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

CHANGE OF ACCOUNTING PERIOD

Return of Organization Exempt From Income Tax

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

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

Go to www.irs.gov/Form990 for instructions and the latest information

OMB No 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 07/01, 2017, and ending 12/31, 2017	
B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization ST. JOSEPH HOSPITAL OF ORANGE Doing business as Number and street (or P O box if mail is not delivered to street address) Room/suite 1100 WEST STEWART DRIVE City or town state or province country, and ZIP or foreign postal code ORANGE, CA 92868 F Name and address of principal officer JEREMY ZOCH 1100 WEST STEWART DR ORANGE, CA 92868 I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no) 4947(a)(1) of 527 J Website WWW.SJO.ORG K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <input type="checkbox"/> L Year of formation 1941 M State of legal domicile CA
D Employer identification number 95-1643359 E Telephone number (714) 771-8000 G Gross receipts \$ 328,164,993. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No" attach a list (see instructions) H(c) Group exemption number 0928	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of all or substantially all of its assets in 25% of its net assets		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	18.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	15.
	5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5	3,393.
	6 Total number of volunteers (estimate if necessary)	6	935.
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,027,731.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	9,575,421.	3,893,264.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	636,471,924.	318,861,225.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c and 11e)	9,042,594.	4,398,622.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	-109,524.	-242,463.
	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	654,980,415.	326,910,648.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	4,509,913.	2,582,848.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	270,181,278.	138,306,347.
	b Total fundraising expenses (Part IX, column (D), line 25)	0.	0.
Expenses	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	2,015,783.	
	18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	206,823,782.	184,621,192.
	19 Revenue less expenses Subtract line 18 from line 12	321,514,973.	325,510,387.
	20 Total assets (Part X, line 16)	176,534,558.	1,400,261.
Net Assets or Fund Balances	21 Total liabilities (Part X, line 26)	Beginning of Current Year	End of Year
	22 Net assets or fund balances Subtract line 21 from line 20	749,680,200.	778,488,105.
		479,411,667.	525,162,412.

Part II Signature Block

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

Sign Here	Signature of officer	Date			
	Kristi Liberatore, CFO, St Joseph Hospital, Orange	11/12/18			
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	KARA ADAMS	Kara Adams	11/06/18		P00023315
	Firm's name ERNST & YOUNG U.S. LLP	Firm's EIN 34-6565596			
	Firm's address 18101 VON KARMAI AVENUE, SUITE 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

Form 990 (2017)

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

AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY
OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE
POOR AND VULNERABLE.

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 \$ 307,719,096 including grants of \$ 2,582,848) (Revenue \$ 318,861,225)
SEE SCHEDULE O

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 ▶ 307,719,096.

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 X	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 X	
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	X
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 X	
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	X
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	X
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	X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III.	8	X
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	X
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 X	
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 X	
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	X
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	X
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	X
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X.	11e X	
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	X
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII.	12a	X
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 X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E.	13	X
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	X
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	X
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	X
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	X
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	X
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 X	
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 X	

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H.	<input checked="" type="checkbox"/>	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<input checked="" type="checkbox"/>	
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.	<input checked="" type="checkbox"/>	
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.	<input checked="" type="checkbox"/>	
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.	<input checked="" type="checkbox"/>	
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.		<input checked="" type="checkbox"/>
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV.		<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M.	<input checked="" type="checkbox"/>	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M.	<input checked="" type="checkbox"/>	
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I.		<input checked="" type="checkbox"/>
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<input checked="" type="checkbox"/>	
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.	<input checked="" type="checkbox"/>	
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.		<input checked="" type="checkbox"/>
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.		<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>	

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☒ **X**

	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?	X	
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. 2a 3,393		
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).	X	
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	X	
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)?		X
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?		X
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
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?		X
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
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?	X	
b If "Yes," did the organization notify the donor of the value of the goods or services provided?	X	
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
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?		X
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	X	
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?		
9 Sponsoring organizations maintaining donor advised funds.		
a Did the sponsoring organization make any taxable distributions under section 4966?		
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
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?		
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		
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?		X
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		

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

Section A. Governing Body and Management

	Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O	18	
1b Enter the number of voting members included in line 1a, above, who are independent	15	
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?		X
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? . .		X
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5 Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6 Did the organization have members or stockholders?	X	
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?	X	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
a The governing body?	X	
b Each committee with authority to act on behalf of the governing body?	X	
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		X

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?		X
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? . . .		
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	X	
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	X	
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
13 Did the organization have a written whistleblower policy?	X	
14 Did the organization have a written document retention and destruction policy?	X	
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		X
b Other officers or key employees of the organization	X	
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?	X	
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?	X	

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 Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 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 ►
 KRISTI LIBERATORE 1100 WEST STEWART DRIVE ORANGE, CA 92868 714-771-8000

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII. ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) JEREMY ZOCH TRUSTEE, EX OFFICIO, CEO	50.00 0.	X		X				0.	621,492.	34,951.
(2) JO ANN ESCASA-HAIGH BD MBR/EVP ASSIST TREAS (SJHS)	2.00 58.00	X						0.	1,372,090.	667,685.
(3) WILLIAM J. CAMPBELL TRUSTEE	2.00 0.	X						0.	0.	0.
(4) MICHELE CARPENTER, MD TRUSTEE, EX OFFICIO, COS	5.00 0.	X						0.	0.	0.
(5) KENNETH COSGROVE TRUSTEE	2.00 0.	X						0.	0.	0.
(6) CESAR COVARRUBIAS TRUSTEE	2.00 0.	X						0.	0.	0.
(7) SR. MARTHA ANN FITZPATRICK CSJ TRUSTEE	2.00 0.	X						0.	0.	0.
(8) MARY ANNE FOO TRUSTEE	2.00 0.	X						0.	0.	0.
(9) JUDI (JUDITH) GORSKI TRUSTEE, VICE CHAIR	5.00 0.	X						0.	0.	0.
(10) MIKE W. IMMELL TRUSTEE	2.00 0.	X						0.	0.	0.
(11) SUDEEP KUKREJA, MD TRUSTEE	2.00 0.	X						0.	0.	0.
(12) SR. CECILIA MAGLADRY, CSJ TRUSTEE	2.00 0.	X						0.	0.	0.
(13) RUSSELL MONTGOMERY TRUSTEE, EX OFFICIO, VICE COS	5.00 0.	X						32,101.	0.	0.
(14) STEPHEN PIHL TRUSTEE, EX OFFICIO, FND CHAIR	2.00 0.	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) FRANK QUEVEDO ----- TRUSTEE	2.00 0.	X						0.	0.	0.
16) SR. SUZANNE SASSUS, CSJ ----- TRUSTEE	2.00 0.	X						0.	0.	0.
17) JOHN TANGREDI ----- TRUSTEE, BOARD CHAIR	5.00 0.	X						0.	0.	0.
18) CHRISTOPHER A. WILLS, MD ----- TRUSTEE	2.00 0.	X						0.	0.	0.
19) LINDA SIMON ----- VP MISSION INTEGRATION	50.00 0.			X				349,366.	0.	31,084.
20) KRISTI LIBERATORE ----- CHIEF FINANCIAL OFFICER	50.00 0.			X				472,331.	0.	31,994.
21) TARA COWELL ----- SECRETARY/VP ASSOC GEN COUNSEL	2.00 50.00			X				0.	447,728.	55,157.
22) THOMAS HILL ----- VP OPERATIONS GENERAL SERVICES	50.00 0.				X			443,086.	0.	54,636.
23) CATHERINE SKELTON ----- VP PATIENT CARE SERVICES/CNO	50.00 0.				X			474,688.	0.	44,736.
24) SCOTT RUSK ----- CHIEF MEDICAL OFFICER	50.00 0.				X			358,821.	0.	12,333.
25) ARMINDER KAHLOH ----- LEAD CARDIOVASCULAR TECH	50.00 0.					X		242,863.	0.	47,120.
1b Sub-total								32,101.	1,993,582.	702,636.
c Total from continuation sheets to Part VII, Section A								3,947,010.	2,085,170.	479,149.
d Total (add lines 1b and 1c)								3,979,111.	4,078,752.	1,181,785.

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 **669**

3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual

	Yes	No
3	X	
4	X	
5		X

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **40**

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

[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 ▶ 669

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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	572,686			
	d	Related organizations	1d	689,491			
	e	Government grants (contributions)	1e	29,215			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	2,601,872			
	g	Noncash contributions included in lines 1a-1f \$		63,047			
	h	Total. Add lines 1a-1f		3,893,264			
Program Service Revenue	2a	NET PATIENT SERVICES	Business Code 622210	308,244,384	308,244,384		
	b	340B DRUG DISCOUNT PROGRAM REVENUE	622210	3,225,725	3,225,725		
	c	LEASE REVENUE	531110	2,240,752	2,240,752		
	d	CAFETERIA REVENUE	722514	869,447	869,447		
	e	PARKING REVENUE	900099	721,961	721,961		
	f	All other program service revenue		3,558,956	2,531,225	1,027,731	
	g	Total. Add lines 2a-2f		318,861,225			
	Other Revenue	3	Investment income (including dividends, interest, and other similar amounts).		2,104,789		
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)					
d		Net rental income or (loss)		0			
7a		Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
				3,175,876			
b		Less cost or other basis and sales expenses					
				882,043			
c		Gain or (loss)					
				2,293,833			
d		Net gain or (loss)		2,293,833			2,293,833
8a		Gross income from fundraising events (not including \$ 572,686 of contributions reported on line 1c) See Part IV, line 18	a	95,339			
b		Less direct expenses	b	372,302			
c		Net income or (loss) from fundraising events		-276,963			-276,963
9a		Gross income from gaming activities See Part IV, line 19	a	34,500			
b	Less direct expenses	b					
c	Net income or (loss) from gaming activities		34,500			34,500	
10a	Gross sales of inventory, less returns and allowances	a					
b	Less cost of goods sold	b					
c	Net income or (loss) from sales of inventory		0				
Miscellaneous Revenue		Business Code					
11a							
b							
c							
d	All other revenue						
e	Total. Add lines 11a-11d		0				
12	Total revenue. See instructions		326,910,648	317,833,494	1,027,731	4,156,159	

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	2,564,976.	2,564,976.		
2 Grants and other assistance to domestic individuals See Part IV, line 22	17,872.	17,872.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	1,918,014.	1,803,768.	114,246.	
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.			
7 Other salaries and wages	93,905,493.	87,247,528.	5,814,842.	843,123.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,040,365.	5,718,684.	269,735.	51,946.
9 Other employee benefits	28,627,757.	26,231,616.	2,180,501.	215,640.
10 Payroll taxes	7,814,718.	7,387,791.	358,483.	68,444.
11 Fees for services (non-employees)				
a Management	21,758,810.	21,758,810.		
b Legal	847,909.		846,446.	1,463.
c Accounting	0.			
d Lobbying	27,510.	27,510.		
e Professional fundraising services See Part IV, line 17.	0.			
f Investment management fees	354,822.		354,822.	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). ATTCH 2	34,343,611.	32,650,871.	1,603,670.	89,070.
12 Advertising and promotion	105,914.	105,914.		
13 Office expenses	4,345,263.	3,772,495.	536,720.	36,048.
14 Information technology	1,421,748.	1,421,748.		
15 Royalties	0.			
16 Occupancy	11,356,942.	11,261,719.	95,223.	
17 Travel	179,861.	94,803.	80,986.	4,072.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	49,622.	19,672.	29,935.	15.
20 Interest	6,884,560.	6,409,157.	418,648.	56,755.
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	15,236,374.	14,334,678.	837,262.	64,434.
23 Insurance	1,812,181.	1,812,181.		
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 HOSPITAL FEE	18,409,236.	18,409,236.		
b MEDICAL SUPPLIES	60,784,428.	60,784,428.		
c HOAG FEES	3,350,522.	3,350,522.		
d SPONSORSHIPS	1,921,862.	6,261.	1,915,601.	
e All other expenses	1,430,017.	526,856.	322,388.	580,773.
25 Total functional expenses. Add lines 1 through 24e	325,510,387.	307,719,096.	15,779,508.	2,011,783.
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 X. ☐

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	2,186,813.	1	5,667,948.
	2 Savings and temporary cash investments	27,348,052.	2	6,571,850.
	3 Pledges and grants receivable, net	0.	3	0.
	4 Accounts receivable, net	57,958,596.	4	58,062,029.
	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	188,361.	7	483,118.
	8 Inventories for sale or use	10,545,652.	8	10,342,389.
	9 Prepaid expenses and deferred charges	2,310,589.	9	8,307,804.
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 903,591,079.		
	b Less accumulated depreciation.	10b 497,911,150.		
		412,878,280.	10c	405,679,929.
	11 Investments - publicly traded securities	217,003,942.	11	255,360,286.
	12 Investments - other securities. See Part IV, line 11	0.	12	0.
	13 Investments - program-related See Part IV, line 11	12,932,470.	13	12,339,014.
14 Intangible assets	600,000.	14	450,000.	
15 Other assets See Part IV, line 11	5,727,445.	15	15,223,738.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	749,680,200.	16	778,488,105.	
Liabilities	17 Accounts payable and accrued expenses	89,487,519.	17	138,532,487.
	18 Grants payable	0.	18	0.
	19 Deferred revenue	2,325,791.	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	176,000.	24	176,000.
	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	387,422,357.	25	386,453,925.
	26 Total liabilities. Add lines 17 through 25	479,411,667.	26	525,162,412.
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	243,890,728.	27	224,596,716.
	28 Temporarily restricted net assets	18,464,204.	28	20,625,092.
	29 Permanently restricted net assets	7,913,601.	29	8,103,885.
	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	270,268,533.	33	253,325,693.	
34 Total liabilities and net assets/fund balances	749,680,200.	34	778,488,105.	

Form **990** (2017)

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI. ☒ X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	326,910,648.
2	Total expenses (must equal Part IX, column (A), line 25)	2	325,510,387.
3	Revenue less expenses Subtract line 2 from line 1	3	1,400,261.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	270,268,533.
5	Net unrealized gains (losses) on investments	5	10,102,675.
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	-28,445,776.
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	253,325,693.

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII ☐

- 1** Accounting method used to prepare the Form 990 ☐ Cash ☒ Accrual ☐ Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O

- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis

- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both
☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis

- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? 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?
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	No
2a		X
2b	X	
2c	X	
3a	X	
3b	X	

Form **990** (2017)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2017

Open to Public
Inspection:

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions

The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ))
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state _____
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions) Enter the name, city, and state of the college or university _____
- 10 ☐ An organization that normally receives (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III)
- 11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**.
Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
 - a ☐ **Type I** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
 - b ☐ **Type II** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
 - c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
 - d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
 - e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations.
 - g Provide the following information about the supported organization(s).

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

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

Section A. Public Support

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

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)).	14	%
15 Public support percentage from 2016 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
b 33 1/3% support test - 2016. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10%-facts-and-circumstances test - 2017. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
b 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<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"/>

Schedule A (Form 990 or 990-EZ) 2017

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

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

Section A. Public Support

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

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 Total support. (Add lines 9, 10c, 11, and 12)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2017. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization. ☐

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).

Schedule A (Form 990 or 990-EZ) 2017

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

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

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

Schedule A (Form 990 or 990-EZ) 2017

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.)

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

- **Complete if the organization is described below.** ► **Attach to Form 990 or Form 990-EZ.**
► **Go to www.irs.gov/Form990 for instructions and the latest information.**

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 organization ST. JOSEPH HOSPITAL OF ORANGE	Employer identification number 95-1643359
---	--

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955. ► \$
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ► \$
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
- 4a Was a correction made?
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-
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

Schedule C (Form 990 or 990-EZ) 2017

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount Enter the amount from the following table in both columns															
<table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a. If zero or less, enter -0-															
i Subtract line 1f from line 1c. If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No													

4-Year Averaging Period Under section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below.

See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(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					

Schedule C (Form 990 or 990-EZ) 2017

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?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		27,510.
j Total Add lines 1c through 1i			27,510.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
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 campaign activity expenditures from the prior year?	3	

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

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

Part IV Supplemental Information

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

OTHER ACTIVITIES

THE LOBBYING EXPENDITURES REPORTED REPRESENTS THE PORTION OF DUES

ALLOCATED TO ST. JOSEPH HOSPITAL OF ORANGE.

Part IV Supplemental Information *(continued)*

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes" on Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2017

Open to Public
Inspection

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year) . .		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7

1 Purpose(s) of conservation easements held by the organization (check all that apply)

<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education)	<input type="checkbox"/> Preservation of a 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	

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 Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8

- 1a If the organization elected, as permitted under 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.

