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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

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

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

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

Department of the Treasury
Internal Revenue Service

A For the 2017 calendar year, or tax year beginning 07-01-2017 , and ending 06-30-2018

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

ST FRANCIS MEDICAL CENTER

% AMANDA HYMEL

Doing business as

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

PO Box 1901

Room/suite

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

Monroe, LA 71210

F Name and address of principal officer

Jeff Limbocker

PO Box 1901

Monroe, LA 71210

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

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

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

H(c) Group exemption number ▶ 0928

D Employer identification number

72-0408970

E Telephone number

(318) 966-4000

G Gross receipts \$ 279,087,031

I Tax-exempt status

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

J Website: ▶ www.stfran.com

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1913

M State of legal domicile LA

Part I Summary

Activities & Governance

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

TO PROVIDE FOR THE CARE OF THE ILL, INJURED, OR DISABLED PERSONS AND TO PROVIDE FOR THE RESEARCH,EDUCATION AND THE ENHANCEMENT OF HEALTH OF THOSE IN NORTHEAST LOUISIANA

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

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

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

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

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

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

Revenue

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

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

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

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

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

Expenses

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

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

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

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

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

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

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

19 Revenue less expenses Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

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

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

JEFF LIMBOCKER CFO

Type or print name and title

2019-05-07

Date

Paid Preparer Use Only

Print/Type preparer's name

BRITTANY ELLISER

Preparer's signature

BRITTANY ELLISER

Date

2019-05-14

Check ☐ if self-employed

PTIN

P01284594

Firm's name ▶ KPMG LLP

Firm's EIN ▶

Firm's address ▶ 301 Main Street Suite 2150

Phone no (225) 344-4000

Baton Rouge, LA 70801

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

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2017)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

INSPIRED BY THE VISION OF ST FRANCIS OF ASSISI AND IN THE TRADITION OF THE ROMAN CATHOLIC CHURCH, WE EXTEND THE HEALING MINISTRY OF JESUS CHRIST TO GOD'S PEOPLE, ESPECIALLY THOSE MOST IN NEED WE CALL FORTH ALL WHO SERVE IN THIS HEALTHCARE MINISTRY, TO SHARE THEIR GIFTS AND TALENTS TO CREATE A SPIRIT OF HEALING - WITH REVERENCE AND LOVE FOR ALL OF LIFE, WITH JOYFULNESS OF SPIRIT, AND WITH HUMILITY AND JUSTICE FOR ALL THOSE ENTRUSTED TO OUR CARE WE ARE, WITH GOD'S HELP, A HEALING AND SPIRITUAL PRESENCE FOR EACH OTHER AND FOR THE COMMUNITIES WE ARE PRIVILEGED TO SERVE

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 \$ 177,927,120 including grants of \$ 18,148) (Revenue \$ 251,973,553)
	See Additional Data

4b	(Code) (Expenses \$ including grants of \$) (Revenue \$)
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4c	(Code) (Expenses \$ including grants of \$) (Revenue \$)
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


4d	Other program services (Describe in Schedule O)
	(Expenses \$ including grants of \$) (Revenue \$)

4e	Total program service expenses ▶	177,927,120
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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)? <i>If "Yes," complete Schedule A</i>	1 Yes	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	4	No
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? <i>If "Yes," complete Schedule C, Part III</i>	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	10	No
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	11b Yes	
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? <i>If "Yes," complete Schedule D, Part VIII</i>	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	11d	No
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i> (see instructions)	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	19	No

Part IV Checklist of Required Schedules (continued)

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

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	134	
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	1,930	
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)	Yes	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		No
b	If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
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?		No
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?		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
d	If "Yes," indicate the number of Forms 8282 filed during the year		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
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?		
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?		
9a	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		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)		
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		
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		
c	Enter the amount of reserves on hand		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		No
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 lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.Check if Schedule O contains a response or note to any line in this Part VI. ☒**Section A. Governing Body and Management**

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

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed▶	
18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> 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. ▶AMANDA HYMEL 5959 S SHERWOOD FOREST BLVD BATON ROUGE, LA 70809 (225) 765-8496	

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

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

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

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

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

[illegible]

