643325 | |
| Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6. | | | | | |
| | | (a) Donor advised funds | | (b) Funds and other accounts | |
| 1 | Total number at end of year | | | | |
| 2 | Aggregate value of contributions to (during year) | | | | |
| 3 | Aggregate value of grants from (during year) | | | | |
| 4 | Aggregate value at end of year | | | | |
| 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <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" on Form 990, Part IV, line 7. | | | | | |
| 1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space</div> | | | | | |
| 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year | | | | | |
| | | | | Held at the End of the Year | |
| a Total number of conservation easements | | | | 2a | |
| b Total acreage restricted by conservation easements | | | | 2b | |
| c Number of conservation easements on a certified historic structure included in (a) | | | | 2c | |
| d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | | | | 2d | |
| 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ► | | | | | |
| 4 Number of states where property subject to conservation easement is located ► | | | | | |
| 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | | | |
| 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► | | | | | |
| 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$ | | | | | |
| 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | | | | | |
| 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements | | | | | |
| Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8. | | | | | |
| 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items | | | | | |
| b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items | | | | | |
| (i) Revenue included on Form 990, Part VIII, line 1 ► \$ | | | | | |
| (ii) Assets included in Form 990, Part X ► \$ | | | | | |
| 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items | | | | | |
| a Revenue included on Form 990, Part VIII, line 1 ► \$ | | | | | |
| b Assets included in Form 990, Part X ► \$ | | | | | |
| For Paperwork Reduction Act Notice, see the Instructions for Form 990. | | | | | |
| | | Cat No 52283D | | Schedule D (Form 990) 2016 | |

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

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

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" on Form 990, Part IV, line 10.

| | (a)Current year | (b)Prior year | (c)Two years back | (d)Three years back | (e)Four years back |
|------------------------------------------------------------|-----------------|---------------|-------------------|---------------------|--------------------|
| 1a Beginning of year balance | 13,738,954 | 13,555,641 | 12,037,885 | 8,592,051 | 7,843,042 |
| b Contributions | 2,575,890 | 753,721 | 1,189,788 | 2,108,616 | 0 |
| c Net investment earnings, gains, and losses | 2,499,283 | -344,211 | 336,268 | 1,563,415 | 975,206 |
| d Grants or scholarships | | | | | 0 |
| e Other expenditures for facilities and programs | 312,770 | 226,197 | 8,300 | 226,197 | 226,197 |
| f Administrative expenses | | | | | |
| g End of year balance | 18,501,357 | 13,738,954 | 13,555,641 | 12,037,885 | 8,592,051 |

2

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

a

Board designated or quasi-endowment ▶ 99 820 %

b

Permanent endowment ▶ 0 %

c

Temporarily restricted endowment ▶ 0 180 %

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

3a

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

(i)

unrelated organizations

(ii)

related organizations

b

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

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

4

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

Part VI

Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 8,637,168 | | 8,637,168 |
| b Buildings | | 674,819,492 | 180,881,734 | 493,937,758 |
| c Leasehold improvements | | 11,277,434 | 10,261,562 | 1,015,872 |
| d Equipment | | 254,904,187 | 192,735,691 | 62,168,496 |
| e Other | | 52,911,885 | | 52,911,885 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶ | | | | 618,671,179 |

Schedule D (Form 990) 2016

Part VII

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

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

Part VIII

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

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

Part IX

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

| (a) Description | (b) Book value |
|---------------------------------------------------------------------|----------------|
| (1) | |
| (2) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 15.) ▶ | |

Part X

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

| (a) Description of liability | (b) Book value |
|---------------------------------------------------------------------|----------------|
| (1) Federal income taxes | 0 |
| INTERCO WITH HEALTH SYSTEM - BONDS | 349,611,435 |
| IC HOSPITAL FEE HOAG | 10,903,012 |
| DEFERRED INCOME | 2,491,858 |
| PAYABLE TO THIRD PARTY PAYERS | 2,298,575 |
| DEFERRED RENT | 2,177,624 |
| PAYABLE TO CHARITY | 1,921,096 |
| LEASE INCENTIVE OBLIGATION | 898,973 |
| OTHER LIABILITES | 17,616,396 |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25.) ▶ | 387,918,969 |

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

☐

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

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

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

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

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

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

Part XIII Supplemental Information

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

| Return Reference | Explanation |
|---------------------------|-------------|
| See Additional Data Table | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Part XIII Supplemental Information *(continued)*

| Return Reference | Explanation |
|------------------|-------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Additional Data

Software ID:
Software Version:
EIN: 95-1643325
Name: ST JUDE HOSPITAL INC

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

| 1 (a) Description of Liability | (b) Book Value |
|------------------------------------|----------------|
| INTERCO WITH HEALTH SYSTEM - BONDS | 349,611,435 |
| IC HOSPITAL FEE HOAG | 10,903,012 |
| DEFERRED INCOME | 2,491,858 |
| PAYABLE TO THIRD PARTY PAYERS | 2,298,575 |
| DEFERRED RENT | 2,177,624 |
| PAYABLE TO CHARITY | 1,921,096 |
| LEASE INCENTIVE OBLIGATION | 898,973 |
| OTHER LIABILITES | 17,616,396 |

Supplemental Information

| Return Reference | Explanation |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE D, PART V, LINE 4 | INTENDED USES OF THE ORGANIZATION'S ENDOWMENT FUNDS THE ENDOWMENT FUNDS PROVIDE INCOME TO SUPPORT CARE FOR THE POOR PROGRAMS, NURSING SCHOLARSHIPS, AND ACTIVITIES DESIGNATED BY THE BOARD TO SUPPORT ST JUDE MEDICAL CENTER'S CONTINUING NEEDS AND MISSION |

Open to Public Inspection

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

95-1643325

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

| Revenue | | (a) Event #1 | (b) Event #2 | (c) Other events | (d) |
|-----------------|-----------------------------------------------------------------------------------|-----------------------------|---------------------------------------|----------------------------|--------------------------------------------------|
| | | <u>GOLF</u> (event type) | <u>WLK AMNG STARS</u> (event type) | <u>1</u> (total number) | Total events (add col (a) through col (c)) |
| | 1 Gross receipts | 233,631 | 280,969 | 174,483 | 689,083 |
| | 2 Less Contributions | 139,556 | 209,059 | 139,556 | 488,171 |
| | 3 Gross income (line 1 minus line 2) | 94,075 | 71,910 | 34,927 | 200,912 |
| Direct Expenses | 4 Cash prizes | 0 | 500 | 0 | 500 |
| | 5 Noncash prizes | 5,234 | 1,466 | 1,334 | 8,034 |
| | 6 Rent/facility costs | 133 | 4,682 | 3,093 | 7,908 |
| | 7 Food and beverages | 34,870 | 51,751 | 495 | 87,116 |
| | 8 Entertainment | 0 | 0 | 0 | 0 |
| | 9 Other direct expenses | 32,882 | 59,816 | 16,054 | 108,752 |
| | 10 Direct expense summary Add lines 4 through 9 in column (d) ▶ | | | | 212,310 |
| | 11 Net income summary Subtract line 10 from line 3, column (d) ▶ | | | | -11,398 |

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

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

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

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

b If "No," explain _____

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

b If "Yes," explain _____

- 11** Does the organization conduct gaming activities with nonmembers? ☐ Yes ☐ No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No
- 13** Indicate the percentage of gaming activity conducted in
- | | | |
|--------------------------------------|------------|---|
| a The organization's facility | 13a | % |
| b An outside facility | 13b | % |
- 14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ►

Address ►

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

- b** If "Yes," enter the amount of gaming revenue received by the organization ► \$ _____ and the amount of gaming revenue retained by the third party ► \$ _____

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

Name ►

Address ►

16 Gaming manager information

Name ►

Gaming manager compensation ► \$

Description of services provided ►

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

- a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No
- b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ► \$ _____

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

Return Reference

Explanation

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493131050608

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

Name of the organization

ST JUDE HOSPITAL INC

Employer identification number

95-1643325

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

► Attach to Form 990.

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

Part I

Financial Assistance and Certain Other Community Benefits at Cost

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----|
| | Yes | No |
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a Yes | |
| b If "Yes," was it a written policy? | 1b Yes | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | |
| <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities | | |
| <input type="checkbox"/> Applied uniformly to most hospital facilities | | |
| <input type="checkbox"/> Generally tailored to individual hospital facilities | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care | 3a Yes | |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other % | | |
| b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care | 3b Yes | |
| <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 500 % | | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 Yes | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a Yes | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | No |
| c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | |
| 6a Did the organization prepare a community benefit report during the tax year? | 6a Yes | |
| b If "Yes," did the organization make it available to the public? | 6b Yes | |
| 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) | | | 4,776,739 | | 4,776,739 | 0 890 % |
| b Medicaid (from Worksheet 3, column a) | | | 81,625,124 | 41,250,031 | 40,375,093 | 7 530 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 86,401,863 | 41,250,031 | 45,151,832 | 8 420 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 3,008,833 | 1,438,077 | 1,570,756 | 0 290 % |
| f Health professions education (from Worksheet 5) | | | 204,024 | | 204,024 | 0 040 % |
| g Subsidized health services (from Worksheet 6) | | | 25,588,382 | 17,527,432 | 8,060,950 | 1 500 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 2,853,409 | 200,000 | 2,653,409 | 0 490 % |
| j Total. Other Benefits | | | 31,654,648 | 19,165,509 | 12,489,139 | 2 320 % |
| k Total. Add lines 7d and 7j | | | 118,056,511 | 60,415,540 | 57,640,971 | 10 740 % |

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|----|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 | | No |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | | |
| | 7,827,650 | | |
| 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | | |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | |

Section B. Medicare

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------|
| 5 Enter total revenue received from Medicare (including DSH and IME). | 5 | 94,258,021 |
| 6 Enter Medicare allowable costs of care relating to payments on line 5. | 6 | 115,078,254 |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall). | 7 | -20,820,233 |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used. | | |
| <input type="checkbox"/> Cost accounting system | <input type="checkbox"/> Cost to charge ratio | <input checked="" type="checkbox"/> Other |

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(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 | | | | |
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| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Part V Facility Information**Section A. Hospital Facilities**

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

How many hospital facilities did the organization operate during the tax year?
1

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)

| | Other (Describe) | ER-other | ER-24 hours | Research facility | Critical access hospital | Teaching hospital | Children's hospital | General medical & surgical | Licensed hospital | Facility reporting group |
|---------------------------|------------------|----------|-------------|-------------------|--------------------------|-------------------|---------------------|----------------------------|-------------------|--------------------------|
| | | | | | | | | | | |
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
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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 JUDE HOSPITAL INC**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

| | Yes | No |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----|
| 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"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input type="checkbox"/> Other (describe in Section C) _____ | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes |
| 6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | 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>SEE SCHEDULE H, PART V, SECTION C</u> | | |
| b <input type="checkbox"/> Other website (list url) _____ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) _____ | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>17</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>SEE SCHEDULE H, PART V, SECTION C</u> | 10 | Yes |
| a _____ | | |
| 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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V

Facility Information *(continued)*

Financial Assistance Policy (FAP)

ST JUDE HOSPITAL INC

Name of hospital facility or letter of facility reporting group _____

| | | Yes | No |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 500 % | | |
| b | <input checked="" 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 checked="" type="checkbox"/> Residency | | |
| h | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE SCHEDULE H, PART V, SECTION C | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE SECTION C | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | |
| j | <input checked="" type="checkbox"/> Other (describe in Section C) | | |

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

ST JUDE HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|--|
| 21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 21 | Yes | |
| 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) | | | |

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

ST JUDE HOSPITAL INC

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

| | Yes | No |
|-----------|-----|----|
| 22 | | |
| 23 | | No |
| 24 | | No |

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

[illegible]