Schedule D (Form 990) 2017

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 **d** ☐ Loan or exchange programs
- b** ☐ Scholarly research **e** ☐ Other _____
- c** ☐ Preservation for future generations
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

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

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 | 24,124,999. | 21,121,773. | 20,648,875. | 19,797,682. | 17,512,898. |
| b Contributions | 182,523. | 289,315. | 913,878. | 402,310. | 313,832. |
| c Net investment earnings, gains, and losses | 1,676,240. | 2,722,845. | -298,769. | 501,968. | 2,887,978. |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | 96,087. | 8,934. | 142,211. | 53,085. | 917,026. |
| f Administrative expenses | | | | | |
| g End of year balance | 25,887,675. | 24,124,999. | 21,121,773. | 20,648,875. | 19,797,682. |
- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ☐ 68.7000 %
- b** Permanent endowment ☐ 31.3000 %
- c** Temporarily restricted endowment ☐ %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | Yes | No |
|---|---------------|----|
| (i) unrelated organizations | 3a(i) | X |
| (ii) related organizations | 3a(ii) | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

- | Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 22,771,660. | | 22,771,660. |
| b Buildings | | 565,224,110. | 249,185,515. | 316,038,595. |
| c Leasehold improvements | | 2,453,229. | 1,527,787. | 925,442. |
| d Equipment | | 290,554,890. | 247,197,848. | 43,357,042. |
| e Other | | 22,587,190. | | 22,587,190. |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) | | | | 405,679,929. |

Schedule D (Form 990) 2017

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.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) INTERCOMPANY W/ HEALTH SYSTEM BONDS	299,539,020.
(3) CAPITAL LEASE OBLIGATION	65,119,525.
(4) PAYABLE TO AFFILIATES	8,021,916.
(5) PAYABLE TO HOMG	4,166,668.
(6) PAYABLE TO THIRD PARTY PAYORS	3,836,889.
(7) FUNDS HELD IN TRUST	3,521,447.
(8) NON CURRENT LIABILITIES	2,137,584.
(9) DEPOSITS FROM MOB AND OFFSITES	110,876.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ►	386,453,925.

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

SCHEDULE D, PART V, LINE 4

THE ENDOWMENT FUNDS MAINTAINED BY THE HOSPITAL ARE INTENDED TO SUPPORT

THE MISSION OF THE HOSPITAL, INCLUDING ACQUISITION OF BUILDINGS AND

EQUIPMENT, AND SUPPORT OF VARIOUS HOSPITAL PROGRAMS, RESEARCH, EDUCATION

AND COMMUNITY OUTREACH.

Part XIII Supplemental Information *(continued)*

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.

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		CELEBRATION (event type)	(event type)	(total number)	(add col (a) through col (c))
Revenue	1 Gross receipts	668,025.			668,025.
	2 Less. Contributions	572,686.			572,686.
	3 Gross income (line 1 minus line 2).	95,339.			95,339.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	6,880.			6,880.
	7 Food and beverages	90,288.			90,288.
	8 Entertainment	205,000.			205,000.
	9 Other direct expenses	70,134.			70,134.
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				372,302.
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				-276,963.

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.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	1 Gross revenue			34,500.	34,500.
	2 Cash prizes				
Direct Expenses	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 checked="" type="checkbox"/> Yes 100.0000 % <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) ▶				34,500.

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

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

b If "No," explain:

THE ORGANIZATION IS NOT REQUIRED TO REGISTER WITH THE CALIFORNIA ATTORNEY GENERAL'S OFFICE.

10 a 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 | 100.0000 % |
- 14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ▶ JOHN KOHL, DIRECTOR OF FOUNDATION FINANCE

Address ▶ 1010 W. LA VETA AVENUE, SUITE 300 ORANGE, CA 92668

- 15 a** 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 ▶ SHANNON KING, MANAGER OF FUNDRAISING

Gaming manager compensation ▶ \$ _____ 200.

Description of services provided ▶ RAFFLE ORGANIZING

☐ 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 to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ 31,050.

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

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

► Attach to Form 990.

► Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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	X	
1b If "Yes," was it a written policy?	X	
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	X	
<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	X	
<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 500.0000 %		
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"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
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?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

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)			2,539,442.		2,539,442.	.76
b Medicaid (from Worksheet 3, column a)			73,243,888.	35,220,024.	38,023,864.	11.43
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			75,783,330.	35,220,024.	40,563,306.	12.19
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,337,534.	448,405.	889,129.	.27
f Health professions education (from Worksheet 5)			146,651.	57,261.	89,390.	.03
g Subsidized health services (from Worksheet 6)			9,426,561.	7,129,898.	2,296,663.	.69
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			662,043.	111,115.	550,928.	.17
j Total. Other Benefits			11,572,789.	7,746,679.	3,826,110.	1.16
k Total. Add lines 7d and 7j.			87,356,119.	42,966,703.	44,389,416.	13.35

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	X
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	5,034,316.
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	56,969,889.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	68,558,086.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-11,588,197.
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 checked="" type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

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 COMPREHENSIVE IMAGIN	DIAGNOSTIC IMAGING CENTER	45.00000		55.00000
2 ST JOSEPH PHYSICIAN	REAL ESTATE: DOCTOR OFFICES	58.51000		41.49000
3 ST JOSEPH SATELLITE	DIALYSIS CENTER	60.77300		39.22700
4 PAVILION SURGERY CEN	OUTPATIENT SURGERY CENTER	50.00000		50.00000
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V	Facility Information
---------------	-----------------------------

Section A. Hospital Facilities

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

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

1 ST JOSEPH HOSPITAL OF ORANGE

1100 WEST STEWART DRIVE

ORANGE CA 92868

WWW.SJO.ORG

060000172

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

2

3

4

5

6

7

8

9

10

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

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

Name of hospital facility or letter of facility reporting group ST. JOSEPH HOSPITAL OF ORANGELine 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**

- 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?
- 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
- 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)
- a ☒ A definition of the community served by the hospital facility
- b ☒ Demographics of the community
- c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d ☒ How data was obtained
- e ☒ The significant health needs of the community
- f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs
- h ☒ The process for consulting with persons representing the community's interests
- i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA 20 16
- 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
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- 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
- 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)
- a ☒ Hospital facility's website (list url) SEE SCHEDULE H, PART V, SECTION C
- b ☐ Other website (list url) _____
- c ☒ Made a paper copy available for public inspection without charge at the hospital facility
- d ☐ Other (describe in Section C)
- 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 17
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If "Yes," (list url) SEE SCHEDULE H, PART V, SECTION C
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 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)?
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

	Yes	No
1		X
2		X
3	X	
4		
5	X	
6a		X
6b	X	
7	X	
8	X	
10	X	
10b		
12a		X
12b		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group ST. JOSEPH HOSPITAL OF ORANGE

	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	X	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 0000</u> % and FPG family income limit for eligibility for discounted care of <u>500 0000</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input checked="" type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
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)	X	
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)	X	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE SECTION C</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input checked="" type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2017

Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group ST. JOSEPH HOSPITAL OF ORANGE

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged		X
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?	X	
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)		

Schedule H (Form 990) 2017

Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group ST. JOSEPH HOSPITAL OF ORANGE**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		X
24		X

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Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 5

THE PROCESS OF COLLECTING QUALITATIVE COMMUNITY INPUT TOOK THREE MAIN
FORMS:

COMMUNITY RESIDENT FOCUS GROUPS, A NONPROFIT AND GOVERNMENT STAKEHOLDER
FOCUS GROUP, AND A COMMUNITY FORUM. EACH GROUP WAS DESIGNED TO CAPTURE
THE COLLECTED KNOWLEDGE AND OPINIONS OF PEOPLE WHO LIVE AND WORK IN THE
COMMUNITIES SERVED BY ST. JOSEPH HOSPITAL ORANGE (SJO). WE DEVELOPED A
PROTOCOL (NOTED IN APPENDIX 3B OF THE CHNA) 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.
APPENDIX 3 OF THE CHNA INCLUDES A FULL REPORT OF THE COMMUNITY INPUT
PROCESS AND FINDINGS ALONG WITH DESCRIPTIONS OF THE PARTICIPANTS.

PUBLIC HEALTH REPRESENTATIVE

ST. JOSEPH HOSPITAL INVITED REPRESENTATIVES FROM THE ORANGE COUNTY PUBLIC
HEALTH DEPARTMENT TO ATTEND THE STAKEHOLDER FOCUS GROUP. UNFORTUNATELY
DUE TO A COUNTY HOLIDAY ON THE DAY OF THE FOCUS GROUP, THEY WERE UNABLE
TO ATTEND.

PUBLIC HEALTH OFFICIALS REVIEWED THE FINAL DRAFT OF THE 2017 CHNA REPORT.
THEIR FEEDBACK STATED THAT MANY OF THE PRIORITIES IDENTIFIED WERE
CONSISTENT WITH THOSE IN THE 2017 OC HEALTH IMPROVEMENT PLAN.

Part V Facility Information (continued)

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

FOCUS GROUP AND COMMUNITY FORUM PARTICIPANTS

RESIDENTS WHO PARTICIPATED IN FOCUS GROUPS AND COMMUNITY FORUMS COMPLETED AN ANONYMOUS SURVEY TO ALLOW REPORTING ON DEMOGRAPHICS OF THE PARTICIPANTS. THE NUMBER AND PERCENTAGES ARE SHOWN FOR THE FOCUS GROUPS, COMMUNITY FORUMS, AND THEN FOR ALL PARTICIPANTS IN BOTH THE FOCUS GROUPS AND COMMUNITY FORUMS. PERCENTAGES WERE CALCULATED USING THE NUMBER OF RESPONDENTS FOR EACH QUESTION, WHICH MAY BE LESS THAN THE TOTAL NUMBER OF RESPONDENTS BECAUSE PEOPLE COULD CHOOSE TO LEAVE A QUESTION UNANSWERED. NOT ALL ATTENDEES COMPLETED A SURVEY OR ANSWERED EVERY QUESTION. THERE WERE A TOTAL OF 45 RESPONDENTS FOR THE RESIDENT FOCUS GROUPS, 27 FOR THE COMMUNITY FORUM AND 72 IN TOTAL FOR ALL COMMUNITY MEMBERS. 80% OF THE RESIDENT FOCUS GROUPS RESPONDENTS WERE FEMALE AND 20% WERE MALE. 77% FEMALE AND 23% MALE RESPONDENTS FOR THE COMMUNITY FORUM. IN TOTAL ALL COMMUNITY MEMBERS WERE MADE UP OF 79% FEMALE AND 21% MALE. OF THE RESIDENT FOCUS GROUPS RESPONDENTS 57% IDENTIFIED AS HISPANIC/LATINO, 34% VIETNAMESE, 9% NON-LATINO WHITE. IN THE COMMUNITY FORUM PARTICIPANTS IDENTIFIED AS 46% HISPANIC/LATINO, 8% AS VIETNAMESE, 12% NON-LATINO WHITE, 15% CAMBODIAN, 4% JAPANESE, 4% FILIPINO, 4% CHINESE, 4% NATIVE HAWAIIAN OR PACIFIC ISLANDER, 4% ASIAN OR PACIFIC ISLANDER-UNSPECIFIED AND 4% NATIVE AMERICAN. 35% OF THE RESIDENT FOCUS GROUP AND 62% OF THE COMMUNITY FORUM RESPONDENTS WERE A PERSON WITH A CHRONIC CONDITION OR A LEADER/REPRESENTATIVE OF INDIVIDUALS WITH CHRONIC CONDITIONS.

COMMUNITY FOCUS GROUPS

ST. JOSEPH HOSPITAL ORANGE HELD 4 COMMUNITY RESIDENT FOCUS GROUPS IN 3

Part V Facility Information (continued)

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

CITIES: ANAHEIM (2), SANTA ANA, AND WESTMINSTER. TO ENSURE THAT LANGUAGE BARRIERS WOULD NOT PREVENT ANYONE FROM PARTICIPATING, TWO FOCUS GROUPS WERE CONDUCTED IN SPANISH (ANAHEIM AND SANTA ANA) AND ONE WAS CONDUCTED IN VIETNAMESE (WESTMINSTER). IN TOTAL, 45 INDIVIDUALS PARTICIPATED IN COMMUNITY RESIDENT FOCUS GROUPS.

STAKEHOLDER FOCUS GROUP

THE STAKEHOLDER FOCUS GROUP WAS HELD IN ORANGE AT ST. JOSEPH HOSPITAL. THERE WERE 8 PARTICIPANTS REPRESENTING VARIOUS COMMUNITY ORGANIZATIONS (A COMPLETE LIST OF PARTICIPANTS IS AVAILABLE IN THE SJO CHNA REPORT APPENDIX 3B). ABOUT HALF OF THE PARTICIPANTS KNEW ONE ANOTHER PRIOR TO PARTICIPATION IN THE FOCUS GROUP. THERE WAS VALUABLE NETWORKING THAT TOOK PLACE AMONG PARTICIPANTS.

LIST OF STAKEHOLDER FOCUS GROUP PARTICIPANTS AND ORGANIZATIONS

THE NON-PROFIT/GOVERNMENT STAKEHOLDER FOCUS GROUP WAS HELD ON FEBRUARY 13, 2017 IN ORANGE. THE LIST OF PARTICIPANTS IS PRESENTED IN THE TABLE IN THE CHNA, ALONG WITH INFORMATION ABOUT THE POPULATION SERVED BY THE NON-PROFIT OR GOVERNMENT ORGANIZATION.

THE PARTICIPANTS OF THE STAKEHOLDER FOCUS GROUP WERE REPRESENTATIVES OF NON-PROFIT OR GOVERNMENT ORGANIZATIONS THAT SERVE THE FOLLOWING POPULATIONS: MINORITY COMMUNITIES, LOW INCOME AND MEDICALLY UNDERSERVED. ADDITIONALLY, TWO OF THE ORGANIZATIONS ALSO SERVE THOSE WHO HAVE CHRONIC CONDITIONS.

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 7A

ST. JOSEPH HOSPITAL OF ORANGE'S CHNA CAN BE FOUND ON THE HOSPITAL'S
WEBSITE AT:

[HTTPS://WWW.SJO.ORG/DOCUMENTS/COMMUNITY_BENEFIT/SJO-CHNA-FY17.PDF](https://www.sjo.org/documents/community_benefit/sjo-chna-fy17.pdf)

SCHEDULE H, PART V, SECTION B, LINE 10

[HTTPS://WWW.SJO.ORG/DOCUMENTS/SJO-CBPLAN-IS-REPORT-FY18-20.PDF](https://www.sjo.org/documents/sjo-cbplan-is-report-fy18-20.pdf)

SCHEDULE H, PART V, SECTION B, LINE 11

FY18-FY20 CB PLAN PRIORITIES/IMPLEMENTATION STRATEGIES

AS A RESULT OF THE FINDINGS OF ST. JOSEPH HOSPITAL ORANGE'S (SJO) FY17
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND THROUGH A PRIORITIZATION
PROCESS ALIGNED WITH OUR MISSION, RESOURCES AND HOSPITAL STRATEGIC PLAN,
SJO WILL FOCUS ON THE FOLLOWING AREAS FOR ITS FY18-FY20 COMMUNITY BENEFIT
EFFORTS:

- ACCESS TO HEALTH CARE FOR THE UNINSURED AND UNDERINSURED
- MENTAL HEALTH
- DIABETES/OBESITY/FOOD AND NUTRITION

WITH AN ADDITIONAL REGIONAL PRIORITY ON EDUCATION EQUITY.

ADDRESSING THE NEEDS OF THE COMMUNITY:

FY18 - FY20 KEY COMMUNITY BENEFIT INITIATIVES AND EVALUATION PLAN

1. INITIATIVE/COMMUNITY NEED BEING ADDRESSED:

Part V Facility Information (continued)

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

ACCORDING TO SECONDARY DATA GATHERED, THE HOSPITAL'S PRIMARY SERVICE AREA IS WORSE OFF THAN THE TOTAL SERVICE AREA AND ORANGE COUNTY ON ALL SOCIOECONOMIC INDICATORS.

GOAL (ANTICIPATED IMPACT): INCREASE ACCESS TO CARE FOR THE UNINSURED AND UNDERINSURED IN CENTRAL ORANGE COUNTY WHO LACK APPROPRIATE HEALTH SERVICES.

OUTCOME MEASURE: NUMBER OF UNINSURED PERSONS SERVED BY EXPANDED HEALTH SERVICES. PARTNER WITH OC HEALTHIER TOGETHER SOCIAL DETERMINANTS OF HEALTH WORK GROUP.