[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 ▶ 127

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
FMOL Health System, 4200 Essen Lane Baton Rouge, LA 70809	Management Services	27,289,135
MORRISON MGMT SPECIALISTS, 5801 Peachtree Dunwoody Rd Atlanta, GA 30342	Dietary Services	5,219,044
Parish Anesthesia of Monroe, 3510 North Causeway Blvd Suite 404 Metairie, LA 70002	Anesthesia Services	2,845,497
Crothall Healthcare Inc, 5000 Hennessy Blvd Baton Rouge, LA 70808	PURCHASED SERVICE	3,317,256
TRIMEDX INC, 5451 Lakeview Parkway S Dr Indianapolis, IN 46268	Maintenance Services	3,586,273

Form 990 (2017)

Part VIII

Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . .	1a				
	b	Membership dues . . .	1b				
	c	Fundraising events . . .	1c				
	d	Related organizations	1d				
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	900,640			
	g	Noncash contributions included in lines 1a-1f \$ _____					
	h	Total. Add lines 1a-1f	900,640				
Program Service Revenue			Business Code				
	2a	PATIENT SERVICE REVENUE	621500	230,174,445	229,209,033	965,412	
	b	CAFETERIA	900099	1,942,168	1,942,168		
	c	MANAGEMENT CONSULTING FEES	900099	1,895,795	1,895,795		
	d	INCOME FROM EQUITY INVESTMENTS	900099	870,229	813,097	57,132	
	e	OTHER	900099	9,178,563	9,178,563		
	f	All other program service revenue					
	g	Total. Add lines 2a-2f	244,061,200				
Other Revenue	3		Investment income (including dividends, interest, and other similar amounts)	1,325,840		1,325,840	
	4		Income from investment of tax-exempt bond proceeds	0			
	5		Royalties	0			
	6a	(i) Real	(ii) Personal				
		Gross rents					
		4,020,910					
		b	Less rental expenses				
	c	Rental income or (loss)	4,020,910	0	4,020,910	4,020,910	
	d	Net rental income or (loss)	4,020,910	4,020,910			
	7a	(i) Securities	(ii) Other				
		Gross amount from sales of assets other than inventory					
		24,023,554	863,445				
		b	Less cost or other basis and sales expenses				
	c	Gain or (loss)	6,866,616	-10,872	6,855,743		6,855,743
	d	Net gain or (loss)	6,855,743				
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18		0			
		a	0				
b		Less direct expenses	0				
c	Net income or (loss) from fundraising events		0				
9a	Gross income from gaming activities See Part IV, line 19		0				
	a	0					
	b	Less direct expenses					0
c	Net income or (loss) from gaming activities		0				
10a	Gross sales of inventory, less returns and allowances		0				
	a	0					
	b	Less cost of goods sold					0
c	Net income or (loss) from sales of inventory		0				
Miscellaneous Revenue		Business Code					
11a	INCREASE IN ACCRUED PENSION			3,891,443	3,891,443		
b							
c							
d	All other revenue						
e	Total. Add lines 11a-11d			3,891,443			
12	Total revenue. See Instructions			261,055,776	250,951,009	1,022,544	
						8,181,583	