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **12**

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART I, LINE 3C | IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE, THE ORGANIZATION ALSO CONSIDERED CERTAIN ASSETS OF A PATIENT IN ADDITION, A PATIENT'S SPECIAL CIRCUMSTANCES WERE ALSO CONSIDERED WHEN DETERMINING ELIGIBILITY, INCLUDING BUT NOT LIMITED TO, DISABILITY AND HOMELESSNESS |
| SCHEDULE H, PART I, LINE 6A | ST JUDE MEDICAL CENTER PREPARES AN ANNUAL REPORT AND IT IS PUBLICLY AVAILABLE AT https //www stjudemedicalcenter org/documents/Community-Benefit/SJMC-CBR-F Y17 pdf |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART I, LINE 7 | THE AMOUNTS REPORTED IN THE TABLE WERE CALCULATED USING VARIOUS METHODS 1 THE ORGANIZATION'S COST ACCOUNTING SYSTEM, 2 CALCULATED USING A COST-TO-CHARGE RATIO, AND 3 ACTUAL AMOUNTS AS REPORTED IN THE GENERAL LEDGER THE COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENT ACCOUNT TYPES (INPATIENT, OUTPATIENT, REHAB AND SKILLED NURSING FACILITY) AS WELL AS ALL TYPES OF INSURANCE (MEDICARE, MEDI-CAL, SELF-PAY, WORKERS COMP, COMMERCIAL, HMO, HMO SENIOR, PPO, COUNTY INDIGENT, OTHER INDIGENT, CAPITATED) |
| SCHEDULE H, PART I, LINE 7G | SUBSIDIZED HEALTH SERVICES INCLUDES PAYMENTS FOR THE SUBSIDIZED CARE OF UNINSURED EMERGENCY DEPARTMENT PATIENTS TO ON CALL PHYSICIAN SPECIALISTS, SUPPORT FOR NON-BILLABLE CANCER CENTER SERVICES SUCH AS PATIENT NAVIGATION, SOCIAL WORK, SUPPORT GROUPS, ETC AND SUBSIDIZED POST-HOSPITAL DISCHARGE CONTINUING CARE SERVICES FOR INDIGENT PATIENTS |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART III, LINE 2 | THE ORGANIZATION ANALYZES ITS HISTORICAL EXPERIENCE AND TRENDS TO ESTIMATE THE APPROPRIATE BAD DEBT EXPENSE DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE RECORDED PRIOR TO CALCULATING BAD DEBT EXPENSE |
| SCHEDULE H, PART III, LINE 3 | THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDERINSURED PATIENT POPULATION MAY NOT ENGAGE IN THE TRADITIONAL FINANCIAL ASSISTANCE APPLICATION PROCESS THEREFORE, THE ORGANIZATION ALSO USED AN AUTOMATED PREDICTIVE SCORING TOOL TO IDENTIFY AND QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE FOR ACCOUNTS THAT WERE INITIALLY CLASSIFIED AS BAD DEBT COLLECTION ACTIONS WERE NOT PURSUED ON THESE ACCOUNTS ONCE THEY WERE RECLASSIFIED BECAUSE RECLASSIFIED ACCOUNTS WERE GRANTED 100 PERCENT FINANCIAL ASSISTANCE (FREE CARE) AFTER THE RECLASSIFICATION THERE WAS NO REMAINING AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER OUR FINANCIAL ASSISTANCE POLICY |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART III, LINE 4 | FOOTNOTE FROM THE PROVIDENCE ST JOSEPH HEALTH COMBINED FINANCIAL STATEMENTS FOR THE YEAR ENDED 12/31/2017 THE HEALTH SYSTEM PROVIDES FOR AN ALLOWANCE AGAINST PATIENT ACCOUNTS RECEIVABLE FOR AMOUNTS THAT COULD BECOME UNCOLLECTIBLE THE HEALTH SYSTEM ESTIMATES THIS ALLOWANCE BASED ON THE AGING OF ACCOUNTS RECEIVABLE, HISTORICAL COLLECTION EXPERIENCE BY PAYOR, AND OTHER RELEVANT FACTORS THERE ARE VARIOUS FACTORS THAT CAN IMPACT THE COLLECTION TRENDS, SUCH AS CHANGES IN THE ECONOMY, WHICH IN TURN HAVE AN IMPACT ON UNEMPLOYMENT RATES AND THE NUMBER OF UNINSURED AND UNDERINSURED PATIENTS, THE INCREASED BURDEN OF COPAYMENTS TO BE MADE BY PATIENTS WITH INSURANCE COVERAGE AND BUSINESS PRACTICES RELATED TO COLLECTION EFFORTS THESE FACTORS CONTINUOUSLY CHANGE AND CAN HAVE AN IMPACT ON COLLECTION TRENDS AND THE ESTIMATION PROCESS USED BY THE HEALTH SYSTEM THE HEALTH SYSTEM RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICES ON THE BASIS OF PAST EXPERIENCE, WHICH HAS HISTORICALLY INDICATED THAT MANY PATIENTS ARE UNRESPONSIVE OR ARE OTHERWISE UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE |
| SCHEDULE H, PART III, LINE 8 | THE ORGANIZATION DOES NOT REPORT MEDICARE REVENUES AND EXPENSES AS COMMUNITY BENEFIT MEDICARE COSTS ARE DETERMINED FROM THE MEDICARE COST REPORT USING CMS STANDARD COSTING METHODS THIS INCLUDES STEP-DOWN ALLOCATION PROCESSES WHICH ARE APPLIED TO CALCULATE ALLOWABLE MEDICARE COSTS |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART III, LINE 9B | PATIENT ACCOUNTS WERE NOT FORWARDED TO COLLECTION STATUS WHEN THE PATIENT MADE A GOOD FAITH EFFORT TO RESOLVE OUTSTANDING ACCOUNT BALANCES SUCH EFFORTS INCLUDE APPLYING FOR FINANCIAL ASSISTANCE, NEGOTIATING A PAYMENT PLAN, OR APPLYING FOR MEDICAID COVERAGE PRIOR TO ADVANCING ANY ACCOUNT FOR EXTERNAL COLLECTION, THE ORGANIZATION PERFORMED AN EVALUATION TO IDENTIFY IF THE ACCOUNT QUALIFIED FOR FINANCIAL ASSISTANCE ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR FREE CARE WERE WRITTEN OFF AND COLLECTION EFFORTS WERE NOT PURSUED THE ORGANIZATION'S COLLECTION POLICY ALSO APPLIED TO ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR DISCOUNTED CARE |
| SCHEDULE H, PART VI, LINE 2 | NEEDS ASSESSMENT THE HOSPITAL UTILIZED THE OCHEALTHIERTOGETHER ORG WEBSITE, THE CALIFORNIA DEPARTMENT OF EDUCATION DATAQUEST WEBSITE AS ADDITIONAL RESOURCES TO THE CHNA In addition to the CHNA, the Medical Center assesses the health care needs of the communities we serve by analyzing hospital data, such as cancer registry data, emergency room data related to mental health, service line data and market assessment data |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART VI, LINE 3 | <p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE THE ORGANIZATION POSTED NOTICES INFORMING THE PUBLIC OF THE FINANCIAL ASSISTANCE PROGRAM NOTICES WERE POSTED IN HIGH VOLUME INPATIENT AND OUTPATIENT SERVICE AREAS NOTICES WERE ALSO POSTED AT LOCATIONS WHERE A PATIENT COULD PAY THEIR BILL NOTICES INCLUDED CONTACT INFORMATION ON HOW A PATIENT COULD OBTAIN MORE INFORMATION ON FINANCIAL ASSISTANCE AS WELL AS WHERE TO APPLY FOR ASSISTANCE THESE NOTICES WERE POSTED IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT WERE REPRESENTATIVE OF 5% OR GREATER OF PATIENTS IN THE HOSPITAL'S SERVICE AREA ALL PATIENTS WHO DEMONSTRATED LACK OF FINANCIAL COVERAGE BY THIRD PARTY INSURERS WERE OFFERED AN OPPORTUNITY TO COMPLETE THE FINANCIAL ASSISTANCE APPLICATION AND WERE OFFERED INFORMATION, ASSISTANCE, AND REFERRAL AS APPROPRIATE TO GOVERNMENT SPONSORED PROGRAMS FOR WHICH THEY MAY HAVE BEEN ELIGIBLE</p> |
| SCHEDULE H, PART VI, LINE 4 | <p>COMMUNITY INFORMATION ST JUDE MEDICAL CENTERS TOTAL HOSPITAL SERVICE AREA ("TSA") INCLUDES ORANGE AND PARTS OF LOS ANGELES, RIVERSIDE AND SAN BERNARDINO COUNTIES OVER 57 PERCENT OF THE POPULATION OF THE TSA IS IN ORANGE COUNTY, AND APPROXIMATELY 24 PERCENT OF ORANGE COUNTYS POPULATION IS WITHIN THE TSA THE TOTAL HOSPITAL SERVICE AREA POPULATION IS 1,349,211 WITH A MEDIAN HOUSHOLD INCOME OF \$73,166 THE TOTAL SERVICE AREA HAS 25 4 PERCENT OF THE POPULATION WITH A HOUSEHOLD INCOME BELOW 200% FPL AND 17 7 PERCENT OF CHILDREN AND 9 3 PERCENT OF OLDER ADULTS LIVE BELOW 100% OF POVERTY LEVEL WHEN LOOKING AT THE PRIMARY SERVICE AREA, 21 7 PERCENT OF THE POPULATION IS UNDER THE AGE OF 18 AND 14 3 PERCENT OF THE POPULATION IS OVER THE AGE OF 65 FUTHERMORE, 21 9 PERCENT OF THE POPULATIONS HOUSEHOLD INCOME IS BELOW 200% FPL AND 15 1 PERCENT OF CHILDREN AND 8 5 PERCENT OF OLDER ADULTS LIVE BELOW 100% OF FEDERAL POVERTY LEVEL THE TSA AND THE PSA ARE MAJORITY MINORITY SERVICE AREAS THE TSA INCLUDES 45 8 PERCENT LATINOS, 24 4 PERCENT ASIANS AND 21 6 PERCENT NON-LATINO WHITE THE PRIMARY SERVICE AREA INCLUDES 34 7 PERCENT LATINO, 33 8 PERCENT WHITE AND 26 5 PERCENT ASIAN PERSONS LOW INCOME/HIGHEST NEED ZIP CODES ARE LOCATED IN ANAHEIM, BUENA PARK, FULLERTON, LA HABRA, ROWLAND HEIGHTS AND WHITTIER OTHER HOSPITALS IN THE COMMUNITY INCLUDE PLACENTIA LINDA HOSPITAL ANAHEIM REGIONAL MEDICAL CENTER, KAISER HOSPITAL ANAHEIM, WEST ANAHEIM HOSPITAL, WHITTIER HOSPITAL AND PRESBYTERIAN INTERCOMMUNITY HOSPITAL HEALTH PROFESSIONS SHORTAGE AREA MENTAL, DENTAL, OTHER THE FEDERAL HEALTH RESOURCES AND SERVICES ADMINISTRATION DESIGNATES HEALTH PROFESSIONAL SHORTAGE AREAS AS AREAS WITH A SHORTAGE OF PRIMARY MEDICAL CARE, DENTAL CARE, OR MENTAL HEALTH PROVIDERS THEY ARE DESIGNATED ACCORDING TO GEOGRAPHY (I E , SERVICE AREA), DEMOGRAPHICS (I E , LOW-INCOME POPULATION), OR INSTITUTIONS (I E , COMPREHENSIVE HEALTH CENTERS) ST JUDE MEDICAL CENTER IS NOT LOCATED IN A SHORTAGE AREA, WITH THE EXCEPTION OF A SMALL AREA IN ANAHEIM MEDICAL UNDERSERVED AREA/MEDICAL PROFESSIONAL SHORTAGE AREA MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ARE DEFINED BY THE FEDERAL GOVERNMENT TO INCLUDE AREAS OR POPULATION GROUPS THAT DEMONSTRATE A SHORTAGE OF HEALTHCARE SERVICES THIS DESIGNATION PROCESS WAS ORIGINALLY ESTABLISHED TO ASSIST THE GOVERNMENT IN ALLOCATING COMMUNITY HEALTH CENTER GRANT FUNDS TO THE AREAS OF GREATEST NEED MEDICALLY UNDERSERVED AREAS ARE IDENTIFIED BY CALCULATING A COMPOSITE INDEX OF NEED INDICATORS COMPILED AND COMPARED WITH NATIONAL AVERAGES TO DETERMINE AN AREAS LEVEL OF MEDICAL "UNDER SERVICE " MEDICALLY UNDERSERVED POPULATIONS ARE IDENTIFIED BASED ON DOCUMENTATION OF UNUSUAL LOCAL CONDITIONS THAT RESULT IN ACCESS BARRIERS TO MEDICAL SERVICES MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ARE PERMANENTLY SET, AND NO RENEWAL PROCESS IS NECESSARY A PORTION OF ST JUDE MEDICAL CENTERS SERVICE AREA IS LOCATED IN MEDICALLY UNDERSERVED POPULATIONS AREA, SIGNIFYING THE IMPORTANCE OF ST JUDE MEDICAL CENTER TO THE COMMUNITY IT SERVES FOR MORE INFORMATION, GO TO THE ST JUDE MEDICAL CENTERS FY17 COMMUNITY BENEFIT REPORT POSTED AT WWW.STJUDEMEDICALCENTER.ORG</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART VI, LINE 5 | <p>PROMOTION OF COMMUNITY HEALTH REALIZING OUR MISSION ST JUDE MEDICAL CENTER IS AN ACUTE-CARE HOSPITAL FOUNDED IN 1957, LOCATED IN FULLERTON AND SERVING THE FOLLOWING REGION NORTH ORANGE COUNTY AND ADJACENT PORTIONS OF LOS ANGELES, RIVERSIDE AND SAN BERNARDINO COUNTIES ST JUDE MEDICAL CENTER PROVIDES VITAL HOSPITAL AND COMMUNITY SERVICES AND ADDRESSES THE NEEDS OF THE UNINSURED AND UNDERSERVED THROUGH ITS FINANCIAL ASSISTANCE PROGRAM PROVIDING FREE (TRADITIONAL CHARITY CARE) AND DISCOUNTED CARE ST JUDE MEDICAL CENTER IS COMMITTED TO PROMOTING THE HEALTH AND QUALITY OF LIFE OF ITS SURROUNDING COMMUNITY THIS IS DEMONSTRATED THROUGH THE FOLLOWING MECHANISMS 1) A COMMUNITY BENEFIT COMMITTEE THAT HAS COMMUNITY REPRESENTATION AND IS A SUBCOMMITTEE OF THE BOARD OF TRUSTEES, 2) AN OPEN MEDICAL STAFF AND 3) ROBUST COMMUNITY BENEFIT PROGRAMS THAT ARE IN PART FUNDED BY CARE FOR THE POOR DOLLARS LOCAL COMMUNITY BENEFIT COMMITTEE THE ROLE OF THE ST JUDE MEDICAL CENTER COMMUNITY BENEFIT COMMITTEE IS TO SUPPORT THE BOARD OF TRUSTEES IN OVERSEEING COMMUNITY BENEFIT EFFORTS THE COMMITTEE ACTS IN ACCORDANCE WITH A BOARD-APPROVED CHARTER THE COMMUNITY BENEFIT COMMITTEE IS CHARGED WITH DEVELOPING POLICIES AND PROGRAMS THAT ADDRESS IDENTIFIED NEEDS IN THE SERVICE AREA PARTICULARLY FOR UNDERSERVED POPULATIONS, OVERSEEING DEVELOPMENT AND IMPLEMENTATION OF THE COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY BENEFIT PLAN/IMPLEMENTATION STRATEGY REPORTS, AND PROVIDING DIRECTION OF COMMUNITY BENEFIT ACTIVITIES THE COMMUNITY BENEFIT COMMITTEE HAS A MINIMUM OF EIGHT MEMBERS INCLUDING THREE MEMBERS OF THE BOARD OF TRUSTEES CURRENT MEMBERSHIP INCLUDES THREE MEMBERS OF THE BOARD OF TRUSTEES AND EIGHT COMMUNITY MEMBERS A MAJORITY OF MEMBERS HAVE KNOWLEDGE AND EXPERIENCE WITH THE POPULATIONS MOST LIKELY TO HAVE DISPROPORTIONATE UNMET HEALTH NEEDS THE COMMUNITY BENEFIT COMMITTEE GENERALLY MEETS QUARTERLY ST JUDE MEDICAL CENTERS FY15-FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT FOCUSED ON ACCESS TO MEDICAL CARE FOR THE UNDERSERVED, OBESITY, BEHAVIORAL HEALTH, AND INFANT AND CHILD HEALTH ACCOMPLISHMENTS INCLUDED 27,140 LOW INCOME PERSONS PROVIDED ACCESS TO HEALTH CARE, 42.9 PERCENT OF TARGET SCHOOLS SHOWED AN INCREASE IN THE PERCENTAGE OF CHILDREN IN THE HEALTHY FITNESS ZONE FOR BODY COMPOSITION, 4,545 PERSONS RECEIVED BEHAVIORAL HEALTH PREVENTION OR TREATMENT SERVICES, AND THE IMMUNIZATIONS RATES FOR TDAP WAS 92.3 PERCENT AND FOR MMR WAS 98.1 PERCENT AT ST JUDE NEIGHBORHOOD HEALTH CENTERS FY17 OTHER COMMUNITY BENEFIT PROGRAM ACCOMPLISHMENTS INCLUDED 6,361 NON-EMERGENCY MEDICAL TRANSPORTATION TRIPS FOR LOW INCOME SENIORS, 5,476 SUPPORT SERVICES TO LOW INCOME SENIORS, 5,310 VISITS FOR COMMUNITY REHABILITATION PROGRAMS, 614 VISITS FOR REHAB NURSE FOLLOW-UP PROGRAM, 43,071 ENCOUNTERS FROM THE CAREGIVER RESOURCE PROGRAM, 2,774 ENCOUNTERS FOR ADULTS WITH TRAUMATIC BRAIN INJURY, 3,987 LBS OF FOOD DONATED TO THE HUNGRY, 7,085 ENCOUNTERS FROM THE NEURO-REHABILITATION CONTINUUM OF CARE, 6,119 AT-RISK YOUTH AND FAMILIES SERVED BY ACT ANAHEIM AND OVER 450 HOMELESS CLIENTS SERVED BY CARE NAVIGATION</p> |
| SCHEDULE H, PART VI, LINE 6 | <p>AFFILIATED HEALTH CARE SYSTEM ST JUDE MEDICAL CENTER IS A HEALING MINISTRY OF PROVIDENCE ST JOSEPH HEALTH, A NEW ORGANIZATION CREATED BY PROVIDENCE HEALTH & SERVICES AND ST JOSEPH HEALTH WITH THE GOAL OF IMPROVING THE HEALTH OF THE COMMUNITIES IT SERVES, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE TOGETHER, OUR 111,000 CAREGIVERS (ALL EMPLOYEES) SERVE IN 50 HOSPITALS, 829 CLINICS AND A COMPREHENSIVE RANGE OF SERVICES ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON THE SYSTEM INCLUDES 50 ACUTE CARE HOSPITALS, HOME HEALTH AGENCIES, HOSPICE CARE, OUTPATIENT SERVICES, COMMUNITY CLINICS, AND PHYSICIAN ORGANIZATIONS ST JOSEPH HEALTH IN 1912, A SMALL GROUP OF SISTERS OF ST JOSEPH LANDED ON THE RUGGED SHORES OF EUREKA, CALIFORNIA, TO PROVIDE EDUCATION AND HEALTH CARE THE MINISTRY LATER ESTABLISHED ROOTS IN ORANGE, CALIFORNIA, AND EXPANDED TO SERVE SOUTHERN CALIFORNIA, THE CALIFORNIA HIGH DESERT, NORTHERN CALIFORNIA AND TEXAS THE HEALTH SYSTEM ESTABLISHED MANY KEY PARTNERSHIPS, INCLUDING A MERGER BETWEEN LUBBOCK METHODIST HOSPITAL SYSTEM AND ST MARY HOSPITAL TO FORM COVENANT HEALTH IN LUBBOCK TEXAS RECENTLY, AN AFFILIATION WAS ESTABLISHED WITH HOAG HEALTH TO INCREASE ACCESS TO SERVICES IN ORANGE COUNTY, CALIFORNIA SJH COMMUNITY PARTNERSHIP FUND (FORMERLY THE ST JOSEPH HEALTH SYSTEM FOUNDATION) IN 1986, ST JOSEPH HEALTH (SJH) CREATED A PLAN AND BEGAN AN EFFORT TO FURTHER ITS COMMITMENT TO NEIGHBORS IN NEED WITH A VISION OF REACHING BEYOND THE WALLS OF ITS HEALTHCARE FACILITIES AND TRANSCENDING TRADITIONAL EFFORTS OF PROVIDING FINANCIAL ASSISTANCE FOR THOSE IN NEED OF ACUTE SERVICES, ST JOSEPH HEALTH SYSTEM CREATED THE ST JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND (FORMERLY KNOWN AS THE ST JOSEPH HEALTH SYSTEM FOUNDATION) TO IMPROVE THE HEALTH OF LOW-INCOME INDIVIDUALS RESIDING IN LOCAL COMMUNITIES EVERY YEAR, EACH ST JOSEPH HEALTH HOSPITAL CONTRIBUTES TEN PERCENT OF THEIR NET INCOME TO THE ST JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND TO SUPPORT OUTREACH EFFORTS FOR THE ECONOMICALLY POOR IN FY17 THIS AMOUNT TOTALLED \$5,020,400 FOR ST JUDE MEDICAL CENTER 75% OF THE CONTRIBUTIONS ARE USED TO SUPPORT CARE FOR POOR PROGRAMS BY EACH HOSPITAL 17.5% OF FUNDS ARE USED TO SUPPORT ST JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND INITIATIVES THE REMAINING 7.5% ARE DESIGNATED TOWARD AN ENDOWMENT WHICH HELPS ENSURE THE FUND'S ABILITY TO SUSTAIN PROGRAMS INTO THE FUTURE THAT ASSIST LOW-INCOME AND UNDERSERVED POPULATIONS COMMUNITY INVESTMENT FUND ST JOSEPH HEALTH FURTHERMORE RECOGNIZES THAT THE HEALTH OF ANY COMMUNITY DEPENDS ON THE MAINTENANCE AND CREATION OF STRONG STRUCTURES- BOTH PHYSICAL AND SOCIAL - THAT CONTRIBUTE TO THE LONG-TERM WELL-BEING OF PEOPLE THAT PHILOSOPHY INSPIRED THE INITIATION OF THE ST JOSEPH HEALTH COMMUNITY INVESTMENT FUND - AN EFFORT TO ENABLE NON PROFIT 501(C)3 ORGANIZATIONS TO ACHIEVE THEIR FULL POTENTIAL AND PLAY A MAJOR ROLE IN THE GROWTH OF THEIR COMMUNITIES IN FY17, A TOTAL OF \$11.5 MILLION WAS INVESTED INTO THE COMMUNITY THROUGH LOANS AND LINES OF CREDIT FUNDED NON-PROFITS INCLUDE THOSE THAT SERVE THE HOMELESS, PROVIDE AFFORDABLE HOUSING, PROVIDE ACCESS TO PRIMARY MEDICAL CARE, AND ADDRESS YOUTH DEVELOPMENT TO LEARN MORE ABOUT ST JOSEPH HEALTH AND PROVIDENCE JOSEPH HEALTH GO TO HTTP //WWW STJHS ORG HTTP //WWW PSJHEALTH ORG/ABOUT-US</p> |

| 990 Schedule H, Supplemental Information | |
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| Form and Line Reference | Explanation |
| SCHEDULE H, PART VI, LINE 7 | STATE FILING OF COMMUNITY BENEFIT REPORT CALIFORNIA |