2. INITIATIVE/COMMUNITY NEED BEING ADDRESSED: FY2017 CHNA QUANTITATIVE DATA SHOWS THAT MENTAL HEALTH, PARTICULARLY STRESS AND DEPRESSION RELATED TO UNDOCUMENTED STATUS, AMONG WOMEN AND ESPECIALLY LATINAS, TRAUMA FROM DOMESTIC VIOLENCE, AND PTSD FROM VIOLENCE IN THEIR HOME COUNTRY BEFORE IMMIGRATING TO THE US, WAS A CONCERN ACROSS ALL FOCUS GROUPS.

GOAL (ANTICIPATED IMPACT): INCREASE ACCESS TO MENTAL HEALTH SERVICES

OUTCOME MEASURE: NUMBER OF UNDERSERVED PERSONS SERVED BY NEW OR EXPANDED MENTAL HEALTH PREVENTION AND TREATMENT SERVICES SUPPORTED BY ST. JOSEPH HOSPITAL.

3. INITIATIVE/COMMUNITY NEED BEING ADDRESSED: 2017 CHNA DATA REPORTS THAT

Part V Facility Information (continued)

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

THE HOSPITAL'S PSA HAS HIGHER RATES OF DIABETES IN ADULTS, HIGHER RATES OF OVERWEIGHT, OBESITY AND SUGARY DRINK CONSUMPTION AND LOWER RATES OF REGULAR EXERCISE.

GOAL (ANTICIPATED IMPACT): IMPROVE MANAGEMENT OF DIABETES, INCREASE PERCENTAGE OF HEALTHY WEIGHT PERSONS, AND PROMOTE HEALTHY BEHAVIOR AND LIFESTYLE.

OUTCOME MEASURE: NUMBER OF DIABETIC PATIENTS WITH IMPROVED CLINICAL VALUES.

ST. JOSEPH HOSPITAL HAS PARTNERED WITH OUR SISTER ST. JOSEPH HOAG HEALTH MINISTRIES ON A REGIONAL PRIORITY ON EDUCATION EQUITY TO ADDRESS INCOME INEQUALITY.

4. REGIONAL INITIATIVE/COMMUNITY NEED BEING ADDRESSED: REGIONAL EDUCATION EQUITY FOCUSED ON LOW INCOME POPULATIONS.

GOAL (ANTICIPATED IMPACT): REDUCE THE EDUCATION ACHIEVEMENT GAP IN THE SCHOOLS.

OUTCOME MEASURE: PERCENT OF CHILDREN DEVELOPMENTALLY ON TRACK IN EDI SCORES IN TARGETED SCHOOL DISTRICTS

FOR MORE INFORMATION ON THE KEY STRATEGIES FOR ADDRESSING THIS HEALTH

Part V Facility Information (continued)

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

NEEDS GO TO THE ST. JOSEPH HOSPITAL FY18-FY20 CB PLAN LOCATED AVAILABLE
ONLINE AT [HTTPS://WWW.SJO.ORG/DOCUMENTS/SJO-CBPLAN-IS-REPORT-FY18-20.PDF](https://www.sjo.org/documents/sjo-cbplan-is-report-fy18-20.pdf)

DUE TO THE FAST PACE AT WHICH THE COMMUNITY AND HEALTH CARE INDUSTRY
CHANGE, ST. JOSEPH HOSPITAL ANTICIPATES THAT IMPLEMENTATION STRATEGIES
MAY EVOLVE AND THEREFORE, A FLEXIBLE APPROACH IS BEST SUITED FOR THE
DEVELOPMENT OF ITS RESPONSE TO THE ST. JOSEPH HOSPITAL COMMUNITY HEALTH
NEEDS ASSESSMENT (CHNA). ON AN ANNUAL BASIS ST. JOSEPH HOSPITAL EVALUATES
ITS CB PLAN, SPECIFICALLY ITS STRATEGIES AND RESOURCES; AND MAKES
ADJUSTMENTS AS NEEDED TO ACHIEVE ITS GOALS/OUTCOME MEASURES, AND TO ADAPT
TO CHANGES IN RESOURCE AVAILABILITY.

NEEDS BEYOND THE HOSPITAL'S SERVICE PROGRAM
NO HOSPITAL FACILITY CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS
COMMUNITY. WE ARE COMMITTED TO CONTINUE OUR MISSION THROUGH COMMUNITY
BENEFIT PROGRAMS AND BY FUNDING OTHER NON-PROFITS THROUGH THE ST. JOSEPH
HEALTH COMMUNITY PARTNERSHIP FUND.

AS PREVIOUSLY MENTIONED, ST. JOSEPH HOSPITAL WILL ENDORSE LOCAL
NON-PROFIT ORGANIZATION PARTNERS TO APPLY FOR FUNDING THROUGH THE ST.
JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND. LOCAL NON-PROFITS THAT RECEIVE
FUNDING PROVIDE SPECIFIC SERVICES AND RESOURCES TO MEET THE IDENTIFIED
NEEDS OF UNDERSERVED COMMUNITIES THROUGHOUT ST. JOSEPH HOSPITAL'S SERVICE
AREAS. THE FOLLOWING COMMUNITY HEALTH NEEDS IDENTIFIED IN THE ST. JOSEPH
HOSPITAL CHNA WILL NOT BE ADDRESSED AND AN EXPLANATION IS PROVIDED

Part V Facility Information (continued)

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

BELOW:

HOUSING CONCERNS: THE HOSPITAL DOES NOT DIRECTLY ADDRESS HOUSING NEEDS. HOWEVER, WE SUPPORT AND ENDORSE GRANT APPLICATIONS TO THE ST. JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND- EMERGENCY FOOD AND SHELTER INITIATIVE FOR SEVERAL LOCAL CENTRAL ORANGE COUNTY COMMUNITY BASED ORGANIZATIONS. IN ADDITION, THE HOSPITAL WILL BE AVAILABLE TO SUPPORT MAINTENANCE/CUSTODIAL SERVICES TO THE NEW MERCY HOUSE PROJECT TO CONVERT THE SISTERS OF ST. JOSEPH MOTHER HOUSE INTO AFFORDABLE HOUSING UNITS FOR WOMEN AND CHILDREN.

LANGUAGE AND CULTURAL BARRIERS: THE HOSPITAL DOES NOT DIRECTLY ADDRESS LANGUAGE AND CULTURAL NEEDS EXCEPT TO PATIENT POPULATION. THE HOSPITAL PROVIDES CULTURAL COMPETENCY TRAINING FOR ITS EMPLOYEES. HOWEVER, THESE TRAININGS ARE NOT OPEN TO THE PUBLIC.

ECONOMIC INSECURITY: THE HOSPITAL DOES NOT DIRECTLY ADDRESS THE EFFECTS OF POVERTY AND ECONOMIC CONCERNS. HOWEVER, THE HOSPITAL PARTNERS WITH TALLER SAN JOSE HOPE BUILDERS TO SUPPORT THEIR GRADUATING PARTICIPANTS SECURE EMPLOYMENT BY PROVIDING PRE-EMPLOYMENT HEALTH SCREENINGS.

IMMIGRATION STATUS: THE HOSPITAL DOES NOT DIRECTLY ADDRESS IMMIGRATION ISSUES. HOWEVER, LA AMISTAD FAMILY HEALTH CENTER (SJNHC) PARTNERS WITH THE PUBLIC LAW CENTER IN REFERRING PATIENTS WHO REQUEST IMMIGRATION SERVICES. FURTHERMORE, SJO MAY DISCLOSE PROTECTED HEALTH INFORMATION TO

Part V Facility Information (continued)

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

LAW ENFORCEMENT INCLUDING THE US IMMIGRATION AND CUSTOMS ENFORCEMENT

(ICE) FOR THE FOLLOWING PURPOSES ONLY: A) INJURY RESULTING FROM A DEADLY WEAPON OR FROM OTHER CRIMINAL ACT; B) RAPE OR OTHER SEXUAL ASSAULT.

ACCESS TO RESOURCES: THE HOSPITAL DOES NOT DIRECTLY OFFER ACCESS TO RESOURCES IN GENERAL. HOWEVER, A PATIENT ADVOCATE IS STATIONED IN THE EMERGENCY CARE CENTER TO ASSISTS LOW INCOME UNDERSERVED PERSONS SEEKING CARE TO ENROLL IN APPROPRIATE AND AFFORDABLE HEALTH INSURANCE PROGRAMS AND SOCIAL SERVICES PROGRAMS. IN ADDITION, WE SUPPORT AND ENDORSE GRANT APPLICATIONS TO THE ST. JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND FOR SEVERAL LOCAL CENTRAL ORANGE COUNTY COMMUNITY BASED ORGANIZATIONS SEEKING FUNDS TO ADDRESS ACCESS TO HEALTH AND SOCIAL SERVICES RESOURCES.

PUBLIC SAFETY: THE HOSPITAL DOES NOT DIRECTLY ADDRESS ISSUES AROUND PUBLIC SAFETY. HOWEVER, WE SUPPORT AND ENDORSE GRANT APPLICATIONS TO THE ST. JOSEPH COMMUNITY PARTNERSHIP FUND- COMMUNITY BUILDING INITIATIVE FOR LOCAL COMMUNITY BASED ORGANIZATIONS WHO DIRECTLY ADDRESS THESE SOCIAL AND INFRASTRUCTURE ISSUES. WITHOUT THIS FUNDING, THESE ORGANIZATIONS WOULD NOT BE ABLE TO SUSTAIN AND/OR FURTHER THEIR WORK IN THIS AREA.

PARKS: THE HOSPITAL DOES NOT DIRECTLY ADDRESS THE PROVISION OF PARKS IN THE COMMUNITY. HOWEVER, WE SUPPORT AND ENDORSE GRANT APPLICATIONS TO THE ST. JOSEPH COMMUNITY PARTNERSHIP FUND- COMMUNITY BUILDING INITIATIVE FOR LOCAL COMMUNITY BASED ORGANIZATIONS WHO DIRECTLY ADDRESS THESE SOCIAL AND INFRASTRUCTURE ISSUES. WITHOUT THIS FUNDING, THESE ORGANIZATIONS WOULD

Part V Facility Information (continued)

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

NOT BE ABLE TO SUSTAIN AND/OR FURTHER THEIR WORK IN THIS AREA.

IN ADDITION, ST. JOSEPH HOSPITAL WILL COLLABORATE WHEN FEASIBLE WITH ORGANIZATIONS THAT ADDRESS AFOREMENTIONED COMMUNITY NEEDS, TO COORDINATE CARE AND REFERRAL TO ADDRESS THESE UNMET NEEDS.

SCHEDULE H, PART V, SECTION B, LINE 13H

THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDER-INSURED 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.

SCHEDULE H, PART V, SECTION B, LINE 16A

[HTTPS://WWW.SJO.ORG/DOCUMENTS/PATIENT-FINANCIAL-ASSISTANCE/FINANCIAL-ASSISTANCE-POLICY-ENGLISH_4.20.16.PDF](https://www.sjo.org/documents/patient-financial-assistance/financial-assistance-policy-english_4.20.16.pdf)

SCHEDULE H, PART V, SECTION B, LINE 16B

[HTTPS://WWW.SJO.ORG/DOCUMENTS/PATIENT-FINANCIAL-ASSISTANCE/FINANCIAL-ASSISTANCE-APPLICATION-SCAL-ENGLISH_3.8.16.PDF](https://www.sjo.org/documents/patient-financial-assistance/financial-assistance-application-scal-english_3.8.16.pdf)

SCHEDULE H, PART V, SECTION B, LINE 16C

[HTTPS://WWW.SJO.ORG/DOCUMENTS/PATIENT-FINANCIAL-ASSISTANCE/SJO_FABROCHURE_2016.PDF](https://www.sjo.org/documents/patient-financial-assistance/sjo_fabrochure_2016.pdf)

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, 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 (OSHPD) 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 TO 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 REQUEST. WRITTEN NOTICES ARE PROVIDED IN ALL LANGUAGES SPOKEN BY 5% OR MORE OF THE HOSPITAL'S SERVICE AREA.

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 OUTPATIENT SURGICENTER 1140 WEST LA VETA ORANGE CA 92868	OUTPATIENT SURGERY
2 RADIOLOGY/IMAGING CENTER 1140 WEST LA VETA ORANGE CA 92868	RADIOLOGY AND IMAGING CENTER
3 CENTER FOR CANCER PREVENTION & TREATMENT 1000 WEST LA VETA ORANGE CA 92868	CANCER CENTER
4 ST JOSEPH SISTER ELIZABETH BUILDING 1300 WEST PALMYRA ORANGE CA 92868	DIALYSIS, BEHAVIORAL HLTH, RENAL TRANS & SLEEP CTR
5 MATERNAL FETAL TESTING 1140 WEST LA VETA ORANGE CA 92868	FETAL TESTING
6 PHYSICAL REHABILITATION 1310 WEST STEWART DRIVE, SUITE 203 ORANGE CA 92868	PHYSICAL THERAPY
7 ST JOSEPH HOSPITAL WOUND CARE CENTER 1140 WEST LA VETA ORANGE CA 92868	WOUND CARE CENTER
8 COMPREHENSIVE IMAGING PARTNERS OF OC LLC 1 CITY BOULEVARD WEST, SUITE 1100 ORANGE CA 92868	IMAGING CENTER
9 CARDIAC REHABILITATION CENTER 1140 WEST LA VETA ORANGE CA 92868	CARDIOLOGY SERVICES
10 HEART & VASCULAR WELLNESS CLINIC 1120 WEST LA VETA ORANGE CA 92868	HEART WELLNESS

Schedule H (Form 990) 2017

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

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

Name and address	Type of Facility (describe)
1 MOTHER BABY 363 SOUTH MAIN STREET ORANGE CA 92868	WOMEN & CHILDREN
2 SINUS CENTER 1140 WEST LA VETA SUITE 510 ORANGE CA 92868	SINUS CENTER
3 -	
4	
5	
6	
7	
8	
9	
10	

Schedule H (Form 990) 2017

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

SCHEDULE H, PART I, LINE 3C

IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE, FPG IS A KEY FACTOR. 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. JOSEPH HOSPITAL OF ORANGE PREPARES AN ANNUAL REPORT AND IT IS PUBLICLY AVAILABLE AT [HTTPS://WWW.SJO.ORG/DOCUMENTS/SJO-CBR-FY17.PDF](https://www.sjo.org/documents/sjo-cbr-fy17.pdf)

SCHEDULE H, PART I, LINE 7

THE AMOUNTS REPORTED IN THE TABLE WERE CALCULATED USING THE ORGANIZATION'S COST ACCOUNTING SYSTEM. THE COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENT SEGMENTS.

Part VI Supplemental Information

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SCHEDULE H, PART I, LINE 7G

NO COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS WERE INCLUDED.

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, SECTION A, 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

Part VI Supplemental Information

Provide the following information

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- 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
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ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER OUR FINANCIAL ASSISTANCE POLICY.

SCHEDULE H, PART III, SECTION A, 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

Part VI Supplemental Information

Provide the following information

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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.

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.

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
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SCHEDULE H, PART VI, LINE 2

NEEDS ASSESSMENT

WITH THE INPUT OF MORE THAN 450 KEY STAKEHOLDERS, ST. JOSEPH HOSPITAL
DEFINED ITS FIVE-YEAR STRATEGIC JOURNEY, WHICH FORMS THE FOUNDATION FOR
OUR COMMITMENT TO EACH PATIENT WE SERVE:

-PERFECT CARE: EVERY PATIENT WILL RECEIVE THE RIGHT CARE, AT THE RIGHT
TIME, IN THE RIGHT SETTING.

-SACRED ENCOUNTERS: WE BELIEVE IN THE DIGNITY OF EACH INDIVIDUAL AND
DESIRE TO SERVE EACH PERSON. WE WILL FIRST SEEK TO UNDERSTAND THEN
DELIVER A COMBINATION OF COMPASSION, RESPECT AND COMPETENCY TO EACH
INDIVIDUAL WE SERVE (PATIENTS, PHYSICIANS, CAREGIVERS, STAFF, ETC.)

-HEALTHIEST COMMUNITIES: TO IMPROVE THE HEALTH STATUS OF ALL RESIDENTS IN
THE AREAS WE SERVE.

-GROWTH: TO EXPAND OUR SERVICE INTO THE COMMUNITY.

LOCAL STRATEGIC PLAN INCLUSIONS:

EXPANDED HOSPITAL SERVICES AND THE NETWORK OF CARE THROUGH NEW DELIVERY

Part VI Supplemental Information

Provide the following information

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- 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
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MODELS, VENTURES AND PARTNERSHIPS.