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 ☐

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.				
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	18,148	18,148		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
4 Benefits paid to or for members.	0			
5 Compensation of current officers, directors, trustees, and key employees.	932,963	573,546	359,417	
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.	86,130,196	52,949,206	33,180,990	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	5,930,980	3,646,116	2,284,864	
9 Other employee benefits.	9,310,576	5,723,749	3,586,827	
10 Payroll taxes.	5,808,857	3,571,040	2,237,817	
11 Fees for services (non-employees):				
a Management.	42,853,096	26,344,273	16,508,823	
b Legal.	404,458	248,644	155,814	
c Accounting.	0			
d Lobbying.	0			
e Professional fundraising services. See Part IV, line 17.	0			
f Investment management fees.	203,721		203,721	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	20,908,575	12,853,709	8,054,866	
12 Advertising and promotion.	349,767	215,022	134,745	
13 Office expenses.	24,305,851	14,942,211	9,363,640	
14 Information technology.	565,647	347,736	217,911	
15 Royalties.	0			
16 Occupancy.	8,040,658	4,943,057	3,097,601	
17 Travel.	662,367	407,195	255,172	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
19 Conferences, conventions, and meetings.	0			
20 Interest.	5,167,559	5,167,559		
21 Payments to affiliates.	0			
22 Depreciation, depletion, and amortization.	10,949,255	6,731,139	4,218,116	
23 Insurance.	3,152,453	1,937,995	1,214,458	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
a MEDICAL SUPPLIES EXPENSE	37,276,726	37,276,726		
b Equity Investments	49	49		
c OTHER	30,000	30,000		
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e.	263,001,902	177,927,120	85,074,782	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		40,561,295	1	26,970,251
	2	Savings and temporary cash investments		3,656,959	2	0
	3	Pledges and grants receivable, net		0	3	0
	4	Accounts receivable, net		28,838,994	4	32,799,186
	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		142,419	7	115,000
	8	Inventories for sale or use		5,571,610	8	5,903,892
	9	Prepaid expenses and deferred charges		3,565,803	9	2,434,707
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	10a 375,513,016			
	b	Less: accumulated depreciation	10b 275,482,193	106,570,162	10c	100,030,823
	11	Investments—publicly traded securities		36,796,793	11	0
	12	Investments—other securities. See Part IV, line 11		51,399,865	12	90,456,046
	13	Investments—program-related. See Part IV, line 11		14,311,790	13	0
	14	Intangible assets		3,736,701	14	3,736,701
	15	Other assets. See Part IV, line 11		10,222,452	15	9,470,408
16	Total assets. Add lines 1 through 15 (must equal line 34)		305,374,843	16	271,917,014	
Liabilities	17	Accounts payable and accrued expenses		40,681,285	17	36,467,276
	18	Grants payable		0	18	0
	19	Deferred revenue		0	19	0
	20	Tax-exempt bond liabilities		126,473,557	20	121,705,457
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		0	23	0
	24	Unsecured notes and loans payable to unrelated third parties		0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		82,507,684	25	86,523,687
	26	Total liabilities. Add lines 17 through 25		249,662,526	26	244,696,420
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		55,122,979	27	26,221,506
	28	Temporarily restricted net assets		589,338	28	999,088
	29	Permanently restricted net assets		0	29	0
	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.		55,712,317	33	27,220,594
34	Total liabilities and net assets/fund balances.		305,374,843	34	271,917,014	

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	261,055,776
2	Total expenses (must equal Part IX, column (A), line 25)	2	263,001,902
3	Revenue less expenses Subtract line 2 from line 1	3	-1,946,126
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	55,712,317
5	Net unrealized gains (losses) on investments	5	-2,124,969
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-24,420,628
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	27,220,594

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

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
b Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
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	Yes	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	Yes	
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

Form 990 (2017)

Form 990, Part III, Line 4a:

St Francis Medical Center provides quality hospital and medical services primarily to residents of Northeast Louisiana. The Medical Center is an active, caring member of the communities it serves. In carrying out its mission of meeting the healthcare needs of the people of God, the Medical Center has established a policy under which it provides care to needy members of its communities. Following that policy, health care services costing approximately, \$1,320,445 were provided without charge. The Medical Center provided 345 licensed beds, 71,635 inpatient days, 220,969 outpatient visits, and 52,221 ER visits in the year ended June 30, 2018.

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
R KEITH WHITE MD DIRECTOR/PHYSICIAN	40 0 0 0	X						858,984	0	30,953
THOMAS J GULLATT MD DIRECTOR/PHYSICIAN	40 0 0 0	X						522,356	0	61,033
KRISTIN WOLKART President/CEO	2 0 58 0	X		X				0	413,819	71,908
ROLF MORSTEAD MD Ex-Officio/Chief of Staff	2 0 0 0	X						0	0	0
SIDNEY BAILEY MD Director	1 0 0 0	X						0	0	0
NICK J BRUNO PH D Director	1 0 0 0	X						0	0	0
SR HELEN CAHILL Director	1 0 11 0	X						0	0	0
WILLIAM CHEEK CHAIRMAN	1 0 0 0	X		X				0	0	0
BISHOP MICHAEL G DUCA Director	1 0 0 0	X						0	0	0
HILL HINKLE MD Director	1 0 0 0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SUSAN HOFFMAN DIRECTOR	1 0 0 0	X						0	0	0
SR MARY ANN SEPULVADO OSF Director	1 0 1 0	X						0	0	0
REV LARRY STAFFORD VICE CHAIRMAN	1 0 1 0	X		X				0	0	0
JOHN REA DIRECTOR	1 0 0 0	X						0	0	0
LJ HOLLAND BOARD SECRETARY	1 0 0 0	X		X				0	0	0
REV EVERETT SLACK DIRECTOR	1 0 0 0	X						0	0	0
JANET DURDEN DIRECTOR	1 0 0 0	X						0	0	0
Tonya Hunter MD DIRECTOR	1 0 0 0	X						0	0	0
JEFF LIMBOCKER REGIONAL CFO	2 0 58 0			X				0	552,329	131,623
DAN MACKSOOD CONTRACT CFO	40 0 0 0			X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Tyler Felt COO	40 0 0 0			X				0	0	0
Fred Tolbert VP Ancillary Services	40 0 0 0			X				0	0	0
KAYLA JOHNSON VP Patient Care Services	40 0 0 0				X			228,624	0	58,953
SABRINA HOGAN VP Physician Services	40 0 0 0				X			242,452	0	67,902
KEVIN M MEYER Physician	40 0 0 0					X		455,213	0	24,847
FRANK B SARTOR Physician	40 0 0 0					X		481,786	0	25,288
MICHAEL LANGIULLI PHYSICIAN	40 0 0 0					X		776,023	0	23,715
John Califano Physician	40 0 0 0					X		504,483	0	27,609
JOHN D BRUCHHAUS PHYSICIAN	40 0 0 0					X		456,255	0	25,552
RONALD E HOGAN FORMER Regional CFO	0 0 0 0						X	0	210,339	0