Additional Data

Software ID:
Software Version:
EIN: 95-1643325
Name: ST JUDE HOSPITAL INC

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

| Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1 | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER—24 hours | ER—other | Other (Describe) | Facility reporting group |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| 1 | ST JUDE HOSPITAL 101 E VALENCIA MESA DRIVE FULLERTON, CA 92835 WWW.STJUDEMEDICALCENTER.ORG HSC30168F | X | X | X | | | | X | | | |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 5 | <p>COMMUNITY INPUT THE PROCESS OF COLLECTING QUALITATIVE COMMUNITY INPUT TOOK TWO MAIN FORMS COMMUNITY RESIDENT FOCUS GROUPS AND A NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP WHICH WERE CONDUCTED FROM FEBRUARY 7 FEBRUARY 23, 2017 EACH TYPE OF FOCUS GROUP WAS DESIGNED TO CAPTURE THE COLLECTED KNOWLEDGE AND OPINIONS OF PEOPLE WHO LIVE AND WORK IN THE COMMUNITIES SERVED BY ST JUDE MEDICAL CENTER WE DEVELOPED A PROTOCOL FOR EACH GROUP TO ENSURE CONSISTENCY ACROSS INDIVIDUAL FOCUS GROUPS, ALTHOUGH THE FACILITATORS HAD SOME DISCRETION ON ASKING FOLLOW-UP QUESTIONS OR PROBES AS THEY SAW FIT INVITATION AND RECRUITMENT PROCEDURES VARIED FOR EACH TYPE OF GROUP RESIDENT FOCUS GROUPS FOR COMMUNITY RESIDENT GROUPS, COMMUNITY BENEFIT STAFF, IN COLLABORATION WITH THEIR COMMITTEES AND THE SYSTEM OFFICE, IDENTIFIED GEOGRAPHIC AREAS WHERE DATA SUGGESTED THERE WERE SIGNIFICANT HEALTH, PHYSICAL ENVIRONMENT, AND SOCIOECONOMIC CONCERNS THIS PROCESS ALSO IDENTIFIED THE LANGUAGE NEEDS OF THE COMMUNITY, WHICH DETERMINED THE LANGUAGE IN WHICH EACH FOCUS GROUP WAS CONDUCTED COMMUNITY BENEFIT STAFF THEN PARTNERED WITH COMMUNITY-BASED ORGANIZATIONS THAT SERVE THOSE AREAS TO RECRUIT FOR AND HOST THE FOCUS GROUPS THE COMMUNITY-BASED ORGANIZATION DEVELOPED AN INVITATION LIST USING THEIR CONTACTS AND KNOWLEDGE OF THE AREA, AND PARTICIPANTS WERE PROMISED A SMALL INCENTIVE FOR THEIR TIME TWO CONSULTANTS STAFFED EACH FOCUS GROUP, SERVING AS FACILITATORS AND NOTE TAKERS THESE CONSULTANTS WERE NOT DIRECTLY AFFILIATED WITH THE MINISTRY TO ENSURE CANDOR FROM THE PARTICIPANTS NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP FOR THE NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP, COMMUNITY BENEFIT STAFF DEVELOPED A LIST OF LEADERS FROM ORGANIZATIONS THAT SERVE DIVERSE CONSTITUENCIES WITHIN THE HOSPITALS SERVICE AREA MINISTRY STAFF SOUGHT TO INVITE ORGANIZATIONS WITH WHICH THEY HAD EXISTING RELATIONSHIPS, BUT ALSO USED THE FOCUS GROUP AS AN OPPORTUNITY TO BUILD NEW RELATIONSHIPS WITH STAKEHOLDERS PARTICIPANTS WERE NOT GIVEN A MONETARY INCENTIVE FOR ATTENDANCE AS WITH THE RESIDENT FOCUS GROUPS, THIS GROUP WAS FACILITATED BY OUTSIDE CONSULTANTS WITHOUT A DIRECT LINK TO ST JOSEPH HEALTH THE GROUPS THAT WERE REPRESENTED AND THE POPULATIONS THEY SERVE INCLUDE CITY OF PLACENTIA COMMUNITY SERVICES SERVE LOW INCOME FAMILIES IN PLACENTIA, HABITAT FOR HUMANITY SERVE LOW INCOME FAMILIES, NATIONAL ALLIANCE FOR THE MENTALLY ILL SERVE MENTALLY ILL AND THEIR FAMILIES, NETWORK ANAHEIM SERVE LOW INCOME RESIDENTS IN ANAHEIM, ORANGE COUNTY HUMAN RELATIONS SERVE DIVERSE COMMUNITIES AND YOUTH, OC UNITED SERVE LOW INCOME FAMILIES IN FULLERTON AND ST JUDE NEIGHBORHOOD HEALTH CENTERS SERVE LOW INCOME FAMILIES IN NORTH ORANGE COUNTY FOR MEDICAL SERVICES COMMUNITY BENEFIT COMMITTEE THE MEDICAL CENTERS COMMUNITY BENEFIT COMMITTEE IS MADE UP OF LEADERS IN GOVERNMENT, EDUCATION, NOT-FOR-PROFIT ORGANIZATIONS AND HEALTH CARE, INCLUDING THE CITY OF BUENA PARK, CITY OF LA HABRA, FULLERTON SCHOOL D</p> |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 5 | ISTRICK, PLACENTIA YORBA LINDA SCHOOL DISTRICT, ORANGE COUNTY HUMAN RELATIONS, ORANGE COUN TY COMMUNITY CONGREGATION ORGANIZATIONS, CITY OF PLACENTIA, FACES, NAMI, AND THE MEDICAL C ENTER A REPRESENTATIVE FROM THE ORANGE COUNTY HEALTH CARE AGENCY PUBLIC HEALTH DIVISION A LSO IS A MEMBER OF THE COMMITTEE THESE MEMBERS PROVIDED INPUT INTO THE CHNA PROCESS AND S ET PRIORITIES FOR THE COMMUNITY BENEFIT STRATEGY AND IMPLEMENTATION PLAN DURING 2017 |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 7A | THE CHNA CAN BE FOUND ON THE ST JUDE MEDICAL CENTER WEBSITE AT https://www.stjudemedicalcenter.org/documents/Community-Benefit/SJMC-CHNA-FY17.pdf |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 10A | THE IMPLEMENTATION STRATEGY CAN BE FOUND ON THE ST JUDE MEDICAL CENTER WEBSITE AT https://www.stjudemedicalcenter.org/documents/Community-Benefit/SJMC-CBR-FY17.pdf |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 11 | <p>THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED THROUGH THE DATA AND FOCUS GROUP PROCESS. MENTAL HEALTH: COMMUNITY MEMBERS ARE EXPERIENCING STRESS, ANXIETY, AND DEPRESSION FROM A NUMBER OF FACTORS, INCLUDING LOW INCOMES, THE HIGH COST OF HOUSING, UNEMPLOYMENT, UNDOCUMENTED STATUS, AND COMMUNITY AND FAMILY VIOLENCE. THE CONTINUING STIGMA AROUND MENTAL HEALTH MAKES PEOPLE RELUCTANT TO ACKNOWLEDGE THEIR PROBLEMS AND SEEK HELP. IMMIGRANTS, REGARDLESS OF LEGAL STATUS, ARE SUSCEPTIBLE TO MENTAL HEALTH CONCERNS BECAUSE OF STIGMA WITHIN THEIR CULTURE AND BECAUSE THEY LIVE FAR FROM THEIR FAMILIES. HOUSING CONCERNS ABOUT HOUSING FOCUSED ON BOTH COST AND QUALITY AND THE DOWNSTREAM EFFECTS OF BOTH. THE HIGH COST OF HOUSING LEADS FAMILIES TO DOUBLE OR TRIPLE-UP IN HOUSING, OR RENT SPACE IN GARAGES. PEOPLE MOVE FREQUENTLY, WHICH MAKES IT DIFFICULT TO MEET NEIGHBORS OR FEEL CONNECTED TO THE COMMUNITY. UNMAINTAINED APARTMENTS HAVE MOLD, DIRT, DUST, OLD CARPETS, AND INSECT AND RODENT INFESTATIONS. SLUMLORDS DO NOT RESPOND TO THE NEEDS OF THEIR TENANTS OR RAISE THE RENT WITHOUT MUCH ADVANCE NOTICE. UNDOCUMENTED RESIDENTS DO NOT KNOW THEIR RIGHTS AND ARE AFRAID TO SPEAK UP. HOUSING CONCERNS WERE CITED AS A CAUSE OF STRESS AMONG COMMUNITY MEMBERS. HOMELESSNESS: THE STAKEHOLDER FOCUS GROUP PARTICIPANTS DEFINED HOMELESSNESS AS INCLUDING FAMILIES WHO LIVE IN MOTELS OR GARAGES OR ARE DOUBLE OR TRIPLED-UP IN APARTMENTS. AT SEVERAL FOCUS GROUPS, PARTICIPANTS DESCRIBED HOW HOMELESS PEOPLE IN PARKS MAKE THEM UNSAFE FOR CHILDREN. JOBS AND SALARIES / POVERTY: THERE ARE TOO FEW JOBS IN THE COMMUNITY THAT PAY A LIVING WAGE, CAUSING PEOPLE TO TRAVEL LONG DISTANCES FOR WORK OR TO TAKE ON MULTIPLE JOBS, BOTH OF WHICH REDUCE TIME WITH FAMILY OR FOR PURSUING HEALTHY ACTIVITIES. IT IS DIFFICULT FOR UNDOCUMENTED IMMIGRANTS TO GET HIRED AND FEARS OF DEPORTATION RAIDS KEEP THEM FROM WORKING, WHICH LEADS TO STRESS AND ANXIETY. LOW WAGES IN AN AREA WITH A HIGH COST OF LIVING AND HOUSING MEAN FAMILIES CANNOT AFFORD HEALTHIER FOODS OR DENTAL AND HEALTH CARE. STRESS AND DEPRESSION FROM ECONOMIC HARDSHIP ALSO CONTRIBUTE TO OVEREATING OF UNHEALTHY FOODS AND WEIGHT GAIN. IMMIGRATION STATUS: STRESS AND FEAR OF ARREST AND DEPORTATION HAVE GROWN CONSIDERABLY SINCE NOVEMBER 2016. UNDOCUMENTED IMMIGRANTS ARE AFRAID TO ACCESS RESOURCES, INCLUDING HEALTH SERVICES, AND CANNOT PURCHASE HEALTH INSURANCE, SO THEY END UP USING THE EMERGENCY ROOM WHEN THEIR HEALTH SITUATION BECOMES DIRE. LANDLORDS AND EMPLOYERS TAKE ADVANTAGE OF THE UNDOCUMENTED, KNOWING THEY ARE AFRAID TO COMPLAIN ABOUT EXPLOITATION. THE IMMIGRANT COMMUNITY ALSO IS EXTREMELY CAUTIOUS ABOUT THEIR RELATIONSHIPS WITH THE POLICE AND SERVICE ORGANIZATIONS, WHICH MEANS IT TAKES A LONG TIME TO BUILD TRUST. FOOD AND NUTRITION: WHILE THE BENEFITS OF HEALTHY EATING ARE WELL KNOWN TO COMMUNITY MEMBERS, THE COST OF A HEALTHY DIET IS PROHIBITIVE FOR MANY. FAST, PROCESSED FOODS ARE MUCH LESS EXPENSIVE AND READILY AVAILABLE IN LOW-INCOME NEIGHBORHOODS.</p> |

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

| Form and Line Reference | Explanation |
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| SCHEDULE H, PART V, LINE 11 | HOODS CHILDREN QUICKLY DEVELOP A TASTE FOR PROCESSED FOODS AND PREFER THEM TO HEALTHIER OPTIONS FREE FOOD IS OFTEN OUTDATED OR OF POOR QUALITY THE KOREAN GROUP NOTED THAT FOOD BANKS RARELY DISTRIBUTE FOOD THAT IS TYPICAL FOR AN ASIAN DIET IN SOME CULTURES, TRADITIONAL DIETS ARE HIGH IN FAT AND IT CAN BE DIFFICULT TO GET PEOPLE TO ADOPT HEALTHY SUBSTITUTES LACK OF EXERCISE / PARKS / WALKABILITY THESE ISSUES ARE CLOSELY LINKED IT CAN BE DIFFICULT FOR PEOPLE TO GET ENOUGH EXERCISE BECAUSE SOME PARKS, STREETS, AND SIDEWALKS ARE UNSAFE SOME PARKS ARE FREQUENTED BY HOMELESS PEOPLE, ARE SITES OF DRUG AND ALCOHOL USE, HAVE GANG ACTIVITY, AND ARE FULL OF TRASH THERE ARE APARTMENT COMPLEXES THAT DO NOT ALLOW CHILDREN TO PLAY OUTSIDE AND SOME SCHOOL DISTRICTS CLOSE THEIR YARDS AFTER SCHOOL HOURS IT IS HARD TO WALK IN SOME NEIGHBORHOODS BECAUSE THERE ARE TOO FEW STREETLIGHTS, SPEEDING CARS, LOOSE DOGS, DOG WASTE LEFT ON SIDEWALKS, UNMAINTAINED ROADS AND SIDEWALKS, GANGS, DRUGS, CRIME, AND A LACK OF TRUST IN THE POLICE OBESITY AND DIABETES THE EASY AVAILABILITY OF SODAS AND SWEETENED JUICES, DIETS HIGH IN FAT, AND LACK OF EXERCISE WERE DISCUSSED AS CONTRIBUTORS TO BOTH OBESITY AND DIABETES IN THE COMMUNITY, ESPECIALLY AMONG CHILDREN PARTICIPANTS IN THE STAKEHOLDER FOCUS GROUP ALSO MENTIONED POVERTY, ANXIETY, AND DEPRESSION AS CAUSES CRIME AND GANGS GANGS ARE INVOLVED IN DRUG SALES AND OTHER CRIMINAL ACTIVITIES THAT MAKE NEIGHBORHOODS UNSAFE, ESPECIALLY AFTER DARK FOCUS GROUP PARTICIPANTS WERE CAUTIOUS IN THESE DISCUSSIONS, MAKING IT CLEAR THAT RESIDENTS ARE AFRAID TO REPORT CRIMINAL ACTIVITY BY GANG MEMBERS MANY COMMUNITY MEMBERS DO NOT TRUST THE POLICE, WHICH COMPOUND THE PROBLEM DRUG ABUSE PARTICIPANTS AT THE SPANISH-LANGUAGE FOCUS GROUPS DESCRIBED WIDESPREAD PROBLEMS WITH EXCESSIVE ALCOHOL CONSUMPTION THROUGHOUT THE COMMUNITY AND SPECIFICALLY AT APARTMENTS AND PARKS THEY NOTED THAT HOMELESS PEOPLE AND OTHER ADULTS WILL PURCHASE ALCOHOL FOR MINORS AND THERE ARE TOO MANY LIQUOR STORES IN THEIR NEIGHBORHOODS PARTICIPANTS ALSO MENTIONED THAT YOUNG TEENS AND PRETEENS BOTH USE DRUGS AND ARE USED TO CARRY AND DELIVER DRUGS FOR DEALERS DRUG USE AND SALES WERE CITED AS REASONS PARKS ARE UNSAFE THE FOLLOWING CONCERNS WERE IDENTIFIED AS CONCERNS FOR THE COMMUNITY BY THE COMMUNITY RESIDENT FOCUS GROUPS BUT WERE NOT DISCUSSED AT THE NONPROFIT/GOVERNMENT STAKEHOLDER FOCUS GROUP HEALTH CONDITIONS IN ADDITION TO OBESITY AND DIABETES, PARTICIPANTS DESCRIBED ASTHMA AND ALLERGIES AS PROBLEMS IN THE COMMUNITY, ESPECIALLY AS A RESULT OF POORLY MAINTAINED HOUSING LANGUAGE BARRIERS THE KOREAN-LANGUAGE FOCUS GROUP PARTICIPANTS MENTIONED THAT THEY OFTEN FACE A LANGUAGE BARRIER AT HEALTH CARE APPOINTMENTS AND NEED TRANSLATORS, WHICH ARE NOT ALWAYS READILY AVAILABLE LACK OF CONNECTION/COMMUNITY WHILE MANY PEOPLE HAVE A STRONG CONNECTION TO THEIR FAMILIES, THEY ARE NOT ALWAYS AS CONNECTED TO THEIR COMMUNITY THIS IS ESPECIALLY TRUE FOR PEOPLE WHO MOVE FRE |