ACHIEVE A HOSPITAL COST STRUCTURE THAT IS MORE COMPETITIVE AND AFFORDABLE. ASPIRE TO DELIVER PERFECT CARE BY DRIVING IMPROVEMENT IN CLINICAL EXCELLENCE, QUALITY, SAFETY AND OUTCOMES.

AN ANNUAL MARKET ASSESSMENT IS COMPLETED FOR OUR LOCAL MARKET THAT PROVIDES INFORMATION ON DEMOGRAPHICS, COUNTY HEALTH RANKINGS, PHYSICIAN LANDSCAPE, ACUTE CARE UTILIZATION RATES, MARKET SHARE, OUT MIGRATION TO OTHER MEDICAL FACILITIES FOR TREATMENT, EMERGENCY DEPARTMENT AND ANCILLARY UTILIZATION, AS WELL AS SERVICE LINE FORECASTS.

SCHEDULE H, PART VI, LINE 3

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

REASONABLE EFFORTS WILL BE MADE TO NOTIFY AND INFORM PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE, UTILIZING THE METHODS OUTLINED BELOW.

Part VI Supplemental Information

Provide the following information

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-PATIENT BILLING STATEMENTS WILL INCLUDE A CLEAR AND CONSPICUOUS NOTICE

ADVISING OF THE AVAILABILITY OF THE SJH FINANCIAL ASSISTANCE PROGRAM.

-A PLAIN LANGUAGE SUMMARY OF THE FAP (BROCHURE) SHALL BE PROVIDED AS PART OF THE ADMISSION OR DISCHARGE PROCESS.

-THE FAP POLICY, PLAIN LANGUAGE SUMMARY (BROCHURE) AND FINANCIAL ASSISTANCE APPLICATION WILL BE AVAILABLE ON EACH SJH HOSPITAL'S WEBSITE.

-THE PLAIN LANGUAGE SUMMARY OF THE FAP (BROCHURE) WILL BE PRINTED IN ENGLISH AND SPANISH, AT A MINIMUM, AND SHALL BE AVAILABLE AT EACH HOSPITAL IN PUBLIC ADMISSION AREAS, INCLUDING, BUT NOT LIMITED TO, THE EMERGENCY ROOM, INPATIENT AND OUTPATIENT ADMISSION AREAS.

-TRANSLATIONS OF THE SJH FINANCIAL ASSISTANCE POLICY, FINANCIAL ASSISTANCE APPLICATION, AND PLAIN LANGUAGE SUMMARY OF THE FAP (BROCHURE) SHALL BE MADE AVAILABLE IN OTHER LANGUAGES AS DETERMINED BY EACH HOSPITAL, IN ACCORDANCE WITH SECTION 501(R) OF THE INTERNAL REVENUE CODE.

-SJH PERSONNEL WILL MAKE A REASONABLE EFFORT TO ORALLY NOTIFY PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE WHEN DISCUSSING PAYMENT OPTIONS.

Part VI Supplemental Information

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-EACH SJH HOSPITAL SHALL POST NOTICES INFORMING THE PUBLIC OF THE
FINANCIAL ASSISTANCE PROGRAM.

SUCH NOTICES SHALL:

-BE POSTED IN HIGH VOLUME INPATIENT AND OUTPATIENT SERVICE AREAS OF THE
HOSPITAL INCLUDING BUT NOT LIMITED TO THE EMERGENCY DEPARTMENT, BILLING
OFFICE, INPATIENT ADMISSION AND OUTPATIENT REGISTRATION AREAS OR OTHER
COMMON PATIENT WAITING AREAS OF THE HOSPITAL AND ANY LOCATION WHERE A
PATIENT MAY PAY HIS OR HER HOSPITAL BILL.

-INCLUDE CONTACT INFORMATION ON HOW A PATIENT MAY OBTAIN MORE INFORMATION
ON FINANCIAL ASSISTANCE AS WELL AS WHERE TO APPLY FOR SUCH ASSISTANCE.

-BE IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT REPRESENT THE
LESSER OF 1,000 INDIVIDUALS OR 5 PERCENT OF THE COMMUNITY SERVED BY THE
SJH HOSPITAL.

AN INDIVIDUAL WHO BELIEVES THAT HE OR SHE MAY QUALIFY FOR FINANCIAL
ASSISTANCE OR HAS REQUESTED FINANCIAL ASSISTANCE MUST SUBMIT A FINANCIAL
ASSISTANCE APPLICATION.

Part VI Supplemental Information

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THE FINANCIAL ASSISTANCE APPLICATION MAY BE OBTAINED FOR FREE AT THE LOCATIONS DESIGNATED BY EACH SJH HOSPITAL, BY MAIL OR BY VISITING THE SJH HOSPITAL'S WEBSITE.

EACH SJH HOSPITAL SHALL MAKE DESIGNATED PERSONNEL AVAILABLE TO ASSIST PATIENTS IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION AND DETERMINING ELIGIBILITY FOR SJH FINANCIAL ASSISTANCE OR FINANCIAL ASSISTANCE FROM GOVERNMENT-FUNDED INSURANCE PROGRAMS, IF APPLICABLE.

INTERPRETATION SERVICES ARE AVAILABLE TO ADDRESS ANY QUESTIONS OR CONCERNS AND TO ASSIST IN THE COMPLETION OF FINANCIAL ASSISTANCE APPLICATIONS.

SCHEDULE H, PART VI, LINE 4

COMMUNITY INFORMATION

ST. JOSEPH HOSPITAL OF ORANGE IS AN ACUTE-CARE HOSPITAL FOUNDED IN 1929, IS LOCATED AT ORANGE, CALIFORNIA. IT BECAME A MEMBER OF ST. JOSEPH HEALTH

Part VI Supplemental Information

Provide the following information

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IN 1982. THE FACILITY HAS 465 LICENSED BEDS, 379 OF WHICH ARE CURRENTLY AVAILABLE, AND A CAMPUS THAT IS APPROXIMATELY 38 ACRES IN SIZE. ST. JOSEPH HOSPITAL HAS A STAFF OF MORE THAN 3,100 AND PROFESSIONAL RELATIONSHIPS WITH MORE THAN 1,000 LOCAL PHYSICIANS. MAJOR PROGRAMS AND SERVICES INCLUDE CARDIAC CARE, CRITICAL CARE, DIAGNOSTIC IMAGING, EMERGENCY MEDICINE AND OBSTETRICS.

ST. JOSEPH HOSPITAL OF ORANGE PROVIDES ORANGE COUNTY COMMUNITIES WITH ACCESS TO ADVANCED CARE AND ADVANCED CARING. THE HOSPITAL'S TOTAL SERVICE AREA EXTENDS FROM YORBA LINDA IN THE NORTH, LAKE FOREST IN THE SOUTH, CORONA IN THE EAST AND HUNTINGTON BEACH IN THE WEST. OUR HOSPITAL TOTAL SERVICE AREA INCLUDES THE CITIES OF ORANGE, SANTA ANA, TUSTIN, ANAHEIM, GARDEN GROVE, VILLA PARK, WESTMINSTER, YORBA LINDA, PLACENTIA, IRVINE, CORONA, FULLERTON, FOUNTAIN VALLEY, COSTA MESA, BUENA PARK, STANTON, SILVERADO, LAKE FOREST, CYPRESS AND FOOTHILL RANCH. THIS INCLUDES A POPULATION OF APPROXIMATELY 2,380,838 PEOPLE, AN INCREASE OF APPROXIMATELY 5% FROM THE PRIOR ASSESSMENT.

Part VI Supplemental Information

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- 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

ST. JOSEPH HOSPITAL, ORANGE TOTAL HOSPITAL SERVICE AREA INCLUDES ORANGE AND RIVERSIDE COUNTIES. OVER 90 PERCENT OF THE POPULATION OF THE TSA IS IN ORANGE COUNTY, AND APPROXIMATELY 10 PERCENT OF RIVERSIDE COUNTY'S POPULATION IS WITHIN THE TSA.

THE TOTAL HOSPITAL SERVICE AREA POPULATION IS 2,380,838 WITH A MEDIAN HOUSEHOLD INCOME OF \$73,637. THE TOTAL SERVICE AREA HAS 27.8% PERCENT OF THE POPULATION WITH A HOUSEHOLD INCOME BELOW 200% FPL AND 20.2% PERCENT OF CHILDREN AND 9.6% PERCENT OF OLDER ADULTS LIVE BELOW 100% OF POVERTY LEVEL.

WHEN LOOKING AT THE PRIMARY SERVICE AREA, 25.8% PERCENT OF THE POPULATION IS UNDER THE AGE OF 18 AND 11% OF THE POPULATION IS OVER THE AGE OF 65. FURTHERMORE, 35.5% OF THE POPULATION'S HOUSEHOLD INCOME IS BELOW 200% FPL THAT INCLUDES ZIP CODES 92683, 92701, 92703, 92704, 92706, 92707, 92780, 92801, 92802, 92804, 92805, 92806, 92840, 92841, 92843, 92844, 90621, AND 90680.

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

25.2% PERCENT OF CHILDREN AND 11.6% PERCENT OF OLDER ADULTS LIVE BELOW
100% OF FEDERAL POVERTY LEVEL THAT INCLUDES ZIP CODES 92683, 92701,
92703, 92704, 92706, 92707, 92801, 92802, 92804, 92805, 92841, 92843,
92844, 90621, AND 90680.

WHEN LOOKING AT THE TOTAL SERVICE AREA, 42% PERCENT OF THE POPULATION IS
LATINO, 30.4% PERCENT IS NON-LATINO WHITE, 22.6% PERCENT IS ASIAN/PACIFIC
ISLANDER, 2.2% PERCENT IS BLACK, AND 2.4% PERCENT IS MORE THAN 1 RACE.
WHEN LOOKING AT THE PRIMARY SERVICE AREA, 53% PERCENT OF THE POPULATION
IS LATINO, 22.7% PERCENT IS NON-LATINO WHITE, 20.7% PERCENT IS
ASIAN/PACIFIC ISLANDER, 1.6% PERCENT IS BLACK, AND 1.7% PERCENT IS MORE
THAN 1 RACE.

OTHER HOSPITALS IN THE COMMUNITY INCLUDE: HOAG, AHMC ANAHEIM, CHOC,
CORONA REGIONAL MEDICAL CENTER, KAISER, KPC HEALTHCARE, INC., ORANGE
COAST MEMORIAL, PRIME HEALTHCARE, TENET HEALTH, UCI MEDICAL CENTER.

HEALTH PROFESSIONS SHORTAGE AREA - MENTAL, DENTAL, OTHER

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

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. JOSEPH HOSPITAL, ORANGE IS NOT LOCATED IN A SHORTAGE AREA, LARGE PORTIONS OF THE SERVICE AREA TO THE WEST AND SOUTH OF ST. JOSEPH HOSPITAL, ORANGE ARE DESIGNATED AS SHORTAGE AREAS.

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

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

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. ALTHOUGH ST. JOSEPH HOSPITAL, ORANGE, IS NOT LOCATED IN A MEDICALLY UNDERSERVED AREA/MEDICALLY UNDERSERVED POPULATION AREA, AREAS TO THE SOUTH AND WEST OF ST. JOSEPH HOSPITAL ARE LOCATED IN A MEDICALLY UNDERSERVED AREA/MEDICALLY UNDERSERVED POPULATIONS AREA, SIGNIFYING THE IMPORTANCE OF ST. JOSEPH HOSPITAL, ORANGE TO THE COMMUNITY IT SERVES.

FOR MORE INFORMATION, GO TO THE ST. JOSEPH HOSPITAL, ORANGE FY17 COMMUNITY BENEFIT REPORT POSTED AT [HTTPS://WWW.SJO.ORG/FOR-COMMUNITY](https://www.sjo.org/for-community)

SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH

ST JOSEPH HOSPITAL OF ORANGE PROVIDES VITAL COMMUNITY HEALTH SERVICES AND ADDRESSES THE NEEDS OF THE UNINSURED AND UNDER-INSURED THROUGH ITS FINANCIAL ASSISTANCE PROGRAM PROVIDING FREE AND DISCOUNTED CARE. ST

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
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- 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

JOSEPH HOSPITAL OF ORANGE IS COMMITTED TO PROMOTING THE HEALTH AND
QUALITY OF LIFE IN 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) OPEN MEDICAL STAFF.
- 3) ROBUST COMMUNITY BENEFIT PROGRAMS THAT ADDRESS COMMUNITY HEALTH NEEDS.
SEE STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS.

SCHEDULE H, PART VI, LINE 6

AFFILIATED HEALTH CARE SYSTEM

ON JULY 1, 2016, PROVIDENCE HEALTH & SERVICES (PHS) AND ST. JOSEPH HEALTH
SYSTEM (SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT. BY COMING
TOGETHER, PROVIDENCE ST. JOSEPH HEALTH SEEKS TO BETTER SERVE ITS
COMMUNITIES THROUGH GREATER PATIENT AFFORDABILITY, OUTSTANDING CLINICAL
CARE, IMPROVEMENTS TO THE PATIENT EXPERIENCE AND INTRODUCTION OF NEW
SERVICES WHERE THEY ARE NEEDED MOST.

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

TOGETHER, OUR CAREGIVERS SERVE IN 50 HOSPITALS AND 829 CLINICS ACROSS
ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON.

SCHEDULE H, PART VI, LINE 7

STATE FILING OF COMMUNITY BENEFIT REPORT

CALIFORNIA

SCHEDULE I
(Form 990)

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

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

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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.

1 (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 MICHAELSON DRIVE, SUITE 100	33-0143024	501(C)(3)	1,996,700				CARE FOR THE POOR SPONSOR
(2) ST JUDE NEIGHBORHOOD HEALTH CENTERS 731 S HIGHLAND AVENUE FULLERTON, CA 92832	45-3977605	501(C)(3)	519,032				CARE FOR THE POOR
(3) ORANGE ELDERLY SERVICES 170 SOUTH OLIVE STREET ORANGE, CA 92866	33-0035445	501(C)(3)		15,422	FMV	FOOD ITEMS	CARE FOR THE POOR
(4) MERCY HOUSE LIVING QUARTERS PO BOX 1905 SANTA ANA, CA 90755	33-0315864	501(C)(3)		15,272	FMV	GOODS FOR HOMELESS	CARE FOR THE POOR
(5) FOOD FINDERS 2301 E 28TH STREET SIGNAL HILL, CA 90755	33-0412749	501(C)(3)		9,449	FMV	FOOD ITEMS	CARE FOR THE POOR
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

Schedule I (Form 990) (2017)

Schedule I (Form 990) (2017)

Page 2

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1 PATIENT HOUSING ASSISTANCE	7	8,828		FMV	
2 PATIENT INSURANCE ASSISTANCE	1	400		FMV	
3 PATIENT UTILITIES ASSISTANCE	1	228		FMV	
4 PATIENT MEDICATION AND SUPPLIES	1	8,137		FMV	
5 PATIENT TRANSPORTATION	1	279		FMV	
6					
7					

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

SCHEDULE I, PART I, LINE 2

PROCEDURES FOR MONITORING THE USE OF GRANTS

ALL ORGANIZATIONS RECEIVING FUNDS MUST BE 501(C)(3) WHICH ARE ENGAGED IN

A CHARITABLE FUNCTION WHICH IS IN LINE WITH THE MISSION OF THE HOSPITAL

AND BENEFITS THE COMMUNITY. NO FURTHER MONITORING IS DONE AFTER THE

INITIAL REQUIREMENTS ARE MET.

Schedule I (Form 990) (2017)

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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						
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.

SCHEDULE I, PART III

ASSISTANCE MONIES IDENTIFIED IN PART III ARE DISBURSED DIRECTLY TO THE

VENDOR OR TO THE PATIENT AFTER APPROPRIATE SUPPORTING DOCUMENTS HAVE BEEN PROVIDED.

SCHEDULE J
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2017

Open to Public
Inspection

Employer identification number

95-1643359

Part I Questions Regarding Compensation

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

☐ First-class or charter travel

☐ Travel for companions

☐ Tax indemnification and gross-up payments

☐ Discretionary spending account

☐ Housing allowance or residence for personal use

☐ Payments for business use of personal residence

☐ Health or social club dues or initiation fees

☐ Personal services (such as, maid, chauffeur, chef)

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

☐ Compensation committee

☐ Independent compensation consultant

☐ Form 990 of other organizations

☐ Written employment contract

☐ Compensation survey or study

☐ Approval by the board or compensation committee

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?

b Participate in, or receive payment from, a supplemental nonqualified retirement plan?

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

Only section 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?

b Any related organization?

If "Yes" on line 5a or 5b, describe in Part III

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?

b Any related organization?

If "Yes" on line 6a or 6b, describe in Part III

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III.

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

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

Yes No

1b

2

4a

4b

4c

5a

5b

6a

6b

7

8

9

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

Schedule J (Form 990) 2017

Schedule J (Form 990) 2017

Page 2

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 aren't 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				
1 ARMINDER KAHLOH LEAD CARDIOVASCULAR TECH	(i) 232,090.	1,300.	9,473.	22,073.	25,047.	289,983.	0.
(ii)	0.	0.	0.	0.	0.	0.	0.
DENISE FRIDAY	(i) 248,482.	4,300.	3,770.	12,712.	27,220.	296,484.	0.
2 LEAD I R /CATH LAB TECH	(ii) 0.	0.	0.	0.	0.	0.	0.
CHANDA PARRETT	(i) 204,951.	77,904.	23,999.	16,585.	10,614.	334,053.	0.
3 VP FOUNDATION/FUND RAISING	(ii) 0.	0.	0.	0.	0.	0.	0.
SAIED AMIRPOOR	(i) 228,001.	21,578.	4,327.	16,477.	25,008.	295,391.	0.
4 DIRECTOR PHARMACY	(ii) 0.	0.	0.	0.	0.	0.	0.
LINDA SIMON	(i) 228,385.	86,711.	34,270.	20,491.	10,593.	380,450.	0.
5 VP MISSION INTEGRATION	(ii) 0.	0.	0.	0.	0.	0.	0.
MARY LEAHY	(i) 0.	0.	0.	0.	0.	0.	0.
6 FORMER KEY EMPLOYEE	(ii) 316,814.	108,841.	44,591.	18,216.	31,746.	520,208.	0.
THOMAS HILL	(i) 278,456.	121,940.	42,690.	21,590.	33,046.	497,722.	0.
7 VP OPERATIONS GENERAL SERVICES	(ii) 0.	0.	0.	0.	0.	0.	0.
KRISTI LIBERATORE	(i) 319,304.	121,780.	31,247.	10,800.	21,194.	504,325.	0.
8 CHIEF FINANCIAL OFFICER	(ii) 0.	0.	0.	0.	0.	0.	0.
CATHERINE SKELTON	(i) 301,277.	128,939.	44,472.	21,600.	23,136.	519,424.	0.
9 VP PATIENT CARE SERVICES/CNO	(ii) 0.	0.	0.	0.	0.	0.	0.
JEREMY ZOCH	(i) 0.	0.	0.	0.	0.	0.	0.
10 TRUSTEE, EX OFFICIO, CEO	(ii) 401,713.	181,581.	38,198.	10,800.	24,151.	656,443.	0.
LAWRENCE WAGMAN	(i) 587,762.	50,721.	150,060.	10,800.	16,560.	815,903.	0.
11 EXECUTIVE MEDICAL DIRECTOR	(ii) 0.	0.	0.	0.	0.	0.	0.
SCOTT RUSK	(i) 269,645.	71,548.	17,628.	0.	12,333.	371,154.	0.
12 CHIEF MEDICAL OFFICER	(ii) 0.	0.	0.	0.	0.	0.	0.
JO ANN ESCASA-HAIGH	(i) 0.	0.	0.	0.	0.	0.	0.
13 BD MBR/EVP ASSIST TREAS (SJHS)	(ii) 623,838.	711,543.	36,709.	647,363.	20,322.	2,039,775.	0.
STEVEN MOREAU	(i) 0.	0.	0.	0.	0.	0.	0.
14 CE & REG VP, SOCIAL (FMR OFCR)	(ii) 232,611.	195,495.	515,225.	10,826.	5,325.	959,482.	0.
TARA COWELL	(i) 0.	0.	0.	0.	0.	0.	0.
15 SECRETARY/VP ASSOC GEN COUNSEL	(ii) 295,922.	112,070.	39,736.	21,542.	33,615.	502,885.	0.
TINA MYCROFT	(i) 0.	0.	0.	0.	0.	0.	0.
16 CFO, SJHH (FORMER OFFICER)	(ii) 0.	0.	223,865.	0.	0.	223,865.	0.

Schedule J (Form 990) 2017

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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

SCHEDULE J, PART I, LINE 3

SUPPLEMENTAL COMPENSATION INFORMATION

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 4A

SEVERANCE PAY

THE FOLLOWING INDIVIDUAL RECEIVED A SEVERANCE PAYMENT DURING THE YEAR:

TINA MYCROFT - \$223,865

STEVEN MOREAU - \$493,204

SCHEDULE J, PART I, LINE 4B

NONQUALIFIED RETIREMENT PLAN

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.

JSA

7E1505 1 000

LB8163 2020

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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

CERTAIN EXECUTIVES PARTICIPATE IN A NON-QUALIFIED SUPPLEMENTAL EXECUTIVE

RETIREMENT PLAN PROVIDED BY A RELATED ENTITY.

SCHEDULE J, PART I, LINE 7

NON-FIXED PAYMENTS

A PORTION OF EXECUTIVE SALARIES ARE PLACED AT-RISK AND 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.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No 1545-0047

2017

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

Part I

Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____
- 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. ▶ \$ _____

Part II

Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												

Total ▶ \$ _____

Part III

Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990 or 990-EZ) 2017

Part IV. Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	523,091	MEDICAL SERVICES		X
(2) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	128,700	MEDICAL SERVICES		X
(3) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	1,526,535	CONSTRUCTION SERVICE		X
(4) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	2,105,216	MEDICAL SERVICES		X
(5) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	139,701	ENVIRONMENTAL SERVICES		X
(6) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	323,316	MEDICAL SERVICES		X
(7) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	441,388	MEDICAL SERVICES		X
(8) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	308,399	MEDICAL SERVICES		X
(9)					
(10)					

Part V. Supplemental Information

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

**SCHEDULE M
(Form 990)**

Department of the Treasury
Internal Revenue Service

Noncash Contributions

- ▶ **Complete** if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for the latest information.**

OMB No 1545-0047

2017

**Open to Public
Inspection**

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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	2.	10,975.	COST
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods	X		12,322.	COST
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles	X	3.	440.	COST
19 Food inventory	X	44.	11,362.	COST
20 Drugs and medical supplies	X	1.	1,200.	COST
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (ATCH 1)		35.	26,748.	
26 Other ▶ ()				
27 Other ▶ ()				
28 Other ▶ ()				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

	Yes	No
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?		X
b If "Yes," describe the arrangement in Part II		
31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	X	
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		X
b If "Yes," describe in Part II		
33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II		

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.

SCHEDULE M, PART I, COLUMN B

THE AMOUNTS REPORTED IN COLUMN B REPRESENT THE NUMBER OF CONTRIBUTIONS
RECEIVED.

SCHEDULE M, PART I, LINE 19

INCLUDES FOOD ITEMS SERVED TO ATTENDEES AT VARIOUS EVENTS VALUED AT
\$10,358

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.

ATTACHMENT 1

SCHEDULE M, PART I - OTHER NONCASH CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>(A) CHECK</u>	<u>(B) NUMBER OF CONTRIBUTIONS</u>	<u>(C) REVENUES REPORTED</u>	<u>(D) METHOD OF DETERMINING</u>
GIFT CERTIFICATES	X	26.	5,855.	COST
AUCTION ITEMS	X	6.	5,819.	COST
INFINITI AUTO LEASE	X	1.	13,624.	FMV
PORTRAITS	X	2.	1,450.	COST
TOTALS		<u>35.</u>	<u>26,748.</u>	

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

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

2017

**Open to Public
Inspection**

Employer identification number

ST. JOSEPH HOSPITAL OF ORANGE

95-1643359

FORM 990, PART III, LINE 4A

PROVIDENCE ST. JOSEPH HEALTH SYSTEM

ON JULY 1, 2016, PROVIDENCE HEALTH & SERVICES (PHS) AND ST. JOSEPH HEALTH
SYSTEM (SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT. BY COMING
TOGETHER, PROVIDENCE ST. JOSEPH HEALTH SEEKS TO BETTER SERVE ITS
COMMUNITIES THROUGH GREATER PATIENT AFFORDABILITY, OUTSTANDING CLINICAL
CARE, IMPROVEMENTS TO THE PATIENT EXPERIENCE AND INTRODUCTION OF NEW
SERVICES WHERE THEY ARE NEEDED MOST.

TOGETHER, OUR CAREGIVERS SERVE IN 50 HOSPITALS, 829 CLINICS ACROSS
ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON.

THE FOUNDERS OF BOTH ORGANIZATIONS WERE COURAGEOUS WOMEN AHEAD OF THEIR
TIME. THE SISTERS OF PROVIDENCE AND THE SISTERS OF ST. JOSEPH OF ORANGE
BROUGHT HEALTH CARE AND OTHER SOCIAL SERVICES TO THE AMERICAN WEST WHEN
IT WAS STILL A RUGGED, UNTAMED FRONTIER. NOW, AS WE FACE A DIFFERENT
LANDSCAPE - A CHANGING HEALTH CARE ENVIRONMENT - WE DRAW UPON THEIR
PIONEERING AND COMPASSIONATE SPIRIT TO PLAN FOR THE NEXT CENTURY OF
HEALTH CARE.

PROVIDENCE HEALTH & SERVICES

IN 1856, MOTHER JOSEPH AND FOUR SISTERS OF PROVIDENCE ESTABLISHED
HOSPITALS, SCHOOLS AND ORPHANAGES ACROSS THE NORTHWEST. OVER THE YEARS,
OTHER CATHOLIC SISTERS TRANSFERRED SPONSORSHIP OF THEIR MINISTRIES TO

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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PROVIDENCE, INCLUDING THE LITTLE COMPANY OF MARY, DOMINICANS AND CHARITY OF LEAVENWORTH. RECENTLY, SWEDISH HEALTH SERVICES, KADLEC REGIONAL MEDICAL CENTER AND PACIFIC MEDICAL CENTERS HAVE JOINED PROVIDENCE AS SECULAR PARTNERS WITH A COMMON COMMITMENT TO SERVING ALL MEMBERS OF THE COMMUNITY. TODAY, PROVIDENCE SERVES ALASKA, CALIFORNIA, MONTANA, OREGON AND WASHINGTON.

ST. JOSEPH HEALTH SYSTEM

IN 1912, A SMALL GROUP OF SISTERS OF ST. JOSEPH LANDED ON THE RUGGED SHORES OF EUREKA, CALIFORNIA TO PROVIDE EDUCATION AND HEALTH CARE. THEY LATER ESTABLISHED ROOTS IN ORANGE, CALIFORNIA, AND EXPANDED TO SERVE SOUTHERN CALIFORNIA, 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.

REALIZING OUR MISSION - TO EXTEND 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.

PROGRAM SERVICE ACCOMPLISHMENTS

-ACCESS TO HEALTH CARE

SJO HEALTH CENTER PROVIDED 9,343 VISITS TO 6,844 LOW-INCOME UNDERSERVED

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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PATIENTS. ADDITIONALLY 1,417 NEW PATIENTS SELECTED SJO HEALTH CENTER AS THEIR MEDICAL HOME WHICH WAS AN INCREASE OVER LAST YEAR. SJO HEALTH CENTER SERVICES INCLUDE MEDICAL, DENTAL, AND VISION.

WE INCREASED THE AVAILABILITY OF SPECIALTY CARE PROVIDERS THROUGH COLLABORATIVE PARTNERSHIPS WITH ST. JOSEPH HERITAGE MEDICAL GROUP (CARDIOLOGY, GYNECOLOGY, AND RHEUMATOLOGY) AND LESTONNAC FREE CLINIC (18-20 SPECIALITIES).

SJO PROVIDED LABS AND IMAGING SERVICES TO 3,165 HEALTH CENTER PATIENTS AND LOCAL FREE COMMUNITY CLINIC PATIENTS AT NO COST.

-CHRONIC DISEASE MANAGEMENT

THE NUMBER OF DIABETIC PATIENTS WHO WERE "UNCONTROLLED" (A1C>9) TOTALED 204. THE NUMBER OF DIABETIC PATIENTS WHO WERE "CONTROLLED" (A1C<9) TOTALED 786. THIS IS AN IMPROVEMENT OVER LAST YEAR.

OF THE 470 VISION MOBILE CLINIC PATIENTS, 59% (279 PATIENTS) RECEIVED A DIABETIC EYE EXAM.

SWEET BEGINNINGS PROGRAM SERVED 148 LOW-INCOME PREGNANT WOMEN WITH GESTATIONAL DIABETES. SERVICES INCLUDED EDUCATION, NUTRITION COUNSELING, INSTRUCTION ON HOW TO USE MEDICAL EQUIPMENT, AND MAINTENANCE OF BLOOD SUGARS.

-MENTAL HEALTH

WE HAVE MAINTAINED INTERVENTIONS TO PROVIDE COMPREHENSIVE MENTAL HEALTH

Name of the organization

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SERVICES TO HEALTH CENTER PATIENT POPULATION. THE REGIONAL COLLABORATIVE INCLUDES ST. JUDE MEDICAL CENTER, MISSION HOSPITAL, HOAG HOSPITAL, AND ST. JOSEPH HOSPITAL. ITS PURPOSE IS TO ADDRESS THE UNMET NEED FOR BEHAVIORAL HEALTH SERVICES FOR THE MOST UNDERSERVED POPULATION IN ORANGE COUNTY. WE HAVE PROVIDED 138 PSYCHIATRIC VISITS AND 238 BEHAVIORAL COGNITIVE VISITS TO PATIENT POPULATION. PSYCHIATRIC VISITS INCLUDE AN EVALUATION AND MEDICATION MANAGEMENT. BEHAVIORAL COGNITIVE THERAPY INCLUDES 6-10 SESSIONS. SERVICES ALSO INCLUDE CARE COORDINATION WITH PRIMARY CARE PROVIDERS.

THE PSYCHIATRIC EMERGENCY SERVICE UNIT (PES) SERVED 1,109 PATIENTS WHO WOULD OTHERWISE RECEIVE CARE IN THE EMERGENCY ROOM ALONG WITH ALL OTHER NON-PSYCHIATRIC PATIENTS. PES IS A 23-HOUR EMERGENCY TRIAGE AND STABILIZATION UNIT AIMED AT ASSISTING PSYCHIATRIC PATIENTS WITH ALTERNATIVE TO INPATIENT TREATMENT AND PROVIDE SOLID HAND-OFFS TO LOWER LEVELS OF CARE SUCH AS PARTIAL HOSPITAL PROGRAM OR A PROVIDER IN THE COMMUNITY.

POSTPARTUM DEPRESSION PROGRAM PROVIDED 1,948 INDIVIDUAL/GROUP SESSIONS TO 388 WOMEN.

SJO PARTNERED WITH JAMBOREE HOUSING CORPORATION TO PROVIDE 6 DEDICATED BEDS TO SJO HOMELESS PATIENTS FOR TEMPORARY RECUPERATIVE/TRANSITIONAL HOUSING. A TOTAL OF 12 RESIDENTS WERE ACCEPTED INTO HOUSING PROGRAM AND 5 HAVE GRADUATED AND MOVED ON TO PERMANENT OR SUPPORTIVE HOUSING.

Name of the organization

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FOR MORE INFORMATION ABOUT PROVIDENCE ST. JOSEPH HEALTH, PLEASE VISIT
WWW.PSJHEALTH.ORG

FOR MORE INFORMATION ABOUT ST. JOSEPH HEALTH, PLEASE VISIT WWW.STJHS.ORG.

FORM 990, PART V, LINE 1A

ST. JOSEPH HEALTH SYSTEM PAYS ALL VENDORS FOR ST. JOSEPH HOSPITAL OF
ORANGE FROM ITS SHARED SERVICES. ST. JOSEPH HEALTH SYSTEM ISSUES FORM
1099-MISC UNDER ITS TAX ID NUMBER AND COMPLIES WITH BACKUP WITHHOLDING
RULES FOR REPORTABLE PAYMENTS TO VENDORS.

FORM 990, PART VI, LINE 6

CLASSES OF MEMBERS OR STOCKHOLDERS

ST. JOSEPH HEALTH SYSTEM AND COVENANT HEALTH NETWORK, INC. ARE THE SOLE
CORPORATE MEMBERS OF ST. JOSEPH HOSPITAL OF ORANGE.

FORM 990, PART VI, LINE 7A

CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS

ST. JOSEPH HOSPITAL OF ORANGE HAS A TIERED GOVERNANCE IN WHICH THE
CORPORATE MEMBERS RESERVE THE RIGHT TO APPOINT TRUSTEES TO THE ST. JOSEPH
HOSPITAL OF ORANGE BOARD.