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

| Form and Line Reference | Explanation |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART V, LINE 11 | QUENTLY THE LACK OF CONNECTION TO THE COMMUNITY MAKES IT DIFFICULT FOR SERVICE PROVIDERS TO ORGANIZE IN NEIGHBORHOODS ST JUDE MEDICAL CENTER WILL ADDRESS THE FOLLOWING PRIORITY AREAS AS PART OF ITS FY18-FY20 CB PLAN/IMPLEMENTATION STRATEGY REPORT - MENTAL HEALTH (IN CLUDING SUBSTANCE ABUSE) IMPLEMENT INNOVATIVE SOLUTIONS AND PARTNERSHIPS THAT ELIMINATE THE STIGMA OF MENTAL ILLNESS AND EASE ACCESS TO CARE, BUILD RESILIENCE IN CHILDREN, TEENS, FAMILIES, AND SENIORS, REDUCE SUFFERING FROM DEPRESSION, ANXIETY, AND SOCIAL ISOLATION, C URTAIL SUBSTANCE ABUSE AND CREATE HOPE FOR PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNE SS - OBESITY (INCLUDING FOOD AND NUTRITON, LACK OF EXERCISE AND WALKABILITY) IMPLEMENT POLICY, SYSTEM, AND ENVIRONMENTAL CHANGES THAT MAKE THE HEALTHY CHOICE THE EASY CHOICE IN LOW INCOME NEIGHBORHOODS IN NORTH ORANGE COUNTY - INCREASE ACCESS TO HEALTH CARE PROVIDE SUPPORT TO AFFILIATED COMMUNITY HEALTH CENTER AND OTHER PROGRAMS, INCREASING ACCESS TO CA RE FOR THE UNDERSERVED THE FOLLOWING HEALTH NEEDS WERE NOT ADDRESSED AS PRIORITY NEEDS H OUSING THIS IS BEING ADDRESSED BY OTHER GROUPS WITH GREATER EXPERTISE HOMELESSNESS WHILE THIS IS NOT A TOP PRIORITY, THE MEDICAL CENTER IS ADDRESSING THIS THROUGH ITS COMMUNITY CA RE NAVIGATION PROGRAM, PARTICIPATION IN THE WHOLE PERSON CARE INITIATIVE AND IN THE STREET TO HOME INITIATIVE IN ADDITION, THE MEDICAL CENTER PARTICIPATES IN SEVERAL COLLABORATIVE S WHERE THIS ISSUE IS BEING ADDRESSED FROM A COMMUNITY-WIDE PERSPECTIVE JOBS AND SALARIES /POVERTY THIS WILL BE ADDRESSED THROUGH THE EDUCATION REGIONAL INITIATIVE IMMIGRATION THI S IS NOT A TOP PRIORITY AS THERE ARE OTHER GROUPS IN ORANGE COUNTY FOCUSING ON THIS WHO HA VE GREATER EXPERTISE CRIMES AND GANGS THIS IS BEING ADDRESSED BY OTHER GROUPS WHO HAVE GR EATER EXPERTISE HEALTH CONDITIONS - ASTHMA AND ALLERGIES IS BEING ADDRESSED BY THE CHOC B REATHMOBILE LANGUAGE BARRIERS THIS IS BEING ADDRESSES BY OTHER ORGANIZATIONS WITH GREATER EXPERTISE LACK OF CONNECTION/COMMUNITY THIS IS BEING ADDRESSES BY A NEW INITIATIVE THAT IS BEING IMPLEMENTED BY WESTERN YOUTH SERVICES FOR FURTHER INFORMATION, PLEASE SEE THE IM PLEMENTATION STRATEGY FOUND AT HTTPS //WWW STJUDEMEDICALCENTER ORG/DOCUMENTS/SJMC_FY12_FY 14_CB_PLAN_501R_ ALIGNED_FINAL PDF HTTP //WWW STJUDEMEDICALCENTER ORG/DOCUMENTS/COMMUNITY- BENEFIT/FY15-17-CBP LAN-AND-IMPLEMENTATION PDF |

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

| Form and Line Reference | Explanation |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART V, LINE 13H | THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDERINSURED PATIENT POPULATION MAY NOT ENGAGE IN THE TRADITIONAL FINANCIAL ASSISTANCE APPLICATION PROCESS THEREFORE, THE ORGANIZATION ALSO USES AN AUTOMATED PREDICTIVE SCORING TOOL TO IDENTIFY AND QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE FOR ACCOUNTS THAT ARE INITIALLY CLASSIFIED AS BAD DEBT |

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

| Form and Line Reference | Explanation |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART V, LINE 16A | https://www.stjudemedicalcenter.org/documents/Patient-Financial-Assistance/Financial-Assistance-Policy-ENGLISH_4.20.16.pdf |

| 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility. | |
| Form and Line Reference | Explanation |
| SCHEDULE H, PART V, LINE 16B | https://www.stjudemedicalcenter.org/documents/Patient-Financial-Assistance/Financial-Assistance-Application-SCAL-ENGLISH_3.8.16.pdf |

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

| Form and Line Reference | Explanation |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART V, LINE 16C | https://www.stjudemedicalcenter.org/documents/Patient-Financial-Assistance/SJMC_FABrochure_2016.pdf |

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

| Form and Line Reference | Explanation |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE H, PART V, LINE 16J | THE ORGANIZATION ADHERES TO STATE REGULATIONS IN PUBLICIZING ITS FINANCIAL ASSISTANCE POLICY THESE REGULATIONS INCLUDE THE POSTING OF THE FULL POLICY ON THE OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHDP) WEBSITE IN ADDITION, POLICY NOTICES ARE POSTED IN CONSPICUOUS AREAS SUCH AS EMERGENCY DEPARTMENTS, BILLING OFFICES, ADMISSIONS OFFICES AND OTHER OUTPATIENT SETTINGS INDIVIDUAL NOTICES OF FINANCIAL ASSISTANCE ARE INCLUDED WITH BILLINGS FOR PATIENTS WHO HAVE NOT PROVIDED PROOF OF THIRD-PARTY COVERAGE ALONG WITH CONTACT INFORMATION IN THE EVENT OF ADDITIONAL INQUIRIES NOTICES OF FINANCIAL ASSISTANCE ARE ALSO PROVIDED UPON INQUIRY WRITTEN NOTICES ARE PROVIDED IN ALL LANGUAGES SPOKEN BY 5% OR MORE OF THE HOSPITAL'S SERVICE AREA |

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) |
|----------------------------------------------------------------------------------------------------|-----------------------------|
| IMAGING SERVICES 2141 N HARBOR BLVD SUITE 16000 FULLERTON, CA 92835 | OUTPATIENT SERVICES |
| ST JUDE PLAZA SURGERY CENTER 2141 N HARBOR BLVD SUITE 41000 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| KNOTT FAMILY ENDOSCOPY CENTER 1839 SUNNYCREST DRIVE FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| IMAGING CENTER 2151 N HARBOR BLVD SUITE 1400 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| RADIATION THERAPY 2151 N HARBOR BLVD SUITE 1500 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| ST JUDE CENTERS FOR REHAB & WELLNESS 2767 E IMPERIAL HWY BREA, CA 92821 | OUTPATIENT FACILITIES |
| BREAST CENTER 2151 N HARBOR BLVD SUITE 2100 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| CARDIAC REHAB CTRHEART FAILURE CLINIC 100 E VALENCIA MESA DRIVE SUITE 20 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| WELLNESS - SYNERGY 2767 E IMPERIAL HWY BREA, CA 92821 | OUTPATIENT FACILITIES |
| ST JUDE MEDICAL PLAZA LABORATORY 2141-2151 N HARBOR BLVD SUITE 1700 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| ONCOLOGY SERVICES 2141 N HARBOR BLVD SUITE 2200 FULLERTON, CA 92835 | OUTPATIENT FACILITIES |
| ST JUDE IMAGING CENTER 4300 ROSE DRIVE SUITE B YORBA LINDA, CA 92886 | OUTPATIENT FACILITIES |

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As Filed Data -

DLN: 93493131050608

Schedule I
(Form 990)

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

OMB No 1545-0047

2016

Open to Public
Inspection

Department of the
Treasury
Internal Revenue Service

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

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

Name of the organization
ST JUDE HOSPITAL INC

Employer identification number
95-1643325

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000 Part II can be duplicated if additional space is needed

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|-----------------------------------------------------------------------------------------|------------|-------------------------------|--------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------|------------------------------------|
| (1) ST JOSEPH HEALTH SYSTEM FOUNDATION 3345 MICHELSON DR STE 100 IRVINE, CA 92612 | 33-0143024 | 501(c)(3) | 5,020,400 | 0 | | | CARE FOR THE POOR |
| (2) MEALS ON WHEELS 170 S OLIVE ORANGE, CA 92866 | 95-6000943 | 501(c)(3) | | 17,131 | FMV | MEALS | COMMUNITY SUPPORT |

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

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

Part III can be duplicated if additional space is needed

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of non-cash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of non-cash assistance |
|----------------------------------|--------------------------|--------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------|
| (1) MEDICAL SERVICES TO PATIENTS | 148 | 9,183 | | | |
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

| Return Reference | Explanation |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE I, PART I, LINE 2 | DESCR OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS EXPENSES ARE MONITORED ON A MONTHLY/QUARTERLY BASIS BY THE VICE PRESIDENT OF HEALTHY COMMUNITIES WE MONITOR THE USE OF GRANT FUNDS BY REQUIRING REPORTS FROM THE ORGANIZATIONS GRANTS ARE GIVEN TO |

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" on Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

| | |
|--------------------------------------------------|----------------------------------------------|
| Name of the organization ST JUDE HOSPITAL INC | Employer identification number 95-1643325 |
|--------------------------------------------------|----------------------------------------------|

Part I

Questions Regarding Compensation

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

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

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

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

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

Part III Supplemental Information

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

| Return Reference | Explanation |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SCHEDULE J, PART I, LINE 1A | ST JOSEPH HEALTH SYSTEM ALLOWS FOR COMPANION TRAVEL TO CERTAIN PRE-APPROVED MINISTRY SPONSORED EVENTS. COMPANION TRAVEL IS TREATED AS TAXABLE COMPENSATION IN MOST CASES. IN THE CASE THAT COMPANION TRAVEL IS NOT TAXABLE COMPENSATION, THE INDIVIDUAL IS PROVIDING A SERVICE TO THE HEALTH SYSTEM AS A REPRESENTATIVE WITH KNOWLEDGE OF THE COMMUNITIES AND MINISTRIES WE SERVE. ST JUDE MEDICAL CENTER MEMBERS OF THE BOARD AND EXECUTIVE MANAGEMENT TEAM ARE SELECTED TO PARTICIPATE IN AN ANNUAL PILGRIMAGE TO LE PUY, FRANCE, WHERE THE SISTERS' FIRST CONGREGATION WAS FORMED. THE PURPOSE OF THE PILGRIMAGE IS FOR THE ORGANIZATION'S LEADERS TO DEVELOP A DEEPER UNDERSTANDING OF THE ROOTS AND HERITAGE OF THE ORGANIZATION IN ORDER TO CARRY OUT THE MISSION. COMPANION TRAVEL IS CONSIDERED TO BE AN ESSENTIAL PART OF THIS EXPERIENCE AND THE COMPANION ACTS AS A REPRESENTATIVE WITH KNOWLEDGE OF THE COMMUNITIES AND MINISTRIES WE SERVE. THE FOLLOWING INDIVIDUAL RECEIVED A BENEFIT FOR COMPANION TRAVEL THAT WAS INTENDED TO BE COMPENSATION: RIAD ABDELKARIM - \$4,343. SCHEDULE J, PART I, LINE 3: DESCRIPTION OF CEO PAID BY EXEMPT PARENT. THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER IS PAID BY ITS TAX-EXEMPT PARENT, ST JOSEPH HEALTH SYSTEM, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION. SEE SCHEDULE O, PART VI, LINE 15A FOR THE PROCESS USED BY ST JOSEPH HEALTH SYSTEM. |
| SCHEDULE J, PART I, LINE 4B | DESCRIPTION OF A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. EXECUTIVES BEGINNING IN JULY 2015, NEW EXECUTIVES PARTICIPATE IN A NON-QUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN. THE PLAN PROVIDES FOR EMPLOYER CONTRIBUTIONS BASED ON A PERCENTAGE OF EXECUTIVE BASE SALARY AND ARE SUBJECT TO A FIVE-YEAR OR AGE 65 VESTING SCHEDULE. NO INDIVIDUALS RECEIVED A 457(F) PAYOUT DURING THE YEAR. |
| SCHEDULE J, PART I, LINE 7 | DESCRIBE ANY NON-FIXED PAYMENTS PROVIDED: A PORTION OF EXECUTIVE SALARIES ARE PLACED "AT-RISK" ARE NOT AWARDED UNLESS SPECIFIC STRATEGIC OBJECTIVE TARGETS ARE MET OR EXCEEDED. THE AT-RISK EXECUTIVE PLAN IS DESIGNED TO MOTIVATE AND REWARD EXECUTIVES FOR TEAM PERFORMANCE THAT SUPPORTS THE STRATEGIC GOALS AND SUCCESSFUL PERFORMANCE OF ST JOSEPH HEALTH SYSTEM. AT-RISK PAY IS AWARDED TO ASSISTANT VICE PRESIDENTS, VICE PRESIDENTS, SENIOR VICE PRESIDENTS, EXECUTIVE VICE PRESIDENTS, AND THE CHIEF EXECUTIVE OFFICER BASED ON ACHIEVING OR SURPASSING SPECIFIC GOALS THAT ARE PREDETERMINED BY THE BOARD OF TRUSTEES PRIOR TO THE BEGINNING OF THE FISCAL YEAR. THE GOALS INCLUDE STRATEGIC OBJECTIVES AS WELL AS FISCAL STEWARDSHIP. EACH OF THESE FACTORS IS TAKEN INTO CONSIDERATION WHEN DETERMINING THE PERCENTAGE OF AT-RISK PAY. |

Additional Data

Software ID:

Software Version:

EIN: 95-1643325

Name: ST JUDE HOSPITAL INC

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---------------------------------------------------------------|------|----------------------------------------------------|-------------------------------------|-------------------------------------|------------------------------------------------|-------------------------|---------------------------------|-----------------------------------------------------------------------|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 BRIAN LEE HELLELAND TRUSTEE/CHIEF EXECUTIVE | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 433,246 | 186,719 | 65,724 | 18,503 | - | - | 0 |
| | | | | | | 32,917 | 737,109 | |
| 1 MARK JABLONSKI VP MISSION INTEGRATION | (i) | 260,738 | 123,309 | 32,721 | 23,850 | 16,742 | 457,360 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 2 LEE PENROSE PRES & CEO (PART YEAR) | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 590,072 | 554,451 | 91,692 | 21,200 | - | - | 0 |
| | | | | | | 24,744 | 1,282,159 | |
| 3 EDUARDO SALVADOR CHIEF FINANCIAL OFFICER | (i) | 287,121 | 128,761 | 32,881 | 13,250 | 24,805 | 486,818 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 4 GRACE POON REGISTERED NURSE III | (i) | 313,761 | 3,600 | 5,966 | 22,260 | 18,276 | 363,863 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 5 KAREN CANNIZZARO VP OPERATIONS | (i) | 224,165 | 99,654 | 25,655 | 20,434 | 15,991 | 385,899 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 6 BARRY ROSS VP HEALTHY COMMUNITIES | (i) | 212,949 | 102,898 | 28,207 | 19,748 | 24,112 | 387,914 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 7 SUSAN SMITH VP PHILANTHROPY | (i) | 227,060 | 101,522 | 27,093 | 20,650 | 15,992 | 392,317 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 8 LAURA RAMOS VP NURSING SERVICES | (i) | 233,149 | 104,107 | 25,458 | 9,497 | 22,594 | 394,805 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 9 KEVIN MURPHY FORMER OFFICER | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 141,428 | 112,341 | 18,384 | 10,214 | - | - | 0 |
| | | | | | | 16,068 | 298,435 | |
| 10 MICHAEL MORINO MD VP - MED AFFAIRS (FMR KEY EMP) | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 440,509 | 198,164 | 54,123 | 13,250 | - | - | 0 |
| | | | | | | 2,837 | 708,883 | |
| 11 TERESA FREY VP CLINICAL EXCELLENCE | (i) | 209,135 | 91,858 | 22,082 | 18,854 | 1,546 | 343,475 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 12 KATAYOUN MOSTAFAIE MEDICAL DIRECTOR | (i) | 257,150 | 26,633 | 4,319 | 0 | 32,829 | 320,931 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 13 DRU ANN COPPING VP MKTG PUBLIC AFFAIRS | (i) | 185,925 | 81,684 | 22,568 | 14,210 | 911 | 305,298 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 14 DON MILLER DIRECTOR OF PHARMACY | (i) | 200,425 | 30,601 | 4,648 | 18,141 | 23,569 | 277,384 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 15 MELINDA BOWLES TRUSTEE (PART YEAR) | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 260,465 | 214,918 | 53,153 | 15,900 | - | - | 0 |
| | | | | | | 32,588 | 577,024 | |
| 16 RIAD ABDELKARIM CHIEF MEDICAL OFFICER (PT YR) | (i) | 226,654 | 142,535 | 20,058 | 9,204 | 16,019 | 414,470 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |
| 17 THERESA PANESecretary | (i) | 125,391 | 1,300 | 5,135 | 11,332 | 7,362 | 150,520 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - | - | 0 |
| | | | | | | 0 | 0 | |

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.
►Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
ST JUDE HOSPITAL INC

Employer identification number
95-1643325

Part I

Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1 Art—Works of art | X | 5 | 950 | COST OR SALES PRICE |
| 2 Art—Historical treasures . . | | | | |
| 3 Art—Fractional interests . . | | | | |
| 4 Books and publications . . | | | | |
| 5 Clothing and household goods | | | | |
| 6 Cars and other vehicles . . . | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded . | X | 13 | 192,809 | COST OR SALES PRICE |
| 10 Securities—Closely held stock . | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous . . | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential . . | | | | |
| 16 Real estate—Commercial . . | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | | | | |
| 20 Drugs and medical supplies . | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts . . . | | | | |
| 25 Other ► (<u>VARIOUS AUCTION ITEM</u>) | X | 784 | 46,145 | COST OR SALES PRICE |
| 26 Other ► (<u> </u>) | | | | |
| 27 Other ► (<u> </u>) | | | | |
| 28 Other ► (<u> </u>) | | | | |
| 29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement | | | 29 | |

30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

30a

No

b If "Yes," describe the arrangement in Part II

31 Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?

31

Yes

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

32a

No

b If "Yes," describe in Part II

33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

Part II **Supplemental Information.**

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

| Return Reference | Explanation |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Schedule M, Part I, Column B | THE AMOUNTS REPORTED IN LINES 1 AND 9 REPRESENT THE NUMBER OF CONTRIBUTIONS RECEIVED THE AMOUNT REPORTED IN LINE 25 REPRESENTS THE NUMBER OF ITEMS RECEIVED |

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
ST JUDE HOSPITAL INC

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2016

**Open to Public
Inspection**

Employer identification number

95-1643325

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART I, LINE 1 & FORM 990, PART III, LINE 1 | ST JUDE MEDICAL CENTER IS COMMITTED TO EXTENDING THE HEALING MINISTRY OF JESUS IN THE TRADITION OF THE SISTERS OF ST JOSEPH OF ORANGE BY CONTINUALLY IMPROVING THE HEALTH AND QUALITY OF LIFE OF PEOPLE IN THE COMMUNITIES WE SERVE |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART III, LINE 4A | <p>ST JOSEPH HEALTH SYSTEM THE SISTERS OF ST JOSEPH OF ORANGE TRACE THEIR ROOTS BACK TO 17TH CENTURY FRANCE AND THE UNIQUE VISION OF A JESUIT PRIEST NAMED JEAN-PIERRE MEDAILLE HE SHOULD TO ORGANIZE AN ORDER OF RELIGIOUS WOMEN WHO, RATHER THAN REMAINING SAFELY CLOISTERED IN A CONVENT, VENTURED OUT INTO THE COMMUNITY TO SEEK OUT "THE DEAR NEIGHBORS" MINISTRY TO THEIR NEEDS THE CONGREGATION MANAGED TO SURVIVE THE TURBULENCE OF THE FRENCH REVOLUTION AND EVENTUALLY EXPANDED, NOT ONLY THROUGHOUT FRANCE, BUT THROUGHOUT THE WORLD IN 1912 A SMALL GROUP OF SISTERS OF ST JOSEPH WENT TO EUREKA, CALIFORNIA, AT THE INVITATION OF THE LOCAL BISHOP, TO ESTABLISH A SCHOOL A FEW YEARS LATER, THE GREAT INFLUENZA EPIDEMIC OF 1918 CAUSED THE SISTERS TO TEMPORARILY SET ASIDE THEIR EDUCATION EFFORTS TO CARE FOR THE ILL THEY REALIZED IMMEDIATELY THAT THE SMALL COMMUNITY DESPERATELY NEEDED A HOSPITAL THROUGH BOLD FAITH, FORESIGHT, AND FLEXIBILITY IN 1920, THE SISTERS OPENED THE 28-BED ST JOSEPH HOSPITAL OF EUREKA, THE FIRST ST JOSEPH HEALTH MINISTRY THE MINISTRY LATER ESTABLISHED ROOTS IN ORANGE, CALIFORNIA, AND EXPANDED TO SERVE SOUTHERN CALIFORNIA, THE CALIFORNIA HIGH DESERT, NORTHERN CALIFORNIA AND TEXAS THE HEALTH SYSTEM ESTABLISHED MANY KEY PARTNERSHIPS, INCLUDING A MERGER BETWEEN LUBBOCK METHODIST HOSPITAL SYSTEM AND ST MARY HOSPITAL TO FORM COVENANT HEALTH IN LUBBOCK TEXAS RECENTLY, AN AFFILIATION WAS ESTABLISHED WITH HOAG HEALTH TO INCREASE ACCESS TO SERVICES IN ORANGE COUNTY, CALIFORNIA PROVIDENCE ST JOSEPH HEALTH ST JUDE MEDICAL CENTER IS A HEALING MINISTRY OF PROVIDENCE ST JOSEPH HEALTH, A NEW ORGANIZATION CREATED BY PROVIDENCE HEALTH & SERVICES AND ST JOSEPH HEALTH WITH THE GOAL OF IMPROVING THE HEALTH OF THE COMMUNITIES IT SERVES, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE TOGETHER, OUR 111,000 CAREGIVERS (ALL EMPLOYEES) SERVE IN 50 HOSPITALS, 829 CLINICS AND A COMPREHENSIVE RANGE OF SERVICES ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON THE SYSTEM INCLUDES 50 ACUTE CARE HOSPITALS, HOME HEALTH AGENCIES, HOSPICE CARE, OUTPATIENT SERVICES, COMMUNITY CLINICS, AND PHYSICIAN ORGANIZATIONS ON JULY 1, 2016, PROVIDENCE HEALTH SERVICES (PHS) AND ST JOSEPH HEALTH SYSTEM (SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT, THE PURPOSE OF WHICH WAS TO BETTER SERVE BOTH ORGANIZATIONS' COMMUNITIES, MAINTAIN STRONG TRADITIONS OF CATHOLIC HEALTHCARE, AND PROVIDE GREATER AFFORDABILITY AND ACCESS TO HEALTHCARE SERVICES AS PART OF THE BUSINESS COMBINATION, PHS AND SJHS ALIGNED UNDER A SINGLE PARENT CORPORATION, PROVIDENCE ST JOSEPH HEALTH, WITH A CONSOLIDATED BOARD OF DIRECTORS AND COSPONSORSHIP FROM THE PUBLIC JURIDIC PERSONS PROVIDENCE MINISTRIES AND ST JOSEPH HEALTH MINISTRY REALIZING OUR MISSION ST JUDE MEDICAL CENTER HAS BEEN MEETING THE HEALTH AND QUALITY OF LIFE NEEDS OF THE LOCAL COMMUNITY FOR OVER 60 YEARS SERVING THE COMMUNITIES OF NORTH ORANGE COUNTY AND PARTS OF LOS ANGELES, SAN BERNARDINO AND RIVERSIDE COUNTIES</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART III, LINE 4A | <p>ES ST JUDE MEDICAL CENTER IS AN ACUTE CARE HOSPITAL THAT PROVIDES QUALITY CARE IN THE AREAS OF ONCOLOGY, STROKE/NEURO, CARDIAC, CANCER, PERINATAL, REHABILITATION, ORTHOPEDICS AND COMMUNITY HEALTH SERVICES WITH 2,472 EMPLOYEES COMMITTED TO REALIZING THE MISSION, ST JUDE MEDICAL CENTER IS ONE OF THE LARGEST EMPLOYERS IN THE NORTH ORANGE COUNTY REGION PATIENT FINANCIAL ASSISTANCE PROGRAM ST JUDE MEDICAL CENTER BELIEVES THAT NO ONE SHOULD DELAY SEEKING NEEDED MEDICAL CARE BECAUSE THEY LACK HEALTH INSURANCE THAT IS WHY ST JUDE MEDICAL CENTER HAS A PATIENT FINANCIAL ASSISTANCE PROGRAM (FAP) THAT PROVIDES FREE OR DISCOUNTED SERVICES TO ELIGIBLE PATIENTS IN FY17, ST JUDE MEDICAL CENTER PROVIDED \$4,776,739 IN FREE AND DISCOUNTED CARE MEDICAID PROGRAM ST JUDE MEDICAL CENTER PROVIDED ACCESS TO UNINSURED AND UNDERINSURED PERSONS BY PARTICIPATING IN THE FEDERAL AND STATE SPONSORED MEDICAID PROGRAM IN FY17, ST JUDE MEDICAL CENTER PROVIDED \$40,375,093 IN MEDICAID SHORTFALL, WHICH INCLUDED THE HOSPITAL FEE PROGRAM PROGRAM SERVICE ACCOMPLISHMENTS NEUROREHABILITATION CONTINUUM OF CARE ST JUDE MEDICAL CENTER OFFERS A COMPREHENSIVE CONTINUUM OF NEUROREHABILITATION SERVICES TO COMMUNITY RESIDENTS THROUGHOUT NORTH ORANGE COUNTY AND THE CITIES OF LA HABRA, ROWLAND HEIGHTS, WALNUT AND DIAMOND BAR IN LOS ANGELES COUNTY IN ORDER TO CONTINUE TO PROVIDE CARE TO THE COMMUNITY, THE NEUROREHABILITATION SERVICES REQUIRED A SUBSIDY OF \$7,831,876 IN FY17 EXCLUDING CHARITY CARE, BAD DEBT AND MEDICAID SHORTFALLS SERVICES PROVIDED TO THE COMMUNITY INCLUDE COMPREHENSIVE INPATIENT REHABILITATION SERVICES STROKE, SPINAL CORD INJURY AND TRAUMATIC BRAIN INJURY, OUTPATIENT NEUROREHABILITATION SERVICES, REHABILITATION SPECIALTY FOLLOW-UP CLINICS, WHEELCHAIR SEATING CLINIC, PROSTHETIC AND ORTHOTIC CLINICS AND COGNITIVE RECOVERY PROGRAM THESE PROGRAMS ARE HIGHLY SPECIALIZED, THEY ARE OPERATING NEAR CAPACITY AND THERE ARE NO SIMILAR PROGRAMS IN THE COMMUNITY IN FY17 THERE WERE 6,066 PATIENT/PROVIDER ENCOUNTERS PROVIDED IN THESE PROGRAMS MOVE MORE EAT HEALTHY INITIATIVE THE MOVE MORE EAT HEALTHY INITIATIVE IS DESIGNED TO ADDRESS THE OBESITY EPIDEMIC IN LOW INCOME NEIGHBORHOODS OF NORTH ORANGE COUNTY BY UTILIZING POLICY, SYSTEM AND ENVIRONMENTAL CHANGE APPROACHES PARTNERING WITH LOCAL CITIES, SCHOOL DISTRICTS, COMMUNITY COLLABORATIONS AND OTHER COMMUNITY BASED ORGANIZATIONS, THIS INITIATIVE PROVIDED OVER 60,200 ENCOUNTERS IN FY17 THROUGH AN INVESTMENT OF \$942,000 IN FY17, 4,145 PARTICIPANTS ESTABLISHED 15,788 HEALTHY LIFESTYLE GOALS OVER THE PAST THREE YEARS, 14 PARKS IN LOW INCOME NORTH ORANGE COUNTY NEIGHBORHOODS HAVE HAD FITNESS CENTERS INSTALLED AS A RESULT OF THE MOVE MORE EAT HEALTHY FUNDING CALFRESH ENROLLMENT IN TARGETED CITIES INCREASED SEVEN-FOLD WITH INVESTMENT IN AN ENROLLMENT COORDINATOR FOR NORTH ORANGE COUNTY 10,000 HOURS OF STUDENT INTERN TIME WAS DEVOTED TO THE LUNCHTIME EXERCISE PROGRAM IN THE SCHOOLS AND PARK COACHING LA HABRA ACHIEVED FIT CITY STATUS</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART III, LINE 4A | <p>US TWO CITIES DECLARED SODA FREE SUMMER CAMPAIGNS WITH OVER 7,000 PARTICIPANTS 42% OF TA RGETED SCHOOLS SAW AN IMPROVEMENT IN THE PERCENTAGE OF 5TH AND 7TH GRADERS IN THE HEALTHY FITNESS ZONE FOR BODY COMPOSITION SENIOR SERVICES/SENIOR TRANSPORTATION ST JUDE SENIOR S ERVICES PROVIDED 5,467 PROGRAM ENCOUNTERS AND 6,066 TRANSPORTATION ENCOUNTERS TO LOW INCOM E SENIORS IN NORTH ORANGE COUNTY WITH AN INVESTMENT OF \$544,653 SERVICES PROVIDED INCLUDE D CARING NEIGHBORS VOLUNTEER PROGRAM PROVIDING IN-HOME SUPPORT TO FRAIL ELDERLY, LATE LIF E DEPRESSION PROGRAM PROVIDING BOTH INDIVIDUAL COUNSELING AND GROUP SUPPORT FOR PERSONS WI TH DEPRESSION, LIVING WITH CHRONIC DISEASE CLASSES, BEREAVEMENT SUPPORT GROUP, STROKE SUPP ORT GROUP IN PARTNERSHIP WITH RTH STROKE FOUNDATION, END OF LIFE CARE PLANNING CLASSES, LE ADERSHIP OF THE NORTH ORANGE COUNTY SENIOR SERVICES COLLABORATIVE, INFORMATION AND REFERRA L AND SENIOR NON-EMERGENCY MEDICAL TRANSPORTATION ST JUDE MEDICAL CENTER IS ONE OF THE F EW HOSPITALS IN THE REGION OFFERING COMMUNITY BASED SERVICES TO SENIORS FOR MORE INFORMAT ION ABOUT ST JUDE MEDICAL CENTER, PLEASE VISIT WWW.STJUDEMEDICALCENTER.ORG FOR MORE INFO RMATION ABOUT ST JOSEPH HEALTH SYSTEM AND PROVIDENCE ST JOSEPH HEALTH, PLEASE VISIT WWW STJHS.ORG AND HTTP //WWW.PSJHEALTH.ORG/ABOUT-US HTTP //WWW.PSJHEALTH.ORG/ABOUT-US</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART IV, LINES 11F AND 12B & PART XII, LINE 2B | ST JUDE HOSPITAL INC WAS INCLUDED IN CONSOLIDATED, INDEPENDENT AUDITED FINANCIAL STATEMENTS FOR PROVIDENCE ST JOSEPH HEALTH FOR THE PERIOD ENDED DECEMBER 31, 2017 AS SUCH, AUDITED FINANCIAL STATEMENTS WERE NOT PREPARED FOR THE TAX YEAR ENDED JUNE 30, 2017 THE REPORTING ORGANIZATION WILL CHANGE ITS TAX YEAR END TO DECEMBER 31 FOR 2017 FORM 990, PART V, LINE 1A ST JOSEPH HEALTH SYSTEM (SJHS) PAYS ALL VENDORS FOR SJH ENTITIES UNDER SJH AP SHARED SERVICES THEREFORE, SJHS ISSUES FORM 1099-MISC UNDER ITS TAX ID SJHS COMPLIES WITH BACKUP WITHHOLDING RULES FOR REPORTABLE PAYMENTS TO VENDORS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 6 | DESCRIPTION OF CLASSES OF MEMBERS OR STOCKHOLDERS ST JOSEPH HEALTH SYSTEM AND COVENANT HEALTH NETWORK, INC ARE THE CORPORATE MEMBERS OF ST JUDE HOSPITAL |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 7A | DESCRIPTION OF CLASSES OF PERSONS & THE NATURE OF THEIR RIGHTS ST JUDE HOSPITAL HAS A TIERED GOVERNANCE IN WHICH THE CORPORATE MEMBERS RESERVE THE RIGHT TO APPOINT TRUSTEES TO THE ST JUDE HOSPITAL BOARD ALL TRUSTEE APPOINTMENTS THAT COME FROM THE ST JUDE HOSPITAL BOARD AS NOMINATIONS MUST BE APPROVED BY THE ST JOSEPH HEALTH SYSTEM, AS THE CORPORATE MEMBER, AND THE ST JOSEPH HEALTH MINISTRY, AS THE ORGANIZATIONAL SPONSOR THE TRUSTEES ARE THEN APPROVED AND ELECTED BY THE COVENANT HEALTH NETWORK, INC BOARD |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 7B | DESCR CLASSES OF PERSONS, DECISIONS REQ APPROVAL & TYPE OF VOTING RIGHTS THE RESERVED RIGHTS IN OUR TIERED GOVERNANCE STRUCTURE CONTEMPLATE APPROVAL BY THE ST JOSEPH HEALTH SYSTEM MEMBER OF FINANCING, BUDGETS, UNBUDGETED EXPENDITURES OF DEFINED AMOUNTS, STRATEGIC PLAN, APPOINTMENT OF AUDITORS, CREATION OR INVESTMENT IN A LEGALLY RECOGNIZED ENTITY, JOINT VENTURES, PURPOSES, SALE OR DISPOSITION OF REAL PROPERTY, MERGER OR SALE OF SUBSTANTIALLY ALL ASSETS, APPOINTMENT AND REMOVAL OF TRUSTEES, ADOPTION OR AMENDMENT OF ARTICLES OR BYLAWS |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 11B | DESCR THE PROCESS USED BY MANAGEMENT &/OR GOVERNING BODY TO REVIEW 990 THE FORM 990 WAS PREPARED BY THE FINANCE DEPARTMENT BASED ON INFORMATION RECEIVED FROM VARIOUS DEPARTMENTS OF THE ORGANIZATION AND WAS REVIEWED BY AN OFFICER OF THE ORGANIZATION A COPY OF THE FORM 990 WAS DISTRIBUTED TO ALL VOTING MEMBERS OF THE BOARD AT THE MARCH 2018 MEETING DURING THE FINANCE COMMITTEE MEETING, MANAGEMENT PRESENTED AND DISCUSSED CERTAIN DISCLOSURES AND INFORMATION INCLUDED IN THE FORM 990 THE FINANCE COMMITTEE CHAIR THEN PROVIDED A SUMMARY AT THE FULL BOARD MEETING |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 12C | <p>DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST OFFICERS, TRUSTEES AND KEY EMPLOYEES ARE REQUIRED TO DISCLOSE THE EXISTENCE AND NATURE OF ANY ACTUAL, APPARENT, OR POTENTIAL CONFLICTS OF INTEREST HE/SHE MAY HAVE THAT MIGHT RESULT IN OR HAVE THE APPEARANCE OF A CONFLICT IN CONNECTION WITH THAT INDIVIDUAL SATISFYING THEIR FIDUCIARY OBLIGATIONS TO THE ORGANIZATION DISCLOSURES SHALL BE MADE PROMPTLY ANY TIME AN ACTUAL, APPARENT OR POTENTIAL CONFLICT OF INTEREST ARISES AND BEFORE THE CONSUMMATION OF ANY CONTRACT, TRANSACTION OR ARRANGEMENT THAT IS THE SUBJECT OF THE POTENTIAL CONFLICT OF INTEREST WITH GUIDANCE FROM THE ST JOSEPH HEALTH SYSTEM CHIEF COMPLIANCE OFFICER (CCO), THE CHIEF EXECUTIVE AND/OR THE GOVERNING BOARD CHAIRPERSON, AS APPROPRIATE, CONSIDERS THE MATTER INITIALLY IF THE MATTER CANNOT BE RESOLVED AT THAT LEVEL, THE MATTER IS ESCALATED TO THE CCO THE CCO, IN CONSULTATION WITH THE ST JOSEPH HEALTH SYSTEM GENERAL COUNSEL, REVIEWS THE MATTER AND PRESENTS RECOMMENDATIONS TO THE GOVERNING BOARD AND/OR BOARD COMMITTEE, AS APPROPRIATE, FOR DISCUSSION AND VOTE THE INDIVIDUAL WHOSE POTENTIAL CONFLICT IS BEING REVIEWED MAY BE REQUESTED TO BE PRESENT DURING ANY MEETING IN WHICH THE BOARD OR BOARD COMMITTEE CONDUCTS ITS EVALUATION BUT SHALL BE EXCUSED FOR ANY DISCUSSION OR VOTE ONCE ALL NECESSARY INFORMATION HAS BEEN OBTAINED, THE COMMITTEE CONDUCTS ITS EVALUATION AND FORWARDS ITS FINDINGS AND RECOMMENDATIONS TO THE SJHS CHIEF COMPLIANCE OFFICER IF THE COMMITTEE DETERMINES AN UNRESOLVED CONFLICT OF INTEREST EXISTS, THE COMMITTEE WILL EVALUATE AND RECOMMEND CONFLICT MITIGATION STRATEGIES THE SJHS CHIEF COMPLIANCE OFFICER, IN CONSULTATION WITH SJHS GENERAL COUNSEL, WILL REVIEW THE COMMITTEE FINDINGS, RECOMMENDATIONS, AND MITIGATION STRATEGIES, AND PRESENT RECOMMENDATIONS TO THE BOARD FOR DISCUSSION AND VOTE</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINES 15A & 15B | <p>OFFICES & POSITIONS FOR WHICH PROCESS WAS USED & YEAR PROCESS WAS BEGUN IT IS ST JOSEPH HEALTH SYSTEM'S INTENTION TO MAKE FINANCIAL INFORMATION ACCESSIBLE AND TRANSPARENT ALTHOUGH THE FILING OF FORM 990 PROVIDES INSIGHT INTO HOW ST JOSEPH HEALTH SYSTEM ACHIEVES ITS MISSION, DELIVERS ITS PROGRAMS AND STEWARDS ITS FINANCES, DECIPHERING THE INFORMATION DIRECTLY FROM FORM 990 CAN BE CHALLENGING THE FOLLOWING PARAGRAPHS PROVIDE FURTHER INFORMATION ABOUT THE PROCESS WE USE TO DETERMINE COMPENSATION FOR TOP MANAGEMENT, OFFICERS AND KEY EMPLOYEES ST JOSEPH HEALTH SYSTEM HAS A SINGLE FIDUCIARY BOARD, WITH RESPONSIBILITY FOR FINANCIAL OVERSIGHT ASSOCIATED WITH FULFILLMENT OF THE ST JOSEPH HEALTH SYSTEM MISSION, DEVELOPING SYSTEM POLICIES, PROTECTING THE ASSETS ENTRUSTED TO THE ORGANIZATION AND OVERSEEING THE STRATEGIC AND OPERATIONAL AFFAIRS OF ST JOSEPH HEALTH SYSTEM'S LEGAL ENTITIES ST JOSEPH HEALTH SYSTEM ALSO MAINTAINS A NETWORK OF COMMUNITY MINISTRY BOARDS WITH RESPONSIBILITY FOR QUALITY OF CARE OVERSIGHT, COMMUNITY RELATIONS, ADVOCACY AND COMMUNITY NEEDS ASSESSMENTS ST JOSEPH HEALTH SYSTEM HAS A CONSISTENT COMPENSATION PHILOSOPHY FOR ALL OF ITS OFFICERS, INCLUDING OUR SENIOR EXECUTIVES SALARIES FOR SENIOR EXECUTIVES ARE REVIEWED BY THE PROVIDENCE ST JOSEPH HEALTH COMMITTEE AND APPROVED BY THE FULL BOARD OF DIRECTORS, NONE OF WHOM IS A ST JOSEPH HEALTH SYSTEM EMPLOYEE THE BOARD RETAINS AN INDEPENDENT CONSULTANT EACH YEAR TO REVIEW SALARIES OF THOSE IN THE MOST SIGNIFICANT LEADERSHIP ROLES IN THE ORGANIZATION PART OF THE CONSULTANT'S ROLE IS TO REVIEW AN EXTENSIVE ARRAY OF COMPENSATION SURVEYS OF LARGE, NOT-FOR-PROFIT HEALTH CARE SYSTEMS IN THE UNITED STATES ST JOSEPH HEALTH SYSTEM IS ONE OF THE LARGER HEALTH SYSTEMS IN THE COUNTRY, AND AS SUCH, THE BOARD BENCHMARKS EXECUTIVE COMPENSATION AGAINST OTHER LARGE, NOT-FOR-PROFIT HEALTH SYSTEMS WHOSE REVENUE IS SIMILAR TO THAT OF ST JOSEPH HEALTH SYSTEM ADDITIONALLY, ST JOSEPH HEALTH SYSTEMS LABOR MARKET CONTINUES TO SPREAD ACROSS HEALTH CARE AND INTO GENERAL INDUSTRY BECAUSE OF THIS, ST JOSEPH HEALTH SYSTEM ALSO TAKES INTO CONSIDERATION GENERAL INDUSTRY FOR-PROFIT MARKET DATA, WHERE APPLICABLE BASE SALARIES FOR ST JOSEPH HEALTH SYSTEM EXECUTIVES ARE GENERALLY TARGETED TO THE MEDIAN LEVEL OF THE MARKET, AS IDENTIFIED BY THE INDEPENDENT CONSULTANT AND REVIEWED WITH THE EXECUTIVE COMPENSATION COMMITTEE THE PRESIDENT/CEO UTILIZES THE MARKET INFORMATION PROVIDED BY THE CONSULTANT ALONG WITH FORMAL PERFORMANCE EVALUATIONS, TO DETERMINE SALARY RECOMMENDATIONS FOR OTHER SENIOR EXECUTIVES THIS PROCESS INCLUDES A RIGOROUS ANALYSIS OF THOSE RECOMMENDATIONS WITH THE EXECUTIVE COMPENSATION COMMITTEE AS A PART OF THE REVIEW AND APPROVAL PROCESS PERFORMANCE INCENTIVES ALLOW EXECUTIVES TO EARN ADDITIONAL COMPENSATION IF THEY ACHIEVE SPECIFIC ORGANIZATIONAL GOALS FOR FURTHERING ST JOSEPH HEALTH SYSTEM OPERATING COMMITMENTS AND STRATEGIC OBJECTIVES THE BOARD OF DIRECTORS CONDUCTS A THOROUGH PRO</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINES 15A & 15B | CESS TO ENSURE PERFORMANCE INCENTIVES ARE ALIGNED WITH APPROPRIATE MARKET PRACTICES THE B OARD'S PROCESS FOR EXECUTIVE COMPENSATION FULLY COMPLIES WITH IRS STANDARDS AND MIRRORS BE ST PRACTICES THIS PROCESS WAS LAST COMPLETED IN SEPTEMBER 2016 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART VI, LINE 19 | AVAIL OF GOV DOCS, CONFLICT OF INTEREST POLICY & FIN STMTS TO GEN PUBLIC THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST THE SJHS COMMUNITY BENEFIT REPORTS, FINANCIAL REPORTS, AND PHILANTHROPY REPORTS ARE ALSO AVAILABLE ON THE SJHS INTERNET SITE AUDITED FINANCIAL STATEMENTS ARE ATTACHED TO FORM 990 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| FORM 990, PART XI, LINE 9 | OTHER CHANGES IN NET ASSETS EQUITY TRANSFER TO SJHS (\$ 16,091,677) EQUITY TRANSFERS WITH SJHH (\$ 37,742,375) OTHER \$ 8,000 ----- TOTAL (\$ 53,826,052) |