ALL TRUSTEE APPOINTMENTS THAT COME FROM THE ST. JOSEPH HOSPITAL OF ORANGE
BOARD AS NOMINATIONS MUST BE APPROVED BY ST. JOSEPH HEALTH SYSTEM, AS A
CORPORATE MEMBER, AND ST. JOSEPH HEALTH MINISTRY, AS THE ORGANIZATIONAL

Name of the organization

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SPONSOR. THE TRUSTEES ARE THEN APPROVED AND ELECTED BY THE COVENANT
HEALTH NETWORK, INC. BOARD.

FORM 990, PART VI, LINE 7B

CLASSES OF PERSONS, DECISIONS REQUIRING APPROVAL & TYPE OF VOTING RIGHTS
THE RESERVED RIGHTS IN OUR TIERED GOVERNANCE STRUCTURE CONTEMPLATE
APPROVAL BY ST. JOSEPH HEALTH SYSTEM OF FINANCING, BUDGETS, UNBUDGETED
EXPENDITURES OF DEFINED AMOUNTS, STRATEGIC PLAN, APPOINTMENT OF AUDITORS,
CREATION OR INVESTMENT IN A LEGALLY RECOGNIZED ENTITY, JOINT VENTURES,
EXEMPT 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.

THE CORPORATE MEMBERS, ST. JOSEPH HEALTH SYSTEM AND COVENANT HEALTH
NETWORK, RESERVE THE RIGHT TO APPROVE THE 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.

FORM 990, PART VI, LINE 11B

PROCESS 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. 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

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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SUMMARY AT THE FULL BOARD MEETING.

FORM 990, PART VI, LINE 12C

PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST

BOARD MEMBERS, SPONSORS, SENIOR LEADERS AND KEY EMPLOYEES ARE REQUIRED TO

DISCLOSE ANY REAL OR POTENTIAL CONFLICT OF INTEREST (COI) IN ACCORDANCE

WITH THE PSJH COI POLICY AND IN CONNECTION WITH THAT INDIVIDUAL

SATISFYING HIS OR HER FIDUCIARY OBLIGATIONS TO THE ORGANIZATION.

DISCLOSURES ARE MADE ANNUALLY AND/OR IF AT ANY TIME AN ACTUAL, REAL OR

POTENTIAL CONFLICT OF INTEREST ARISES. PSJH CHIEF LEGAL OFFICER AND/OR

THE PSJH CHIEF RISK OFFICER, REVIEW ALL DISCLOSURES. WHERE APPROPRIATE,

THE CEO AND/OR THE BOARD CHAIR CONSIDER MATTERS THAT INVOLVE SENIOR

LEADERSHIP OR A BOARD MEMBER. PSJH CHIEF LEGAL OFFICER AND/OR CHIEF RISK

OFFICER REVIEW MATTERS WHERE CONFLICT IS DIFFICULT OR CANNOT BE RESOLVED

AND PRESENT RECOMMENDATIONS TO THE APPROPRIATE BOARD COMMITTEE OR THE

CEO, FOR DISCUSSION AND RESOLUTION. WHEN APPROPRIATE, THE INDIVIDUAL WITH

THE REAL/POTENTIAL CONFLICT THAT IS BEING REVIEWED MAY PARTICIPATE IN THE

DISCUSSION BUT IS EXCUSED FROM THE MEETING WHEN ACTION IS DECIDED. WHERE

APPROPRIATE, THE CHIEF RISK OFFICER OR CHIEF LEGAL OFFICER WILL PROVIDE

PLAN TO MANAGE CONFLICTS. AUDITING AND MONITORING OF THIS PROCESS IS DONE

PERIODICALLY.

ALL DOCUMENTATION OF COI DISCLOSURES IS RETAINED PER ORGANIZATION

RETENTION POLICY.

FORM 990, PART VI, LINES 15A AND 15B

PROCESS FOR DETERMINING COMPENSATION

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER/PRESIDENT/EXECUTIVE DIRECTOR IS PAID BY ITS TAX EXEMPT PARENT, ST. JOSEPH HEALTH SYSTEM, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION.

IT IS PROVIDENCE ST. JOSEPH HEALTH'S INTENTION TO MAKE FINANCIAL INFORMATION ACCESSIBLE AND TRANSPARENT. ALTHOUGH THE FILING OF FORM 990 PROVIDES INSIGHT INTO HOW PROVIDENCE ST. JOSEPH HEALTH 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.

PROVIDENCE ST. JOSEPH HEALTH HAS A SINGLE FIDUCIARY BOARD, WITH RESPONSIBILITY FOR FINANCIAL OVERSIGHT ASSOCIATED WITH FULFILLMENT OF THE PROVIDENCE ST. JOSEPH HEALTH MISSION, DEVELOPING SYSTEM POLICIES, PROTECTING THE ASSETS ENTRUSTED TO THE ORGANIZATION AND OVERSEEING THE STRATEGIC AND OPERATIONAL AFFAIRS OF PROVIDENCE ST. JOSEPH HEALTH'S LEGAL ENTITIES. PROVIDENCE ST. JOSEPH HEALTH ALSO MAINTAINS A NETWORK OF COMMUNITY ENTITY BOARDS WITH RESPONSIBILITY FOR QUALITY OF CARE OVERSIGHT, COMMUNITY RELATIONS, ADVOCACY AND COMMUNITY NEEDS ASSESSMENTS.

PROVIDENCE ST. JOSEPH HEALTH 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.

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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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. PROVIDENCE ST. JOSEPH HEALTH 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 PROVIDENCE ST. JOSEPH HEALTH. ADDITIONALLY, PROVIDENCE ST. JOSEPH HEALTH'S LABOR MARKET CONTINUES TO SPREAD ACROSS HEALTH CARE AND INTO GENERAL INDUSTRY. BECAUSE OF THIS, PROVIDENCE ST. JOSEPH HEALTH ALSO TAKES INTO CONSIDERATION GENERAL INDUSTRY FOR-PROFIT MARKET DATA, WHERE APPLICABLE. BASE SALARIES FOR PROVIDENCE ST. JOSEPH HEALTH 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 PROVIDENCE

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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ST. JOSEPH HEALTH OPERATING COMMITMENTS AND STRATEGIC OBJECTIVES. THE BOARD OF DIRECTORS CONDUCTS A THOROUGH REVIEW PROCESS TO ENSURE PERFORMANCE INCENTIVES ARE ALIGNED WITH APPROPRIATE MARKET PRACTICES.

THE BOARD'S PROCESS FOR EXECUTIVE COMPENSATION FULLY COMPLIES WITH IRS STANDARDS AND MIRRORS BEST PRACTICES.

THE PROCESS TO REVIEW COMPENSATION WAS LAST COMPLETED IN MARCH 2018. WHILE THE ORGANIZATION COMPLETES THIS PROCESS ANNUALLY, DUE TO THE TAX YEAR BEING A SHORT PERIOD, THE PROCESS TO REVIEW COMPENSATION WAS NOT COMPLETED AND APPROVED WITHIN THE TAX YEAR.

FORM 990, PART VI, LINE 19

GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY & FINANCIAL STATEMENTS

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.

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

EQUITY TRANSFER TO ST. JOSEPH HERITAGE HEALTHCARE	(\$ 21,564,786)
EQUITY TRANSFERS TO SYSTEM OFFICE	(\$ 7,397,811)
DONATED CAPITAL AND FOUNDATION ADJUSTMENTS	\$ 641,821
CAPITAL CONTRIBUTION TO ST JOSEPH PAVILION SURGERY CENTER	(\$ 125,000)

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TOTAL

(\$ 28,445,776)

ATTACHMENT 1990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
PULMONARY CONSULTANTS AND PRIMARY CARE 1310 WEST STEWART DRIVE, SUITE 410 ORANGE, CA 92868	MEDICAL SERVICES	3,036,220.
REPUBLIC BUSINESS CREDIT LLC PO BOX 203152 DALLAS, TX 75320	MEDICAL SERVICES	2,044,234.
POLSINELLI PC PO BOX 878681 KANSAS CITY, MO 64187	MEDICAL SERVICES	1,112,617.
OC PROGRESSIVE RECOVERY INC 2102 BUSINESS CENTER DRIVE IRVINE, CA 92612	MEDICAL SERVICES	1,048,591.
GENETIC DISEASE SCREENING PROGRAM CA DEPT OF PUBLIC HEALTH ACCOUNTING UNIT EL CERRITO, CA 94530	MEDICAL SERVICES	629,922.

ATTACHMENT 2FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
PURCHASED SERVICES	11,050,822.	11,050,822.	0.	0.
PHYSICIAN FEES	8,664,595.	8,528,977.	135,618.	0.
CONTRACT MEDICAL THERAPISTS	1,481,526.	1,481,526.	0.	0.
PURCHASED MEDICAL SERVICES	1,371,517.	1,359,379.	12,138.	
CONSULTING	1,058,230.	425,599.	632,631.	0.
OTHER PURCHASED SERVICES	10,716,921.	9,804,568.	823,283.	89,070.

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

ATTACHMENT 2 (CONT'D)FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A)	(B)	(C)	(D)
	<u>TOTAL</u> <u>FEES</u>	<u>PROGRAM</u> <u>SERVICE EXP.</u>	<u>MANAGEMENT</u> <u>AND GENERAL</u>	<u>FUNDRAISING</u> <u>EXPENSES</u>
TOTALS	<u>34,343,611.</u>	<u>32,650,871.</u>	<u>1,603,670.</u>	<u>89,070.</u>

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2017**Open to Public Inspection**

Employer identification number

95-1643359

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

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
							Yes No
(1)	COVENANT HEALTH NETWORK, INC 3345 MICHELSON DRIVE, STE 100 IRVINE, CA 92612	HEALTHCARE	CA	501 (C) (3)	12, III	SJHS	X
(2)	COVENANT ACO 3615 19TH STREET LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	12, I	CHS	X
(3)	COVENANT HEALTH SYSTEM 3615 19TH STREET LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	3	SJHS	X
(4)	COVENANT HEALTH SYSTEM FOUNDATION 3623 22ND PLACE LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	7	CHS	X
(5)	COVENANT MEDICAL GROUP 3420 22ND PLACE LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	3	CHS	X
(6)	COVENANT HEALTH PARTNERS 3615 19TH STREET LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	12, I	CHS	X
(7)	HMTS, INC 1 HOAG DRIVE NEWPORT BEACH, CA 92658	HEALTHCARE	CA	501 (C) (3)	12, I	HMHP	X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.**Schedule R (Form 990) 2017**

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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95-1643359

OMB No. 1545-0047

2017**Open to Public Inspection****Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33

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(3)						
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(1)	(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?	
(1)	HOAG CHARITY SPORTS	SUPPORT	CA	501 (C) (3)	7	HHF	X	
	330 PLACENTIA AVE NEWPORT BEACH, CA 92663							
(2)	HOAG HOSPITAL FOUNDATION	FUNDRAISING	CA	501 (C) (3)	7	HMHP	X	
	330 PLACENTIA AVE NEWPORT BEACH, CA 92663							
(3)	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	HEALTHCARE	CA	501 (C) (3)	3	CHN	X	
	1 HOAG ROAD, BOX 6100 NEWPORT BEACH, CA 92663							
(4)	HOSPICE OF LUBBOCK	HEALTHCARE	TX	501 (C) (3)	10	CHS	X	
	3702 21ST STREET LUBBOCK, TX 79410							
(5)	LUBBOCK METHODIST HOSPITAL FOUNDATION	HEALTHCARE	TX	501 (C) (3)	7	CHS	X	
	3615 19TH STREET LUBBOCK, TX 79410							
(6)	METHODIST CHILDREN'S HOSPITAL	HEALTHCARE	TX	501 (C) (3)	3	CHS	X	
	3610 21ST STREET LUBBOCK, TX 79410							
(7)	METHODIST HOSPITAL LEVELLAND	HEALTHCARE	TX	501 (C) (3)	3	CHS	X	
	1900 COLLEGE AVENUE LEVELLAND, TX 79336							

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

Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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OMB No. 1545-0047

2017**Open to Public Inspection**Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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							Yes No
(1)	METHODIST HOSPITAL PLAINVIEW 2601 DIMMITT ROAD PLAINVIEW, TX 79072 75-2426010	HEALTHCARE	TX	501(C)(3)	3	CHS	X
(2)	MISSION HOSPITAL REGIONAL MEDICAL CTR 27700 MEDICAL CENTER ROAD MISSION VIEJO, CA 92691 95-1643360	HEALTHCARE	CA	501(C)(3)	3	CHN	X
(3)	QUEEN OF THE VALLEY MEDICAL CENTER 1000 TRANCAS STREET NAPA, CA 94558 94-1243669	HEALTHCARE	CA	501(C)(3)	3	SJHS	X
(4)	REDWOOD MEMORIAL FOUNDATION 3300 RENNEN DRIVE FORTUNA, CA 95540 94-2779313	HEALTHCARE	CA	501(C)(3)	7	RMH	X
(5)	REDWOOD MEMORIAL HOSPITAL 3300 RENNEN DRIVE FORTUNA, CA 95540 94-1384665	HEALTHCARE	CA	501(C)(3)	3	SJHS	X
(6)	SANTA ROSA MEMORIAL HOSPITAL 1165 MONTGOMERY DRIVE SANTA ROSA, CA 95405 94-1231005	HEALTHCARE	CA	501(C)(3)	3	SJHS	X
(7)	SRM ALLIANCE HOSPITAL SERVICES (PVH) 400 NORTH MCDOWELL BLVD PETALUMA, CA 94954 68-0395200	HEALTHCARE	CA	501(C)(3)	3	SRMH	X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.**Schedule R (Form 990) 2017**

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service**Related Organizations and Unrelated Partnerships**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

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▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2017Open to Public
Inspection

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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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	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section (if section 501(c)(3))	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	SISTERS OF ST. JOSEPH OF ORANGE 480 S BATAVIA ORANGE, CA 92868	RELIGIOUS ORG	CA	501 (C) (3)	1	N/A		X
(2)	ST. JOSEPH HEALTH MINISTRY 3345 MICHELSON DRIVE, STE 100 IRVINE, CA 92612	RELIGIOUS ORG	CA	501 (C) (3)	1	SSJO		X
(3)	ST. JOSEPH HEALTH NOR CAL, LLC 3345 MICHELSON DRIVE, STE 100 IRVINE, CA 92612	HEALTHCARE	CA	501 (C) (3)	3	SJHS	X	
(4)	ST. JOSEPH HEALTH SYSTEM 3345 MICHELSON DRIVE IRVINE, CA 92612	HEALTHCARE	CA	501 (C) (3)	12, I	PSJH		X
(5)	ST. JOSEPH HEALTH SYSTEM FOUNDATION 3345 MICHELSON DRIVE, STE 100 IRVINE, CA 92612	HEALTHCARE	CA	501 (C) (3)	7	SJHS	X	
(6)	ST. JOSEPH HOME CARE NETWORK 1111 SONOMA, STE 308 SANTA ROSA, CA 95405	HEALTHCARE	CA	501 (C) (3)	10	SJHS	X	
(7)	ST. JOSEPH HOSPITAL OF EUREKA 2700 DOLBEER STREET EUREKA, CA 95501	HEALTHCARE	CA	501 (C) (3)	3	SJHS	X	

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

Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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Employer identification number

95-1643359

OMB No. 1545-0047
2017

Open to Public Inspection

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

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							Yes No
(1)	ST JOSEPH HERITAGE HEALTHCARE 200 WEST CENTER ST PROMENADE ANAHEIM, CA 92805	HEALTHCARE	CA	501 (C) (3)	3	SJHS	X
(2)	ST JUDE HOSPITAL, INC 101 EAST VALENCIA MESA DRIVE FULLERTON, CA 92635	HEALTHCARE	CA	501 (C) (3)	3	CHN	X
(3)	ST MARY MEDICAL CENTER 18300 HIGHWAY 18 APPLE VALLEY, CA 92307	HEALTHCARE	CA	501 (C) (3)	3	CHN	X
(4)	ST MARY OF THE PLAINS HOSPITAL FDN 4000 24TH STREET LUBBOCK, TX 79410	HEALTHCARE	TX	501 (C) (3)	7	CHS	X
(5)	E WA & MT UNEMPLOYMENT COMP INSR TRUST 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	UNEMPLOYMENT	WA	501 (C) (3)	12, I	PHS WA	X
(6)	EVERETT TRANSITIONAL CARE SERVICES P O BOX 5128 EVERETT, WA 98206-5128	TRANS. CARE	WA	501 (C) (3)	10	N/A	X
(7)	FACEDY MEDICAL FOUNDATION 15451 SAN FERNANDO MISSION BLV MISSION HILLS, CA 91345	SUPPORT	CA	501 (C) (3)	7	PHS SOCAL	X