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
ST JUDE HOSPITAL INC

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

2016

Open to Public Inspection

Employer identification number

95-1643325

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 |
|---------------------------------------------------------------------|-------------------------|--------------------------------------------------|---------------------|---------------------------|----------------------------------|
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Part II

Identification of Related Tax-Exempt Organizations

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

See Additional Data Table

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

See Additional Data Table

| (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 | |
| | | | | | | | | | | | | |
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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.

See Additional Data Table

| (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 |
| | | | | | | | | | |
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Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

| | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----|
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | 1a Yes | |
| b Gift, grant, or capital contribution to related organization(s) | 1b Yes | |
| c Gift, grant, or capital contribution from related organization(s) | 1c Yes | |
| d Loans or loan guarantees to or for related organization(s) | 1d | No |
| e Loans or loan guarantees by related organization(s) | 1e | No |
| f Dividends from related organization(s) | 1f | No |
| g Sale of assets to related organization(s) | 1g | No |
| h Purchase of assets from related organization(s) | 1h | No |
| i Exchange of assets with related organization(s) | 1i | No |
| j Lease of facilities, equipment, or other assets to related organization(s) | 1j Yes | |
| k Lease of facilities, equipment, or other assets from related organization(s) | 1k Yes | |
| l Performance of services or membership or fundraising solicitations for related organization(s) | 1l Yes | |
| m Performance of services or membership or fundraising solicitations by related organization(s) | 1m Yes | |
| n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | 1n Yes | |
| o Sharing of paid employees with related organization(s) | 1o Yes | |
| p Reimbursement paid to related organization(s) for expenses | 1p Yes | |
| q Reimbursement paid by related organization(s) for expenses | 1q Yes | |
| r Other transfer of cash or property to related organization(s) | 1r Yes | |
| 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) ST JOESPH HEALTH SYSTEM FOUNDATION | c | 3,070,588 | ACCRUAL |
| (2) ST JOSEPH HEALTH SYSTEM FOUNDATION | b | 5,020,800 | ACCRUAL |
| (3) ST JOSEPH HERITAGE HEALTHCARE | b | 54,203,400 | ACCRUAL |
| (4) ST JOSEPH HERITAGE HEALTHCARE | A-IV | 4,710,542 | FMV |
| (5) ST JOSEPH HERITAGE HEALTHCARE | l | 963,871 | FMV |
| | | | |

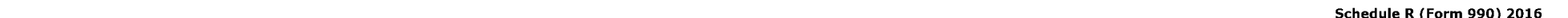
Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

Part VII Supplemental Information

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

| Return Reference | Explanation |
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| SCHEDULE R, PART III | <p>IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS A PARTNERSHIP ADVANCED SURGERY INSTITUTE, LLC EIN 26-2299255 ADDRESS 1739 4TH STREET, SANTA ROSA, CA 95404 COVENANT LONG-TERM CARE, LP EIN 20-5033419 ADDRESS 4000 24TH STREET, LUBBOCK, TX 79410 HERITAGE INVESTMENT GROUP I, LLC EIN 27-1000061 ADDRESS 500 S MAIN STREET, STE 1000, ORANGE, CA 92868 HOAG ORTHOPEDIC INSTITUTE EIN 61-1588294 ADDRESS 1 HOAG DRIVE, BOX 6100, NEWPORT BEACH, CA 92658 METHODIST DIAGNOSTIC IMAGING EIN 75-2343261 ADDRESS 4005 24TH STREET, LUBBOCK, TX 79410 NEWPORT IMAGING CENTER EIN 33-0191776 ADDRESS 360 SAN MIGUEL, NEWPORT BEACH, CA 92660 SHA, LLC EIN 75-2569094 ADDRESS 12940 NORTH HIGHWAY 183, AUSTIN, TX 78750 ST JOSEPH PHYSICIAN VENTURES I, LLC EIN 45-4521884 ADDRESS 1100 WEST STEWART DRIVE, ORANGE, CA 92868 NORTH BAY ENDOSCOPY CENTER, LLC EIN 61-1559876 ADDRESS 1383 N MCDOWELL BLVD, STE 110, PETALUMA, CA 94954 SOUTHERN CALIFORNIA SURGERY CENTER, LLC EIN 33-0939000 ADDRESS 18321 VENTURA BLVD, STE 740, TARZANA, CA 91356 COASTAL ASC HOLDINGS LLC EIN 81-0986844 ADDRESS 1 HOAG DRIVE, BOX 6100, NEWPORT BEACH, CA 92664 ST JOSEPH/SATELLITE DIALYSIS CENTERS, LLC EIN 81-4657391 ADDRESS 300 SANTANA ROW, STE 300, SAN JOSE, CA 95128 ALPHA MEDICAL LABORATORY, LLC EIN 91-2017347 ADDRESS 611 N PERRY, SPOKANE, WA 99202 BROADWAY IMAGING, LLC EIN 52-2405971 ADDRESS 500 W BROADWAY, MISSOULA, MT 59802 CALIFORNIA LABORATORY ASSOCIATES, LLC EIN 27-3888692 ADDRESS 501 BUENA VISTA, BURBANK, CA 91505 CENTER FOR SPECIALTY SURGERY, LLC EIN 26-3638838 ADDRESS 11782 SW BARNES ROAD, PORTLAND, OR 97225 CLACKAMAS RADIATION ONCOLOGY CENTER, LLC EIN 26-0381897 ADDRESS 4400 NE HALSEY ST, BLDG II #495, PORTLAND, OR 97213 CENTER FOR MEDICAL IMAGING-BRIDGEPORT, LLC EIN 26-0796953 ADDRESS 4400 NE HALSEY #495, PORTLAND, OR 97213 CENTER FOR MEDICAL IMAGING-TANASBOURNE, LLC EIN 20-0477972 ADDRESS 4400 NE HALSEY #495, PORTLAND, OR 97213 GREATER VALLEY MEDICAL BUILDING, LP EIN 95-4570858 ADDRESS 501 S BUENA VISTA STREET, BURBANK, CA 91505 MINOR & JAMES MEDICAL, PLLC EIN 91-1340223 ADDRESS 515 MINOR AVENUE #200, SEATTLE, WA 98104 MOUNTAINSTAR CLINICAL LABORATORIES, LLC EIN 26-1345983 ADDRESS 611 N PERRY, SPOKANE, WA 99202 OREGON ADVANCED IMAGING, LLC EIN 45-0471748 ADDRESS 881 O'HARE PARKWAY, MEDFORD, OR 97504 OREGON OUTPATIENT SURGERY CENTER EIN 22-3883387 ADDRESS 7300 SW CHILDS ROAD, TIGARD, OR 97224 PACLAB, LLC EIN 91-1743952 ADDRESS 611 N PERRY, SPOKANE, WA 99202 PATHOLOGY ASSOCIATES MEDICAL LABORATORIES, LLC EIN 27-0943279 ADDRESS 611 N PERRY, SPOKANE, WA 99202 PET/CT IMAGING AT SWEDISH CANCER INSTITUTE, LLC EIN 20-3132044 ADDRESS 1221 MADISON STREET, SEATTLE, WA 98104 PORTLAND MEDICAL IMAGING, LLC EIN 20-1054971 ADDRESS 4400 NE HALSEY #495, PORTLAND, OR 97213 PROVIDENCE RADIATION ONCOLOGY DEVELOPMENT ASSOCIATION, LLC EIN 26-0682491 ADDRESS 4400 NE HALSEY #495, PORTLAND, OR 97213 PROVIDENCE IMAGING CENTER EIN 92-0118807 ADDRESS 3340 PROVIDENCE DRIVE, ANCHORAGE, AK 99508 PROVIDENCE PARTNERS FOR HEALTH, LLC EIN 45-4041798 ADDRESS 501 S BUENA VISTA STREET, BURBANK, CA 91505 PROVIDENCE SURGERY CENTER, LLC EIN 84-1401625 ADDRESS 902 N ORANGE STREET, MISSOULA, MT 59802 PROVIDENCE/SILVERTON REHAB, LLC EIN 48-1287267 ADDRESS 4400 NE HALSEY #425, PORTLAND, OR 97213 PROVIDENCE/USP SANTA CLARITA GP LLC EIN 20-2829660 ADDRESS 11550 INDIAN HILLS ROAD #160, MISSION HILLS, CA 91345 PROVIDENCE/USP SURGERY CENTERS, LLC EIN 20-0905938 ADDRESS 11550 INDIAN HILLS ROAD #160, MISSION HILLS, CA 91345 SOUTHERN IDAHO REGIONAL LABORATORY, LLC EIN 82-0511819 ADDRESS 611 N PERRY, SPOKANE, WA 99202 THE MADISON SPOKANE INN, LLC EIN 84-1606484 ADDRESS 15 WEST ROCKWOOD BLVD, SPOKANE, WA 99204 TRI-CITIES LABORATORY, LLC EIN 91-1773986 ADDRESS 611 N PERRY, SPOKANE, WA 99202 HCSA PROPERTIES LLC EIN 46-0620892 ADDRESS 1600 M STREET NW, AUBURN, WA 98001 PHS INVESTMENT TRUST HEDGE FUND PORTFOLIO EIN 47-2293255 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST BANK LOANS PORTFOLIO EIN 47-2357735 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRANSITION PORTFOLIO EIN 47-2279711 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST RISK PARITY PORTFOLIO EIN 47-2336377 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST LONG TREASURIES PORTFOLIO EIN 47-2385238 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST MLP PORTFOLIO EIN 47-2367538 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST RELATIVE VALUE PORTFOLIO EIN 47-2314743 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST TIPS PORTFOLIO EIN 47-2402609 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST PUBLIC EQUITY PORTFOLIO EIN 47-2283974 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST LDI PORTFOLIO EIN 47-2392060 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST PUBLIC DEBT PORTFOLIO EIN 47-2353569 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST TACTICAL TRADING PORTFOLIO EIN 47-2327491 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST COMMODITIES PORTFOLIO EIN 47-2269004 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST 2015 PRIVATE ASSETS PORTFOLIO EIN 47-3393740 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST SHORT TERM INVESTMENT PORTFOLIO EIN 81-2701056 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST 2016 PRIVATE ASSETS PORTFOLIO EIN 81-1532735 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 PHS INVESTMENT TRUST 2016 PRIVATE REAL ESTATE PORTFOLIO EIN 81-2960145 ADDRESS 1801 LIND AVENUE SW, #9016, RENTON, WA 98057 LSC REAL PROPERTY, LLC EIN 47-4646059 ADDRESS 2301 QUAKER AVE, LUBBOCK, TX 79410 CALIFORNIA SPECIALTY SURGERY CENTER, LP EIN 33-0939003 ADDRESS 26371 CROWN VALLEY PARKWAY, MISSION VIEJO, CA 92691</p> |