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Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service

Name of the organization

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Related Organizations and Unrelated Partnerships

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2017**Open to Public**
Inspection

Employer identification number

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						Yes No
(1) GAMELIN WASHINGTON ASSOCIATION 1423 FIRST AVENUE SEATTLE, WA 98101 20-1910170	SUPPORT	WA	501 (C) (3)	7	PHS WA	X
(2) GLOBAL TO LOCAL HEALTH INITIATIVE 2800 SOUTH 192ND ST, #104 SEATAAC, WA 98188 27-3133200	HEALTHCARE	WA	501 (C) (3)	7	SHS	X
(3) INLAND NORTHWEST HEALTH SERVICES 601 W 1ST AVENUE SPOKANE, WA 99201 91-1307555	HEALTHCARE	WA	501 (C) (3)	3	PHS WA	X
(4) INSTITUTE FOR MENTAL HEALTH & WELLNESS 1801 LIND AVENUE SW, #9016 RENTON, WA 98057 81-4260130	HEALTHCARE	WA	501 (C) (3)	7	PHS / SJHS	X
(5) INSTITUTE FOR SYSTEMS BIOLOGY 401 TERRY AVE N SEATTLE, WA 98109 91-2003593	HEALTHCARE	WA	501 (C) (3)	7	WHC	X
(6) JOHN WAYNE CANCER INSTITUTE 2200 SANTA MONICA BLVD SANTA MONICA, CA 90404 95-4291515	HEALTHCARE	CA	501 (C) (3)	4	PSJHC	X
(7) KADLEC AUXILIARY, INC 888 SWIFT BLVD RICHLAND, WA 99352 91-6033089	SUPPORT	WA	501 (C) (3)	12, III	KRMC	X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.**Schedule R (Form 990) 2017**

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SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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						Yes	No
(1) KADLEC FOUNDATION 888 SWIFT BLVD RICHLAND, WA 99352	SUPPORT	WA	501 (C) (3)	12, I	KRMC	X	
(2) KADLEC NEUROLOGICAL RESOURCE CENTER 1268 LEE BLVD RICHLAND, WA 99352	HEALTHCARE	WA	501 (C) (3)	10	WHC	X	
(3) KADLEC REGIONAL MEDICAL CENTER 888 SWIFT BLVD RICHLAND, WA 99352	HEALTHCARE	WA	501 (C) (3)	3	WHC	X	
(4) LITTLE COMPANY OF MARY ANCILLARY SVCS CO 4101 TORRANCE BLVD TORRANCE, CA 90503	IMAGING SVCS	CA	501 (C) (3)	10	PHS SOCIAL	X	
(5) LUNDBERG ASSOCIATION/PROVIDENCE HOUSE 5921 E BURNSIDE PORTLAND, OR 97215	SUPPORT	OR	501 (C) (3)	7	PHS OR	X	
(6) MARSHA RIVKIN CENTER FOR OVARIAN CANCER 747 BROADWAY SEATTLE, WA 98122	RESEARCH	WA	501 (C) (3)	7	SHS	X	
(7) PACMED CLINICS 1200 12TH AVENUE S SEATTLE, WA 98144	HEALTHCARE	WA	501 (C) (3)	10	WHC	X	

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(Form 990)Department of the Treasury
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							Yes	No
(1)	PHAS FOUNDATION/SFVSA & SCVSA 501 S BUENA VISTA STREET BURBANK, CA 91505	HEALTHCARE	CA	501 (C) (3)	7	PHS SOCIAL	X	
(2)	PROVIDENCE ALASKA FOUNDATION 3300 PROVIDENCE DR, TOWER #2 ANCHORAGE, AK 99508	HEALTHCARE	AK	501 (C) (3)	12, I	PHS WA	X	
(3)	PROVIDENCE BENEDICTINE NURSING CTR FNDN 540 SOUTH MAIN STREET MT ANGEL, OR 97362-9532	HEALTHCARE	OR	501 (C) (3)	7	PHS OR	X	
(4)	PROVIDENCE BLANCHET ASSOCIATION 1700 PROVIDENCE PL CENTRALIA, WA 98531	SUPPORT	WA	501 (C) (3)	7	PHS WA	X	
(5)	PROVIDENCE CHILD CENTER FOUNDATION 830 NE 47TH PORTLAND, OR 97213	SUPPORT	OR	501 (C) (3)	7	PHS OR	X	
(6)	PROVIDENCE COMMUNITY HEALTH FOUNDATION 1111 CRATER LAKE AVE MEDFORD, OR 97504	HEALTHCARE	OR	501 (C) (3)	7	PHS OR	X	
(7)	PROVIDENCE DETHMAN HOUSE 1205 MONTELEO AVE HOOD RIVER, OR 97031	SUPPORT	WA	501 (C) (3)	7	N/A		X

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Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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Department of the Treasury
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							Yes No
(1)	PROVIDENCE FOUNDATION 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	WA	501 (C) (3)	12, I	PHS WA	X
(2)	PROVIDENCE GAMELIN HOUSE ASSOCIATION 4515 MLK JR WAY S, STE 200 SEATTLE, WA 98108	SUPPORT	WA	501 (C) (3)	7	PHS WA	X
(3)	PROVIDENCE HEALTH & SERVICES 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	WA	501 (C) (3)	12, II	PSJH	X
(4)	PROVIDENCE HEALTH & SERVICES - MONTANA 500 W BROADWAY, P O BOX 4587 MISSOULA, MT 59806-4587	HEALTHCARE	MT	501 (C) (3)	3	PHS WA	X
(5)	PROVIDENCE HEALTH & SERVICES - OREGON 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	OR	501 (C) (3)	3	PHS	X
(6)	PROVIDENCE HEALTH & SERVICES - WA 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	WA	501 (C) (3)	3	PHS	X
(7)	PROVIDENCE HEALTH & SERVICES - WEST WA 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	WA	501 (C) (3)	3	PM/WHC	X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.**Schedule R (Form 990) 2017**

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Employer identification number

95-1643359

OMB No 1545-0047

2017Open to Public
inspection**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
							Yes No
(1)	PROVIDENCE HEALTH ASSURANCE 4400 NE HALSEY, BLDG #2 PORTLAND, OR 97213	MEDICAID	OR	501 (C) (4)	N/A	PHP	X
(2)	PROVIDENCE HEALTH CARE FNDN - E WA 101 W 8TH AVENUE SPOKANE, WA 99204	HEALTHCARE	WA	501 (C) (3)	7	PHS WA	X
(3)	PROVIDENCE HEALTH CARE FNDN (CENTRALIA) 914 S SCHEUBER ROAD CENTRALIA, WA 98531	HEALTHCARE	WA	501 (C) (3)	7	PHS W WA	X
(4)	PROVIDENCE HEALTH PLAN 4400 NE HALSEY, BLDG #2 PORTLAND, OR 97213	HEALTHCARE	OR	501 (C) (4)	N/A	PPP	X
(5)	PROVIDENCE HEALTH SYSTEM - SO CAL 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	HEALTHCARE	CA	501 (C) (3)	3	PHS	X
(6)	PROVIDENCE HOOD RIVER MEM HOSP FDN 811 13TH ST HOOD RIVER, OR 97031	HEALTHCARE	OR	501 (C) (3)	7	PHS OR	X
(7)	PROVIDENCE HOSPICE AND HOME CARE FNDN 2731 WETMORE AVENUE, STE 500 EVERETT, WA 98201	HEALTHCARE	WA	501 (C) (3)	7	PHS W WA	X

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

Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

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Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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Employer identification number

95-1643359

OMB No. 1545-0047

2017Open to Public
Inspection**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
							Yes No
(1)	PROVIDENCE HOSPICE OF SEATTLE FOUNDATION 425 PONTIUS AVENUE NORTH, #300 SEATTLE, WA 98019-5452	HEALTHCARE	WA	501(C)(3)	12,I	PHS W WA	X
(2)	PROVIDENCE LITTLE COMPANY OF MARY FNDN 4101 TORRANCE BLVD TORRANCE, CA 90503	HEALTHCARE	CA	501(C)(3)	7	PHS SOCAL	X
(3)	PROVIDENCE MARIANWOOD FOUNDATION 3725 PROVIDENCE POINT DRIVE SE ISSAQUAH, WA 98029-7219	HEALTHCARE	WA	501(C)(3)	12,I	PHS W WA	X
(4)	PROVIDENCE MEDICAL INSTITUTE 4101 TORRANCE BLVD TORRANCE, CA 90503	HEALTHCARE	CA	501(C)(3)	12,I	PHS SOCAL	X
(5)	PROVIDENCE MILWAUKIE FOUNDATION 10150 SE 32ND MILWAUKIE, OR 97222	HEALTHCARE	OR	501(C)(3)	7	PHS OR	X
(6)	PROVIDENCE MINISTRIES 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	RELIGIOUS ORG	WA	501(C)(3)	1	N/A	X
(7)	PROVIDENCE MOUNT ST VINCENT FOUNDATION 4831 35TH AVENUE SW SEATTLE, WA 98126-2799	HEALTHCARE	WA	501(C)(3)	7	PHS WA	X

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

Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

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OMB No. 1545-0047

2017Open to Public
Inspection

Employer identification number

95-1643359

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
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(6)						

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.

(1)	(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)	PROVIDENCE NEWBERG HEALTH FOUNDATION 1001 PROVIDENCE DRIVE NEWBERG, OR 97132	HEALTHCARE	OR	501 (C) (3)	7	PHS OR		X
(2)	PROVIDENCE PETER CLAVER ASSOCIATION 7101 38TH AVENUE SOUTH SEATTLE, WA 98118	SUPPORT	WA	501 (C) (3)	7	PHS WA		X
(3)	PROVIDENCE PLAN PARTNERS 4400 NE HALSEY, BLDG #2 PORTLAND, OR 97213	HEALTHCARE	WA	501 (C) (4)	N/A	PHS OR		X
(4)	PROVIDENCE PORTLAND MEDICAL FOUNDATION 4805 NE GLISAN STREET PORTLAND, OR 97213-2967	HEALTHCARE	OR	501 (C) (3)	7	PHS OR		X
(5)	PROVIDENCE ROSSI ASSOCIATION 1700 PROVIDENCE PLACE CENTRALIA, WA 98531	SUPPORT	WA	501 (C) (3)	10	PHS WA		X
(6)	PROVIDENCE SAINT JOHN'S HEALTH CENTER 2121 SANTA MONICA BLVD SANTA MONICA, CA 90404	HEALTHCARE	CA	501 (C) (3)	3	PHS SOCIAL		X
(7)	PROVIDENCE SAINT JOHN'S MEDICAL FNDN 20555 EARL ST TORRANCE, CA 90503	HEALTHCARE	CA	501 (C) (3)	PENDING	PHS SOCIAL		X

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

Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

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Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

OMB No. 1545-0047

2017Open to Public
Inspection**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
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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

	(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)	PROVIDENCE SEASIDE HOSPITAL FOUNDATION 725 S WAHANNA RD SEASIDE, OR 97138	HEALTHCARE	OR	501 (C) (3)	7	PHS OR	X
(2)	PROVIDENCE ST ELIZABETH HOUSE ASSOC 3201 SW GRAHAM ST SEATTLE, WA 98126	SUPPORT	WA	501 (C) (3)	7	PHS WA	X
(3)	PROVIDENCE ST FRANCIS ASSOCIATION 3415 12TH AVENUE NE OLYMPIA, WA 98506	SUPPORT	WA	501 (C) (3)	7	PHS WA	X
(4)	PROVIDENCE ST JOSEPH HEALTH 1801 LIND AVENUE SW, #9016 RENTON, WA 98057	HEALTHCARE	WA	501 (C) (3)	12, III	N/A	X
(5)	PROVIDENCE ST JOSEPH MEDICAL CENTER P O BOX 1010 POLSON, MT 59860-1010	HEALTHCARE	MT	501 (C) (3)	3	PHS WA	X
(6)	PROVIDENCE ST MARY FOUNDATION 401 W POPLAR STREET WALLA WALLA, WA 99362	HEALTHCARE	WA	501 (C) (3)	7	PHS WA	X
(7)	PROVIDENCE ST PETER FOUNDATION 413 LILLY ROAD NE OLYMPIA, WA 98506-5166	SUPPORT	WA	501 (C) (3)	7	PHS W WA	X

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Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

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Employer identification number

95-1643359

OMB No. 1545-0047

2017**Open to Public Inspection****Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
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	(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)	PROVIDENCE ST VINCENT MEDICAL FNDN 9205 SW BARNES ROAD PORTLAND, OR 97225	HEALTHCARE	OR	501 (C) (3)	7	PHS OR	X	
(2)	PROVIDENCE TRINITYCARE HOSPICE 5315 TORRANCE BLVD, STE B1 TORRANCE, CA 90503	HEALTHCARE	CA	501 (C) (3)	10	PHS SOCAL	X	
(3)	PROVIDENCE TRINITYCARE HOSPICE FNDN 5315 TORRANCE BLVD, STE B1 TORRANCE, CA 90503	HEALTHCARE	CA	501 (C) (3)	7	PTCH	X	
(4)	PROVIDENCE WILLAMETTE FALLS MEDICAL FNDN 1500 DIVISION STREET OREGON CITY, OR 97045	HEALTHCARE	OR	501 (C) (3)	12, I	PHS OR	X	
(5)	SAINT JOHN'S HOSPITAL/HEALTH CENTER FNDN 2121 SANTA MONICA BLVD SANTA MONICA, CA 90404	SUPPORT	CA	501 (C) (3)	7	PSJHC	X	
(6)	SEATTLE SCIENCE FOUNDATION 550 17TH AVENUE SEATTLE, WA 98122	PHYSN COLLAB	WA	501 (C) (3)	7	WHC	X	
(7)	SISTERS OF PROVIDENCE OF MONTANA CORP 1801 LIND AVENUE SW, #9016 RENTON, WA 98057-9016	SHELL CORP	MT	501 (C) (3)	1	PHS WA		

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SCHEDULE R
(Form 990)**Related Organizations and Unrelated Partnerships**

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OMB No. 1545-0047

2017**Open to Public Inspection**Department of the Treasury
Internal Revenue Service

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	ST LUKE ASSOCIATION 350 WASHINGTON AVE SE CHEHALIS, WA 98352	SUPPORT	WA	501 (C) (3)	7	PHS WA	X	
(2)	ST PATRICK HOSPITAL FOUNDATION 500 WEST BROADWAY, P O BOX 45 MISSOULA, MT 59806-4587	HEALTHCARE	MT	501 (C) (3)	7	PHS WA	X	
(3)	ST THOMAS CHILD AND FAMILY CENTER 1710 BENEFIS COURT GREAT FALLS, MT 59405	EDUCATION	MT	501 (C) (3)	10	PHS WA	X	
(4)	SWEDISH EDMONDS 21601 76TH AVENUE EDMONDS, WA 98026	HEALTHCARE	WA	501 (C) (3)	3	WHC	X	
(5)	SWEDISH HEALTH SERVICES 747 BROADWAY SEATTLE, WA 98122	HEALTHCARE	WA	501 (C) (3)	3	WHC	X	
(6)	SWEDISH MEDICAL CENTER FOUNDATION 747 BROADWAY SEATTLE, WA 98122	HEALTHCARE	WA	501 (C) (3)	7	SHS	X	
(7)	SWEDISH MJM HOLDINGS 747 BROADWAY SEATTLE, WA 98122	HOLDING CO	WA	501 (C) (3)	12, I	SHS	X	

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Schedule R (Form 990) 2017

SCHEDULE R
(Form 990)Department of the Treasury
Internal Revenue Service**Related Organizations and Unrelated Partnerships**

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OMB No. 1545-0047

2017Open to Public
Inspection

Name of the organization

ST. JOSEPH HOSPITAL OF ORANGE

Employer identification number

95-1643359

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

(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
						Yes No
(1) THE GAMELIN ASSOCIATION 312 NORTH FOURTH STREET YAKIMA, WA 98901	SUPPORT	WA	501 (C) (3)	7	PHS WA	X
(2) THE GAMELIN CALIFORNIA ASSOCIATION 540 23RD STREET OAKLAND, CA 94612	SUPPORT	CA	501 (C) (3)	10	PHS SOCAL	X
(3) THE GAMELIN OREGON ASSOCIATION 5520 NE GLISAN PORTLAND, OR 97213	SUPPORT	OR	501 (C) (3)	10	PHS OR	X
(4) UNIVERSITY OF GREAT FALLS 1301 20TH STREET SOUTH GREAT FALLS, MT 59405	EDUCATION	MT	501 (C) (3)	2	PHS	X
(5) WESTERN HEALTHCONNECT 747 BROADWAY SEATTLE, WA 98122	SHELL CORP	WA	501 (C) (3)	12, II	PHS W WA	X
(6)						
(7)						

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Schedule R (Form 990) 2017

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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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) CA SPECIALTY SURGERY CENTER SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(2) COASTAL ASC HOLDINGS, LLC SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(3) COVENANT LONG-TERM CARE, LP SEE PART VII	HEALTHCARE	TX	N/A	N/A								
(4) HERITAGE INVESTMENT GROUP SEE PART VII	INVESTMENTS	CA	N/A	N/A								
(5) HOAG ORTHOPEDIC INSTITUTE SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(6) LSC REAL PROPERTY, LLC SEE PART VII	REAL ESTATE	TX	N/A	N/A								
(7) METHODIST DIAGNOSTIC IMAGING SEE PART VII	HEALTHCARE	TX	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
								Yes No
(1) AMERICAN UNITY GROUP, LTD 90 PITTS BAY ROAD PEMBROKE, BD HM08	CAPTIVE INSURANCE	BD	N/A	C-CORP				
(2) HOAG CLINIC 1 HOAG DRIVE, BOX 6100 NEWPORT BEACH, CA 92658	HEALTHCARE	CA	N/A	C-CORP				
(3) DATU HEALTH, INC AND SUBSIDIARIES 16150 MAIN CIRCLE DR, SUITE 250 CHESTERFIELD, MO 63017	IT SVCS	DE	N/A	C-CORP				
(4) HOAG MANAGEMENT SERVICES, INC 1 HOAG DRIVE, BOX 6100 NEWPORT BEACH, CA 92658	HEALTHCARE	CA	N/A	C-CORP				
(5) LUBBOCK METHODIST HOSP PRACTICE MGMT 2107 OXFORD STREET, STE 300 LUBBOCK, TX 79410	INACTIVE	TX	N/A	C-CORP				
(6) LUBBOCK METHODIST HOSPITAL SVCS P O BOX 1201 LUBBOCK, TX 79410	HEALTHCARE	TX	N/A	C-CORP				
(7) MISSION VIEJO MEDICAL VENTURES 27800 MEDICAL CENTER RD MISSION VIEJO, CA 92691	HEALTHCARE	CA	N/A	C-CORP				

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) NEWPORT IMAGING CENTER SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(2) NORTH BAY ENDOSCOPY CENTER SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(3) SHA, LLC SEE PART VII	HEALTHCARE	TX	N/A	N/A								
(4) SOUTHERN CALIFORNIA SURG CTR SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(5) ST JOSEPH PHYSICIAN VENTURES SEE PART VII	REAL ESTATE	CA	SJHO	UNRELATED	246,665	11,417,414		X	268,671	X		58 5122
(6) ST JOSEPH/SATELLITE DIALYSIS SEE PART VII	HEALTHCARE	CA	SJHO	RELATED	601,675	23,656,052		X	0	X		60 7735
(7) ALPHA MEDICAL LABORATORY, LLC SEE PART VII	OUTPATIENT LAB	ID	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) OPHE HEALTHCARE SERVICES, INC 3345 MICHELSON DRIVE, SUITE 100 IRVINE, CA 92612	HEALTHCARE	CA	N/A	C-CORP					
(2) ST JOSEPH HEALTH 3345 MICHELSON DRIVE, SUITE 100 IRVINE, CA 92612	HOLDING COMPANY	CA	N/A	C-CORP					
(3) ST JOSEPH HEALTH SOURCE, INC 3345 MICHELSON DRIVE, SUITE 100 IRVINE, CA 92612	HEALTHCARE	CA	N/A	C-CORP					
(4) ST JOSEPH PROF SVCS ENTERPRISES, INC 3345 MICHELSON DRIVE, SUITE 100 IRVINE, CA 92612	HEALTHCARE	CA	N/A	C-CORP					
(5) 1221 MADISON STREET OWNERS ASSOC 747 BROADWAY SEATTLE, WA 98122	OWNERS' ASSOC	WA	N/A	C-CORP					
(6) BOURGET HEALTH SERVICES, INC P O BOX 2687 SPOKANE, WA 99220	CLIN/MED LAB	WA	N/A	C-CORP					
(7) CARON HEALTH CORPORATION 510 W FRONT ST MISSOULA, MT 59802	MED PHYS SVCS	MT	N/A	C-CORP					

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Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) BROADWAY IMAGING, LLC SEE PART VII	MEDICAL IMAGING	MT	N/A	N/A								
(2) CALIFORNIA LABORATORY ASSOCS SEE PART VII	OUTPATIENT LAB	CA	N/A	N/A								
(3) CENTER FOR SPECIALTY SURGERY SEE PART VII	AMBULATORY SURG	OR	N/A	N/A								
(4) CLACKAMAS RADIATION ONCOL CTR SEE PART VII	RADIATION ONCOL	OR	N/A	N/A								
(5) CTR FOR MED IMAGING-BRIDGEPORT SEE PART VII	IMAGING DIAG	OR	N/A	N/A								
(6) CTR FOR MED IMAGING-TANASBOURNE SEE PART VII	IMAGING DIAG	OR	N/A	N/A								
(7) GREATER VALLEY MED BLDG SEE PART VII	REAL ESTATE - MOB	CA	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1) PHN HOLDINGS 20555 EARL STREET TORRANCE, CA 90503 46-1814184	STRAT PLAN SVCS	CA	N/A	C-CORP				
(2) PIONEER INNOVATIONS, INC 800 5TH AVE, 10TH FLOOR SEATTLE, WA 98104 36-4818191	HEALTH INNOVATNS	WA	N/A	C-CORP				
(3) PROVIDENCE HEALTH VENTURES, INC 4101 TORRANCE BLVD TORRANCE, CA 90503 33-0122216	INVESTMENT	CA	N/A	C-CORP				
(4) PROVIDENCE HEALTH NETWORK 20555 EARL STREET TORRANCE, CA 90503 80-0886966	PREPAID HEALTH	CA	N/A	C-CORP				
(5) PROVIDENCE HEALTH CARE VENTURES, INC 101 W 8TH AVE, TAF C-9 SPOKANE, WA 99204 90-0155714	CLIN/MED LAB	WA	N/A	C-CORP				
(6) VINSERRA, INC 1328 22ND STREET SANTA MONICA, CA 90403 95-3943315	INVESTMENTS	CA	N/A	C-CORP				
(7) WESTERN HEALTHCONNECT VENTURES, INC 1801 LIND AVE SW #9016 RENTON, WA 98057 80-0953654	INVESTMENTS	WA	N/A	C-CORP				

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) HCSA PROPERTIES LLC SEE PART VII	REAL ESTATE RENT	WA	N/A	N/A								
(2) MOUNTAINSTAR CLIN LAB SEE PART VII	OUTPATIENT LAB	MT	N/A	N/A								
(3) OREGON ADVANCED IMAGING, LLC SEE PART VII	MEDICAL IMAGING	OR	N/A	N/A								
(4) OREGON OUTPATIENT SURGERY CTR SEE PART VII	AMBULATORY SURG	OR	N/A	N/A								
(5) PACLAB, LLC SEE PART VII	OUTPATIENT LAB	WA	N/A	N/A								
(6) PATHOLOGY ASSOCS MED LAB SEE PART VII	OUTPATIENT LAB	WA	N/A	N/A								
(7) PET/CT IMG SWEDISH CANCER INST SEE PART VII	MEDICAL IMAGING	WA	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) YAKIMA MEDICAL ARTS, INC 611 N PERRY, #100 SPOKANE, WA 99202 91-0787963	RENT REAL ESTATE	WA	N/A	C-CORP					
(2) VINSERRA, INC 1328 22ND STREET SANTA MONICA, CA 90403 95-3943315	INVESTMENTS	CA	N/A	C-CORP					
(3) PROVIDENCE ASSURANCE, INC 3131 CAMELBACK ROAD, STE 400 PHOENIX, AZ 85016 20-8194071	CAPTIVE INSURANCE	AZ	N/A	C-CORP					
(4)									
(5)									
(6)									
(7)									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHS INVESTMENT TRUST HEDGE FUN SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(2) PHS INVESTMENT TRUST BANK LOAN SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(3) PHS INVESTMENT TRANSITION PORT SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(4) PHS INVESTMENT TRUST RISK PART SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(5) PHS INVESTMENT TRUST LONG TREA SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(6) PHS INVESTMENT TRUST MLP PORTF SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(7) PHS INVESTMENT TRUST RELATIVE SEE PART VII	INVESTMENTS	WA	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)								Yes No
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHS INVESTMENT TRUST TIPS PORT SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(2) PHS INVESTMENT TRUST PUBLIC EQ SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(3) PHS INVESTMENT TRUST LDI PORTF SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(4) PHS INVESTMENT TRUST PUBLIC DE SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(5) PHS INVESTMENT TRUST TACTICAL SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(6) PHS INVESTMENT TRUST COMMODITI SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(7) PHS INVESTMENT TRUST 2015 PRIV SEE PART VII	INVESTMENTS	WA	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)								Yes No
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHS INVESTMENT TRUST SHORT TER SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(2) PHS INVESTMENT TRUST 2016 PRIV SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(3) PHS INVESTMENT TRUST 2016 PRIV SEE PART VII	INVESTMENTS	WA	N/A	N/A								
(4) PORTLAND MEDICAL IMAGING, LLC SEE PART VII	IMAGING DIAGNOSTI	OR	N/A	N/A								
(5) PROV RADIATION ONCOLOGY DEV SEE PART VII	REAL ESTATE - MOB	OR	N/A	N/A								
(6) PROVIDENCE IMAGING CENTER SEE PART VII	MEDICAL IMAGING	AK	N/A	N/A								
(7) PROVIDENCE PARTNERS FOR HEALTH SEE PART VII	CLIN QUALITY/INT	CA	N/A	N/A								

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
									Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PROVIDENCE SURGERY CENTER, LLC SEE PART VII	AMBULATORY SURG	MT	N/A	N/A								
(2) PROVIDENCE/SILVERTON REHAB SEE PART VII	REHAB SERVICES	OR	N/A	N/A								
(3) PROVIDENCE/USP SANTA CLARITA SEE PART VII	AMBULATORY SURG	CA	N/A	N/A								
(4) PROVIDENCE/USP SURGERY CTRS SEE PART VII	AMBULATORY SURG	CA	N/A	N/A								
(5) SOUTHERN IDAHO REGIONAL LAB SEE PART VII	OUTPATIENT LAB	ID	N/A	N/A								
(6) THE MADISON SPOKANE INN, LLC SEE PART VII	HOTEL SERVICES	WA	N/A	N/A								
(7) TRI-CITIES LABORATORY, LLC SEE PART VII	OUTPATIENT LAB	WA	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)								Yes No
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) SJO ASC HOLDINGS LLC SEE PART VII	HEALTHCARE	CA	SJO	RELATED	-93,839	2,981,161		X	0		X	80 3920
(2) COMPREHENSIVE IMAGING PARTNERS SEE PART VII	HEALTHCARE	CA	SJO	RELATED	142,367	3,588,089		X	0	X		45 0000
(3) HOAG OUTPATIENT CENTERS, LLC SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(4) NEWPORT BAY SURGERY CTR, LLC SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(5) NEWPORT BEACH ENDOSCOPY CTR SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(6) NEWPORT SURGICAL PARTNERS, LLC SEE PART VII	HEALTHCARE	CA	N/A	N/A								
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
(1)								Yes No
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

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.		<input checked="" type="checkbox"/>
b Gift, grant, or capital contribution to related organization(s).	<input checked="" type="checkbox"/>	
c Gift, grant, or capital contribution from related organization(s).	<input checked="" type="checkbox"/>	
d Loans or loan guarantees to or for related organization(s).		<input checked="" type="checkbox"/>
e Loans or loan guarantees by related organization(s).		<input checked="" type="checkbox"/>
f Dividends from related organization(s).		<input checked="" type="checkbox"/>
g Sale of assets to related organization(s).		<input checked="" type="checkbox"/>
h Purchase of assets from related organization(s).		<input checked="" type="checkbox"/>
i Exchange of assets with related organization(s).		<input checked="" type="checkbox"/>
j Lease of facilities, equipment, or other assets to related organization(s).	<input checked="" type="checkbox"/>	
k Lease of facilities, equipment, or other assets from related organization(s).		<input checked="" type="checkbox"/>
l Performance of services or membership or fundraising solicitations for related organization(s).		<input checked="" type="checkbox"/>
m Performance of services or membership or fundraising solicitations by related organization(s).	<input checked="" type="checkbox"/>	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s).		<input checked="" type="checkbox"/>
o Sharing of paid employees with related organization(s).		<input checked="" type="checkbox"/>
p Reimbursement paid to related organization(s) for expenses.		<input checked="" type="checkbox"/>
q Reimbursement paid by related organization(s) for expenses.		<input checked="" type="checkbox"/>
r Other transfer of cash or property to related organization(s).		<input checked="" type="checkbox"/>
s Other transfer of cash or property from related organization(s).		<input checked="" type="checkbox"/>

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. JOSEPH HEALTH SYSTEM FOUNDATION	C	674,491.	ACCRUAL
(2)	ST. JOSEPH HEALTH SYSTEM FOUNDATION	B	1,996,700.	ACCRUAL
(3)	ST. JOSEPH HERITAGE HEALTHCARE	J	1,290,138.	ACCRUAL
(4)	ST. JOSEPH HERITAGE HEALTHCARE	M	1,702,496.	ACCRUAL
(5)	ST. JOSEPH HERITAGE HEALTHCARE	R	26,833,954.	ACCRUAL
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

JSA

Schedule R (Form 990) 2017

Part VII**Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.

SCHEDULE R, PART III

IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS A PARTNERSHIP

CALIFORNIA SPECIALTY SURGERY CENTER, LP

EIN: 33-0939003

ADDRESS: 26371 CROWN VALLEY PARKWAY, MISSION VIEJO, CA 92691

COASTAL ASC HOLDINGS, LLC

EIN: 81-0986844

ADDRESS: ONE HOAG DRIVE, BOX 6100, NEWPORT BEACH, CA 92658

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: ONE HOAG DRIVE, BOX 6100, NEWPORT BEACH, CA 92658

LSC REAL PROPERTY, LLC

EIN: 47-4646059

ADDRESS: 2301 QUAKER AVE, LUBBOCK, TX 79410

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

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

NORTH BAY ENDOSCOPY CENTER, LLC

EIN: 61-1559876

ADDRESS: 1383 N. MCDOWELL BLVD, STE 110, PETALUMA, CA 94954

SHA, LLC

EIN: 75-2569094

ADDRESS: 12940 NORTH HIGHWAY 183, AUSTIN, TX 78750

SOUTHERN CALIFORNIA SURGERY CENTER, LLC

EIN: 33-0939000

ADDRESS: 18321 VENTURA BLVD, STE 740, TARZANA, CA 91356

ST. JOSEPH PHYSICIAN VENTURES I, LLC

EIN: 45-4521884

ADDRESS: 1100 WEST STEWART DRIVE, ORANGE, CA 92868

ST. JOSEPH/SATELLITE DIALYSIS CENTERS, LLC

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

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

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

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

HCSA PROPERTIES, LLC

EIN: 46-0620892

ADDRESS: 1600 M STREET NW, AUBURN, WA 98001

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

Part VII**Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.

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

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

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

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

Part VII. Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions

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

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions

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

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

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

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

Part VII Supplemental Information

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SJO ASC HOLDINGS LLC

EIN: 82-1655501

ADDRESS: 1140 W. LA VETA AVE, ORANGE, CA, 92868

COMPREHENSIVE IMAGING PARTNERS OF ORANGE COUNTY

EIN: 26-4591502

ADDRESS: ONE CITY BLVD. WEST, SUITE 1100, ORANGE, CA 92868

HOAG OUTPATIENT CENTERS, LLC

EIN: 45-3587572

ADDRESS: 27271 LAS RAMBLAS #350, MISSION VIEJO, CA 92691

NEWPORT BAY SURGERY CENTER, LLC

EIN: 56-2518360

ADDRESS: 3333 W. PACIFIC COAST HWY, #100, NEWPORT BEACH, CA 92663

NEWPORT BEACH ENDOSCOPY CENTER, LLC

EIN: 77-0368744

ADDRESS: 27271 LAS RAMBLAS #350, MISSION VIEJO, CA 92691

NEWPORT SURGICAL PARTNERS, LLC

EIN: 39-2060266

ADDRESS: 27271 LAS RAMBLAS #350, MISSION VIEJO, CA 92691