Additional Data

Software ID:
Software Version:
EIN: 95-1643325
Name: ST JUDE HOSPITAL INC

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) 3345 MICHELSON DRIVE STE 100 IRVINE, CA 92612 46-1259908 | HEALTHCARE | CA | 501(C)(3) | 12,III | SJHS | Yes | |
| (1) 3615 19TH STREET LUBBOCK, TX 79410 61-1573313 | HEALTHCARE | TX | 501(C)(3) | 12,I | CHS | Yes | |
| (2) 3615 19TH STREET LUBBOCK, TX 79410 75-2765566 | HEALTHCARE | TX | 501(C)(3) | 3 | SJHS | Yes | |
| (3) 3623 22ND PLACE LUBBOCK, TX 79410 75-2897026 | HEALTHCARE | TX | 501(C)(3) | 7 | CHS | Yes | |
| (4) 3420 22ND PLACE LUBBOCK, TX 79410 75-2743883 | HEALTHCARE | TX | 501(C)(3) | 3 | CHS | Yes | |
| (5) 3615 19TH STREET LUBBOCK, TX 79410 46-3516417 | HEALTHCARE | TX | 501(C)(3) | 12,I | CHS | Yes | |
| (6) 1 HOAG DRIVE NEWPORT BEACH, CA 92658 45-3583707 | HEALTHCARE | CA | 501(C)(3) | 12,I | HMHP | Yes | |
| (7) 330 PLACENTIA AVE NEWPORT BEACH, CA 92663 45-2982422 | SUPPORT | CA | 501(C)(3) | 7 | HHF | Yes | |
| (8) 330 PLACENTIA AVE NEWPORT BEACH, CA 92663 95-3222343 | FUNDRAISING | CA | 501(C)(3) | 7 | HMHP | Yes | |
| (9) 1 HOAG ROAD BOX 6100 NEWPORT BEACH, CA 92663 95-1643327 | HEALTHCARE | CA | 501(C)(3) | 3 | CHN | Yes | |
| (10) 3702 21ST STREET LUBBOCK, TX 79410 75-2133781 | HEALTHCARE | TX | 501(C)(3) | 10 | CHS | Yes | |
| (11) 3615 19TH STREET LUBBOCK, TX 79410 75-2220963 | HEALTHCARE | TX | 501(C)(3) | 7 | CHS | Yes | |
| (12) 3610 21ST STREET LUBBOCK, TX 79410 75-2428911 | HEALTHCARE | TX | 501(C)(3) | 3 | CHS | Yes | |
| (13) 1900 COLLEGE AVENUE LEVELLAND, TX 79336 75-2246348 | HEALTHCARE | TX | 501(C)(3) | 3 | CHS | Yes | |
| (14) 2601 DIMMITT ROAD PLAINVIEW, TX 79072 75-2426010 | HEALTHCARE | TX | 501(C)(3) | 3 | CHS | Yes | |
| (15) 27700 MEDICAL CENTER ROAD MISSION VIEJO, CA 92691 95-1643360 | HEALTHCARE | CA | 501(C)(3) | 3 | CHN | Yes | |
| (16) 1000 TRANCAS STREET NAPA, CA 94558 94-1243669 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | Yes | |
| (17) 3300 RENNER DRIVE FORTUNA, CA 95540 94-2779313 | HEALTHCARE | CA | 501(C)(3) | 7 | RMH | Yes | |
| (18) 3300 RENNER DRIVE FORTUNA, CA 95540 94-1384665 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | Yes | |
| (19) 1165 MONTGOMERY DRIVE SANTA ROSA, CA 95405 94-1231005 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | 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) 400 NORTH MCDOWELL BLVD PETALUMA, CA 94954 68-0395200 | HEALTHCARE | CA | 501(C)(3) | 3 | SRMH | Yes | |
| (1) 3345 MICHELSON DRIVE IRVINE, CA 92612 95-3589356 | HEALTHCARE | CA | 501(C)(3) | 12,I | PSJH | | No |
| (2) 3345 MICHELSON DRIVE STE 100 IRVINE, CA 92612 33-0143024 | HEALTHCARE | CA | 501(C)(3) | 7 | SJHS | Yes | |
| (3) 1111 SONOMA STE 308 SANTA ROSA, CA 95405 68-0331084 | HEALTHCARE | CA | 501(C)(3) | 10 | SJHS | Yes | |
| (4) 2700 DOLBEER STREET EUREKA, CA 95501 94-1156596 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | Yes | |
| (5) 1100 WEST STEWART DRIVE ORANGE, CA 92868 95-1643359 | HEALTHCARE | CA | 501(C)(3) | 3 | CHN | Yes | |
| (6) 200 WEST CENTER ST PROMENADE ANAHEIM, CA 92805 33-0185031 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | Yes | |
| (7) 18300 HIGHWAY 18 APPLE VALLEY, CA 92307 95-1914489 | HEALTHCARE | CA | 501(C)(3) | 3 | CHN | Yes | |
| (8) 4000 24TH STREET LUBBOCK, TX 79410 75-1653181 | HEALTHCARE | TX | 501(C)(3) | 7 | CHS | Yes | |
| (9) 3345 MICHELSON DRIVE STE 100 IRVINE, CA 92612 81-4791043 | HEALTHCARE | CA | 501(C)(3) | 3 | SJHS | Yes | |
| (10) 480 S BATAVIA ORANGE, CA 92868 95-1643383 | RELIGIOUS ORG | CA | 501(C)(3) | 1 | NA | | No |
| (11) 3345 MICHELSON DRIVE STE 100 IRVINE, CA 92612 27-1666576 | RELIGIOUS ORG | CA | 501(C)(3) | 1 | SSJO | | No |
| (12) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 91-1082119 | UNEMPLOYMENT | WA | 501(C)(3) | 12,I | PHS WA | Yes | |
| (13) PO BOX 5128 EVERETT, WA 982065128 94-3264605 | TRANS CARE | WA | 501(C)(3) | 10 | NA | | No |
| (14) 15451 SAN FERNANDO MISSION BLVD 2 MISSION HILLS, CA 91345 95-4322584 | SUPPORT | CA | 501(C)(3) | 7 | PHS SOCAL | Yes | |
| (15) 1423 FIRST AVENUE SEATTLE, WA 98101 20-1910170 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (16) 2800 SOUTH 192ND ST 104 SEATAC, WA 98188 27-3133200 | HEALTHCARE | WA | 501(C)(3) | 7 | SHS | Yes | |
| (17) 601 W 1ST AVENUE SPOKANE, WA 99201 91-1307555 | HEALTHCARE | WA | 501(C)(3) | 3 | PHS WA | Yes | |
| (18) 1801 LIND AVENUE SW 9016 RENTON, WA 98057 81-4260130 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS SJHS | Yes | |
| (19) 401 TERRY AVE N SEATTLE, WA 98109 91-2003593 | HEALTHCARE | WA | 501(C)(3) | 7 | WHC | 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 |
| (41) 2200 SANTA MONICA BLVD SANTA MONICA, CA 90404 95-4291515 | HEALTHCARE | CA | 501(C)(3) | 4 | PSJHC | Yes | |
| (1) 888 SWIFT BLVD RICHLAND, WA 99352 91-6033089 | SUPPORT | WA | 501(C)(3) | 12,III | KRMC | Yes | |
| (2) 888 SWIFT BLVD RICHLAND, WA 99352 23-7005501 | SUPPORT | WA | 501(C)(3) | 12,I | KRMC | Yes | |
| (3) 1268 LEE BLVD RICHLAND, WA 99352 91-1266345 | HEALTHCARE | WA | 501(C)(3) | 10 | WHC | Yes | |
| (4) 888 SWIFT BLVD RICHLAND, WA 99352 91-0655392 | HEALTHCARE | WA | 501(C)(3) | 3 | WHC | Yes | |
| (5) 4101 TORRANCE BLVD TORRANCE, CA 90503 33-0844408 | IMAGING SVCS | CA | 501(C)(3) | 10 | PHS SOCAL | Yes | |
| (6) 5921 E BURNSIDE PORTLAND, OR 97215 91-1562797 | SUPPORT | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (7) 747 BROADWAY SEATTLE, WA 98122 91-2054035 | RESEARCH | WA | 501(C)(3) | 7 | SHS | Yes | |
| (8) 1200 12TH AVENUE S SEATTLE, WA 98144 56-2290878 | HEALTHCARE | WA | 501(C)(3) | 10 | WHC | Yes | |
| (9) 501 S BUENA VISTA STREET BURBANK, CA 91505 95-3544877 | HEALTHCARE | CA | 501(C)(3) | 7 | PHS SOCAL | Yes | |
| (10) 3300 PROVIDENCE DR TOWER 2 ANCHORAGE, AK 99508 92-0093565 | HEALTHCARE | AK | 501(C)(3) | 12,I | PHS WA | Yes | |
| (11) 540 SOUTH MAIN STREET MT ANGEL, OR 973629532 91-1940286 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (12) 1700 PROVIDENCE PL CENTRALIA, WA 98531 91-1789266 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (13) 830 NE 47TH PORTLAND, OR 97213 93-0800140 | SUPPORT | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (14) 1111 CRATER LAKE AVE MEDFORD, OR 97504 93-0692907 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (15) 1205 MONTELLO AVE HOOD RIVER, OR 97031 47-3385506 | SUPPORT | WA | 501(C)(3) | 7 | NA | | No |
| (16) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 94-3078543 | HEALTHCARE | WA | 501(C)(3) | 12,I | PHS WA | Yes | |
| (17) 4515 MLK JR WAY S STE 200 SEATTLE, WA 98108 31-1744654 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (18) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 91-1549796 | HEALTHCARE | WA | 501(C)(3) | 12,II | PSJH | | No |
| (19) 500 W BROADWAY PO BOX 4587 MISSOULA, MT 598064587 81-0231793 | HEALTHCARE | MT | 501(C)(3) | 3 | PHS WA | 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 |
| (61) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 51-0216587 | HEALTHCARE | OR | 501(C)(3) | 3 | PHS | Yes | |
| (1) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 51-0216586 | HEALTHCARE | WA | 501(C)(3) | 3 | PHS | Yes | |
| (2) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 91-1303277 | HEALTHCARE | WA | 501(C)(3) | 3 | PMWHC | Yes | |
| (3) 4400 NE HALSEY BLDG 2 PORTLAND, OR 97213 55-0828701 | MEDICAID | OR | 501(C)(4) | N/A | PHP | Yes | |
| (4) 101 W 8TH AVENUE SPOKANE, WA 99204 32-0014330 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (5) 914 S SCHEUBER ROAD CENTRALIA, WA 98531 91-1433382 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (6) 4400 NE HALSEY BLDG 2 PORTLAND, OR 97213 93-0863097 | HEALTHCARE | OR | 501(C)(4) | N/A | PPP | Yes | |
| (7) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 51-0216589 | HEALTHCARE | CA | 501(C)(3) | 3 | PHS | Yes | |
| (8) 811 13TH ST HOOD RIVER, OR 97031 93-0921990 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (9) 2731 WETMORE AVENUE STE 500 EVERETT, WA 98201 27-2552749 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (10) 425 PONTIUS AVENUE NORTH 300 SEATTLE, WA 980195452 91-2077378 | HEALTHCARE | WA | 501(C)(3) | 12,I | PHS WA | Yes | |
| (11) 4101 TORRANCE BLVD TORRANCE, CA 90503 51-0224944 | HEALTHCARE | CA | 501(C)(3) | 7 | PHS SOCAL | Yes | |
| (12) 3725 PROVIDENCE POINT DRIVE SE ISSAQUAH, WA 980297219 93-1554288 | HEALTHCARE | WA | 501(C)(3) | 12,I | PHS WA | Yes | |
| (13) 4101 TORRANCE BLVD TORRANCE, CA 90503 33-0283773 | HEALTHCARE | CA | 501(C)(3) | 12,I | PHS SOCAL | Yes | |
| (14) 10150 SE 32ND MILWAUKIE, OR 97222 94-3079515 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (15) 4831 35TH AVENUE SW SEATTLE, WA 981262799 91-1188119 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (16) 1001 PROVIDENCE DRIVE NEWBERG, OR 97132 93-0889144 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (17) 7101 38TH AVENUE SOUTH SEATTLE, WA 98118 31-1629656 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (18) 4400 NE HALSEY BLDG 2 PORTLAND, OR 97213 91-1861964 | HEALTHCARE | WA | 501(C)(4) | N/A | PHS OR | Yes | |
| (19) 4805 NE GLISAN STREET PORTLAND, OR 972132967 93-1231494 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | 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 |
| (81) 1700 PROVIDENCE PLACE CENTRALIA, WA 98531 31-1584166 | SUPPORT | WA | 501(C)(3) | 10 | PHS WA | Yes | |
| (1) 2121 SANTA MONICA BLVD SANTA MONICA, CA 90404 95-1684082 | HEALTHCARE | CA | 501(C)(3) | 3 | PHS SOCAL | Yes | |
| (2) 20555 EARL ST TORRANCE, CA 90503 81-4542216 | HEALTHCARE | CA | 501(C)(3) | Pending | PHS SOCAL | Yes | |
| (3) 725 S WAHANNA RD SEASIDE, OR 97138 93-0927320 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (4) 3201 SW GRAHAM ST SEATTLE, WA 98126 91-2171539 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (5) 3415 12TH AVENUE NE OLYMPIA, WA 98506 94-3244854 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (6) 1801 LIND AVENUE SW 9016 RENTON, WA 98057 81-1244422 | HEALTHCARE | WA | 501(C)(3) | 12,III | NA | | No |
| (7) PO BOX 1010 POLSON, MT 598601010 81-0463482 | HEALTHCARE | MT | 501(C)(3) | 3 | PHS WA | Yes | |
| (8) 401 W POPLAR STREET WALLA WALLA, WA 99362 45-2841492 | HEALTHCARE | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (9) 413 LILLY ROAD NE OLYMPIA, WA 985065166 91-1097056 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (10) 9205 SW BARNES ROAD PORTLAND, OR 97225 93-0575982 | HEALTHCARE | OR | 501(C)(3) | 7 | PHS OR | Yes | |
| (11) 5315 TORRANCE BLVD STE B1 TORRANCE, CA 90503 95-3264139 | HEALTHCARE | CA | 501(C)(3) | 10 | PHS SOCAL | Yes | |
| (12) 5315 TORRANCE BLVD STE B1 TORRANCE, CA 90503 33-0261016 | HEALTHCARE | CA | 501(C)(3) | 7 | PTCH | Yes | |
| (13) 1500 DIVISION STREET OREGON CITY, OR 97045 93-1003750 | HEALTHCARE | OR | 501(C)(3) | 12, I | PHS OR | Yes | |
| (14) 2121 SANTA MONICA BLVD SANTA MONICA, CA 90404 95-6100079 | SUPPORT | CA | 501(C)(3) | 7 | PSJHC | Yes | |
| (15) 550 17TH AVENUE SEATTLE, WA 98122 61-1502822 | PHYSN COLLAB | WA | 501(C)(3) | 7 | WHC | Yes | |
| (16) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 26-2612415 | SHELL CORP | MT | 501(C)(3) | 1 | PHS WA | | |
| (17) 350 WASHINGTON AVE SE CHEHALIS, WA 98352 94-3176618 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (18) 500 WEST BROADWAY PO BOX 4587 MISSOULA, MT 598064587 23-7056976 | HEALTHCARE | MT | 501(C)(3) | 7 | PHS WA | Yes | |
| (19) 1710 BENEFIS COURT GREAT FALLS, MT 59405 81-0233495 | EDUCATION | MT | 501(C)(3) | 10 | PHS WA | 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 |
| (101) 21601 76TH AVENUE EDMONDS, WA 98026 27-2305304 | HEALTHCARE | WA | 501(C)(3) | 3 | WHC | Yes | |
| (1) 747 BROADWAY SEATTLE, WA 98122 91-0433740 | HEALTHCARE | WA | 501(C)(3) | 3 | WHC | Yes | |
| (2) 747 BROADWAY SEATTLE, WA 98122 91-0983214 | HEALTHCARE | WA | 501(C)(3) | 7 | SHS | Yes | |
| (3) 747 BROADWAY SEATTLE, WA 98122 27-3139262 | HOLDING CO | WA | 501(C)(3) | 12,I | SHS | Yes | |
| (4) 312 NORTH FOURTH STREET YAKIMA, WA 98901 91-1180824 | SUPPORT | WA | 501(C)(3) | 7 | PHS WA | Yes | |
| (5) 540 23RD STREET OAKLAND, CA 94612 91-1293869 | SUPPORT | CA | 501(C)(3) | 10 | PHS SOCAL | Yes | |
| (6) 5520 NE GLISAN PORTLAND, OR 97213 91-1214491 | SUPPORT | OR | 501(C)(3) | 10 | PHS OR | Yes | |
| (7) 1301 20TH STREET SOUTH GREAT FALLS, MT 59405 81-0231777 | EDUCATION | MT | 501(C)(3) | 2 | PHS | Yes | |
| (8) 747 BROADWAY SEATTLE, WA 98122 45-4171900 | SHELL CORP | WA | 501(C)(3) | 12,II | PHS W WA | Yes | |
| (9) 1801 LIND AVENUE SW 9016 RENTON, WA 980579016 | RELIGIOUS ORG | WA | 501(C)(3) | 1 | NA | | No |

| Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|----------------------------------------|----|----------------------------------------------------------------------|----------------------------------------------|----|--------------------------------|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
| | | | | | | | Yes | No | | Yes | No | |
| (1) ADVANCED SURGERY INSTITUTE LLC 1739 4TH STREET SANTA ROSA, CA 95404 26-2299255 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (1) COVENANT LONG-TERM CARE LP 4000 24TH STREET LUBBOCK, TX 79410 20-5033419 | HEALTHCARE | TX | NA | N/A | | | | | | | | |
| (2) HERITAGE INVESTMENT GROUP I LLC 500 S MAIN STREET STE 1000 ORANGE, CA 92868 27-1000061 | INVESTMENTS | CA | NA | N/A | | | | | | | | |
| (3) HOAG ORTHOPEDIC INSTITUTE 1 HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 61-1588294 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (4) METHODIST DIAGNOSTIC IMAGING 4005 24TH STREET LUBBOCK, TX 79410 75-2343261 | HEALTHCARE | TX | NA | N/A | | | | | | | | |
| (5) NEWPORT IMAGING CENTER 360 SN MIGUEL NEWPORT BEACH, CA 92660 33-0191776 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (6) SHA LLC 12940 NORTH HIGHWAY 183 AUSTIN, TX 78750 75-2569094 | HEALTHCARE | TX | NA | N/A | | | | | | | | |
| (7) ST JOSEPH PHYSICIAN VENTURES I LLC 1100 WEST STEWART DRIVE ORANGE, CA 92868 45-4521884 | REAL ESTATE | CA | NA | N/A | | | | | | | | |
| (8) NORTH BAY ENDOSCOPY CENTER 1383 N MCDOWELL BLVD SUITE 110 PETALUMA, CA 94954 61-1559876 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (9) SOUTHERN CALIFORNIA SURGERY CENTER LLC 18321 VENTURA BLVD STE 740 TARZANA, CA 91356 33-0939000 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (10) COASTAL ASC HOLDINGS LLC ONE HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92664 81-0986844 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (11) ST JOSEPHSATELLITE DIALYSIS CENTERS 300 SANTANA ROW SUITE 300 SAN JOSE, CA 95128 81-4657391 | HEALTHCARE | CA | NA | N/A | | | | | | | | |
| (12) ALPHA MEDICAL LABORATORY LLC 611 N PERRY SPOKANE, WA 99202 91-2017347 | OUTPATIENT LAB | ID | NA | N/A | | | | | | | | |
| (13) BROADWAY IMAGING LLC 500 W BROADWAY MISSOULA, MT 59802 52-2405971 | MEDICAL IMAGING | MT | NA | N/A | | | | | | | | |
| (14) CALIFORNIA LABORATORY ASSOCIATES LLC 501 BUENA VISTA BURBANK, CA 91505 27-3888692 | OUTPATIENT LAB | CA | NA | N/A | | | | | | | | |

| Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|----------------------------------------|----|----------------------------------------------------------------------|----------------------------------------------|----|--------------------------------|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproprtionate allocations? | | (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 | |
| (16) CENTER FOR SPECIALTY SURGERY LLC 11782 SW BARNES RD PORTLAND, OR 97225 26-3638838 | AMBULATORY SURG | OR | NA | N/A | | | | | | | | |
| (1) CLACKAMAS RADIATION ONCOLOGY CENTER LLC 4400 NE HALSEY ST BLDG II 495 PORTLAND, OR 97213 26-0381897 | RADIATION ONCOL | OR | NA | N/A | | | | | | | | |
| (2) CTR FOR MED IMAGING- BRIDGEPORT LLC 4400 NE HALSEY 495 PORTLAND, OR 97213 26-0796953 | IMAGING DIAG | OR | NA | N/A | | | | | | | | |
| (3) CTR FOR MED IMAGING- TANASBOURNE LLC 4400 NE HALSEY 495 PORTLAND, OR 97213 20-0477972 | IMAGING DIAG | OR | NA | N/A | | | | | | | | |
| (4) GREATER VALLEY MEDICAL BUILDING LP 501 S BUENA VISTA ST BURBANK, CA 91505 95-4570858 | REAL ESTATE - MOB | CA | NA | N/A | | | | | | | | |
| (5) MINOR & JAMES MEDICAL PLLC 515 MINOR AVENUE 200 SEATTLE, WA 98104 91-1340223 | PHYSICIAN CLINIC | WA | NA | N/A | | | | | | | | |
| (6) MOUNTAINSTAR CLINICAL LABORATORIES LLC 611 N PERRY SPOKANE, WA 99202 26-1345983 | OUTPATIENT LAB | MT | NA | N/A | | | | | | | | |
| (7) OREGON ADVANCED IMAGING LLC 881 OHARE PARKWAY MEDFORD, OR 97504 45-0471748 | MEDICAL IMAGING | OR | NA | N/A | | | | | | | | |
| (8) OREGON OUTPATIENT SURGERY CENTER 7300 SW CHILDS RD TIGARD, OR 97224 22-3883387 | AMBULATORY SURG | OR | NA | N/A | | | | | | | | |
| (9) PACLAB LLC 611 N PERRY SPOKANE SPOKANE, WA 99202 91-1743952 | OUTPATIENT LAB | WA | NA | N/A | | | | | | | | |
| (10) PATHOLOGY ASSOCIATES MEDICAL LABORATORIE 611 N PERRY SPOKANE SPOKANE, WA 99202 27-0943279 | OUTPATIENT LAB | WA | NA | N/A | | | | | | | | |
| (11) PETCT IMAGING AT SWEDISH CANCER INSTITU 1221 MADISON STREET SEATTLE, WA 98104 20-3132044 | MEDICAL IMAGING | WA | NA | N/A | | | | | | | | |
| (12) PORTLAND MEDICAL IMAGING LLC 4400 NE HALSEY PORTLAND, OR 97213 20-1054971 | IMAGING DIAGNOSTI | OR | NA | N/A | | | | | | | | |
| (13) PROV RADIATION ONCOLOGY DEVELOP ASSN 4400 NE HALSEY PORTLAND, OR 97213 26-0682491 | REAL ESTATE - MOB | OR | NA | N/A | | | | | | | | |
| (14) PROVIDENCE IMAGING CENTER 3340 PROVIDENCE DRIVE ANCHORAGE, AK 99508 92-0118807 | MEDICAL IMAGING | AK | NA | N/A | | | | | | | | |

| Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|----------------------------------------|----|-------------------------------------------------------------------------|----------------------------------------------|----|--------------------------------|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproprtionate allocations? | | (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 | |
| (31) PROVIDENCE PARTNERS FOR HEALTH LLC 501 S BUENA VISTA ST BURBANK, CA 91505 45-4041798 | CLIN QUALITY/INT | CA | NA | N/A | | | | | | | | |
| (1) PROVIDENCE SURGERY CENTER LLC 902 N ORANGE ST MISSOULA, MT 59802 84-1401625 | AMBULATORY SURG | MT | NA | N/A | | | | | | | | |
| (2) PROVIDENCESILVERTON REHAB LLC 4400 NE HALSEY 425 PORTLAND, OR 97213 48-1287267 | REHAB SERVICES | OR | NA | N/A | | | | | | | | |
| (3) PROVIDENCEUSP SANTA CLARITA GP LLC 11550 INDIAN HILLS ROAD MISSION HILLS, CA 91345 20-2829660 | AMBULATORY SURG | CA | NA | N/A | | | | | | | | |
| (4) PROVIDENCEUSP SURGERY CTRS LLC 11550 INDIAN HILLS ROAD MISSION HILLS, CA 91345 20-0905938 | AMBULATORY SURG | CA | NA | N/A | | | | | | | | |
| (5) SOUTHERN IDAHO REGIONAL LABORATORY LLC 611 N PERRY SPOKANE SPOKANE, WA 99202 82-0511819 | OUTPATIENT LAB | ID | NA | N/A | | | | | | | | |
| (6) THE MADISON SPOKANE INN LLC 15 WEST ROCKWOOD BLVD SPOKANE, WA 99204 84-1606484 | HOTEL SERVICES | WA | NA | N/A | | | | | | | | |
| (7) TRI-CITIES LABORATORY LLC 611 N PERRY SPOKANE, WA 99202 91-1773986 | OUTPATIENT LAB | WA | NA | N/A | | | | | | | | |
| (8) HCSA PROPERTIES LLC 1600 M STREET NW AUBURN, WA 98001 46-0620892 | REAL ESTATE RENT | WA | NA | N/A | | | | | | | | |
| (9) PHS INVESTMENT TRUST HEDGE FUND PORTFOLI 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2293255 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (10) PHS INVESTMENT TRUST BANK LOANS PORTFOLI 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2357735 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (11) PHS INVESTMENT TRANSITION PORTFOLIO 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2279711 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (12) PHS INVESTMENT TRUST RISK PARITY PORTFOL 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2336377 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (13) PHS INVESTMENT TRUST LONG TREASURIES POR 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2385238 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (14) PHS INVESTMENT TRUST MLP PORTFOLIO 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2367538 | INVESTMENTS | WA | NA | N/A | | | | | | | | |

| Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|----------------------------------------|----|----------------------------------------------------------------------|----------------------------------------------|----|--------------------------------|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproprtionate allocations? | | (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 | |
| (46) PHS INVESTMENT TRUST RELATIVE VALUE PORT 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2314743 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (1) PHS INVESTMENT TRUST TIPS PORTFOLIO 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2402609 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (2) PHS INVESTMENT TRUST PUBLIC EQUITY PORTF 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2283974 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (3) PHS INVESTMENT TRUST LDI PORTFOLIO 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2392060 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (4) PHS INVESTMENT TRUST PUBLIC DEBT PORTFOL 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2353569 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (5) PHS INVESTMENT TRUST TACTICAL TRADING PO 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2327491 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (6) PHS INVESTMENT TRUST COMMODITIES PORTFOL 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-2269004 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (7) PHS INVESTMENT TRUST 2015 PRIVATE ASSETS 1801 Lind Avenue SW No 9016 Renton, WA 98057 47-3393740 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (8) PHS INVESTMENT TRUST SHORT TERM INVESTME 1801 Lind Avenue SW No 9016 Renton, WA 98057 81-2701056 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (9) PHS INVESTMENT TRUST 2016 PRIVATE ASSETS 1801 Lind Avenue SW No 9016 Renton, WA 98057 81-1532735 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (10) PHS INVESTMENT TRUST 2016 PRIVATE REAL E 1801 Lind Avenue SW No 9016 Renton, WA 98057 81-2960145 | INVESTMENTS | WA | NA | N/A | | | | | | | | |
| (11) LSC REAL PROPERTY LLC 2301 QUAKER AVENUE LUBBOCK, TX 79410 47-4646059 | REAL ESTATE | TX | NA | N/A | | | | | | | | |
| (12) CALIFORNIA SPECIALTY SURGERY CENTER LP 26371 CROWN VALLEY PARKWAY MISSION VIEJO, CA 92691 33-0939003 | HEALTHCARE | CA | NA | N/A | | | | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of- year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|-------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------------|--------------------------------------------------------|---------------------------------|-------------------------------------------|--------------------------------|--------------------------------------------------------|----|
| | | | | | | | | Yes | No |
| (1) AMERICAN UNITY GROUP LTD 90 PITTS BAY ROAD PEMBROKE HM08 BD | CAPTIVE INSURANCE | BD | NA | C-CORP | | | | | |
| (1) COASTAL MANAGEMENT SERVICES ORGANIZATION 1 HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 33-0676831 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (2) DATU HEALTH INC AND SUBSIDIARIES 16150 MAIN CIRCLE DR SUITE 250 CHESTERFIELD, MO 63017 46-3070062 | IT SVCS | DE | NA | C-CORP | | | | | |
| (3) HOAG MANAGEMENT SERVICES INC 1 HOAG DRIVE BOX 6100 NEWPORT BEACH, CA 92658 33-0731587 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (4) LUBBOCK METHODIST HOSP PRACTICE MGMT 2107 OXFORD STREET STE 300 LUBBOCK, TX 79410 75-2578995 | INACTIVE | TX | NA | C-CORP | | | | | |
| (5) LUBBOCK METHODIST HOSPITAL SVCS PO BOX 1201 LUBBOCK, TX 79410 75-2118585 | HEALTHCARE | TX | NA | C-CORP | | | | | |
| (6) MISSION VIEJO MEDICAL VENTURES 27800 MEDICAL CENTER RD MISSION VIEJO, CA 92691 33-0212905 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (7) ST JOSEPH HEALTH 3345 MICHELSON DRIVE SUITE 100 IRVINE, CA 92612 46-2340232 | HOLDING COMPANY | CA | NA | C-CORP | | | | | |
| (8) ST JOSEPH HEALTH SOURCE INC 3345 MICHELSON DRIVE SUITE 100 IRVINE, CA 92612 46-1900168 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (9) ST JOSEPH PROF SVCS ENTERPRSES INC 3345 MICHELSON DRIVE SUITE 100 IRVINE, CA 92612 33-0155323 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (10) OPHIE HEALTHCARE SERVICES INC 3345 MICHELSON DRIVE SUITE 100 IRVINE, CA 92612 27-1002825 | HEALTHCARE | CA | NA | C-CORP | | | | | |
| (11) PROVIDENCE HEALTH VENTURES INC 4101 TORRANCE BLVD TORRANCE, CA 90503 33-0122216 | INVESTMENT | CA | NA | C-CORP | | | | | |
| (12) CARON HEALTH CORPORATION 510 W FRONT ST MISSOULA, MT 59802 81-0486082 | MED PHYS SVCS | MT | NA | C-CORP | | | | | |
| (13) PROVIDENCE HEALTH CARE VENTURES INC 101 W 8TH AVE TAF C-9 SPOKANE, WA 99204 90-0155714 | CLIN/MED LAB | WA | NA | C-CORP | | | | | |
| (14) PROVIDENCE PHYSICIAN SERVICES CO 101 W 8TH AVE TAF C-9 SPOKANE, WA 99204 91-1216033 | CLIN/MED LAB | WA | NA | C-CORP | | | | | |

| 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 |
| (16) YAKIMA MEDICAL ARTS INC 611 N PERRY 100 SPOKANE, WA 99202 91-0787963 | RENT REAL ESTATE | WA | NA | C-CORP | | | | | |
| (1) BOURGET HEALTH SERVICES INC PO BOX 2687 SPOKANE, WA 99220 91-1354431 | CLIN/MED LAB | WA | NA | C-CORP | | | | | |
| (2) 1221 MADISON STREET OWNERS ASSOC 747 BROADWAY SEATTLE, WA 98122 20-1954319 | OWNERS' ASSOC | WA | NA | C-CORP | | | | | |
| (3) WESTERN HEALTHCONNECT VENTURES INC 1801 LIND AVE SW 9016 RENTON, WA 98057 80-0953654 | INVESTMENTS | WA | NA | C-CORP | | | | | |
| (4) PHN HOLDINGS 20555 EARL STREET TORRANCE, CA 90503 46-1814184 | STRAT PLAN SVCS | CA | NA | C-CORP | | | | | |
| (5) PROVIDENCE HEALTH NETWORK 20555 EARL STREET TORRANCE, CA 90503 80-0886966 | PREPAID HEALTH | CA | NA | C-CORP | | | | | |
| (6) PIONEER INNOVATIONS INC 800 5TH AVE 10TH FLOOR SEATTLE, WA 98104 36-4818191 | HEALTH INNOVATNS | WA | NA | C-CORP | | | | | |
| (7) VINSERRA INC 1328 22ND STREET SANTA MONICA, CA 90403 95-3943315 | INVESTMENTS | CA | NA | C-CORP | | | | | |
| (8) CHARITABLE REMAINDER TRUST (1) | SUPPORT | CA | NA | TRUST | | | | | |