SCHEDULE A (Form 990 or 990EZ)	Public Charity Status and Public Support Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990 .	OMB No 1545-0047 2017 Open to Public Inspection
	Department of the Treasury Internal Revenue Service Name of the organization ST FRANCIS MEDICAL CENTER	Employer identification number 72-0408970

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

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

- 1

☐

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

☐

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

☒

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

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

☐

An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III)
- 11

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

☐

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

Enter the number of supported organizations _____
- g

Provide the following information about the supported organization(s)

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

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

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

Section A. Public Support

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

Section B. Total Support

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

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

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

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

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

Part V

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

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

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

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

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

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493135046099									
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div>			<div>OMB No 1545-0047</div> <div>2017</div> <div>Open to Public Inspection</div>								
Name of the organization ST FRANCIS MEDICAL CENTER				Employer identification number 72-0408970									
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.													
		(a) Donor advised funds		(b) Funds and other accounts									
1		Total number at end of year											
2		Aggregate value of contributions to (during year)											
3		Aggregate value of grants from (during year)											
4		Aggregate value at end of year											
5		Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?											
		<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>											
6		Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?											
		<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>											
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.													
1 Purpose(s) of conservation easements held by the organization (check all that apply)													
<div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education)</div> <div><input type="checkbox"/> Preservation of an historically important land area</div> <div><input type="checkbox"/> Protection of natural habitat</div> <div><input type="checkbox"/> Preservation of a certified historic structure</div> <div><input type="checkbox"/> Preservation of open space</div>													
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year													
<div><div>Held at the End of the Year</div><table><tr><td>2a</td><td></td></tr><tr><td>2b</td><td></td></tr><tr><td>2c</td><td></td></tr><tr><td>2d</td><td></td></tr></table></div>						2a		2b		2c		2d	
2a													
2b													
2c													
2d													
a Total number of conservation easements													
b Total acreage restricted by conservation easements													
c Number of conservation easements on a certified historic structure included in (a)													
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register													
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►													
4 Number of states where property subject to conservation easement is located ►													
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?													
<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>													
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►													
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$													
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?													
<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>													
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements													
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.													
1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items													
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items													
(i) Revenue included on Form 990, Part VIII, line 1 ► \$													
(ii) Assets included in Form 990, Part X ► \$													
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items													
a Revenue included on Form 990, Part VIII, line 1 ► \$													
b Assets included in Form 990, Part X ► \$													
For Paperwork Reduction Act Notice, see the Instructions for Form 990.													
Cat No 52283D		Schedule D (Form 990) 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

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

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

☐

Part V

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

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

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Temporarily restricted endowment ▶

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

	Yes	No
3a(i)		
3a(ii)		
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		15,041,313		15,041,313
b Buildings		205,068,210	138,046,220	67,021,990
c Leasehold improvements		2,296,581	1,446,096	850,485
d Equipment		150,299,138	133,776,029	16,523,109
e Other		2,807,774	2,213,848	593,926
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				100,030,823

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) CAPITAL RESERVE INVESTMENTS	90,456,046	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12) ▶	90,456,046	

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	0
ACCRUED PENSION COSTS	66,143,804
GENERAL & PROFESSIONAL LIABILI	5,098,059
OTHER LIABILITIES	2,035,516
DUE TO RELATED PARTIES	13,246,308
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	86,523,687

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

☒

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

Supplemental Information

Return Reference	Explanation
FIN 48 (ASC 740) FOOTNOTE	SCHEDULE D, PART XIII "FMOLHS recognizes the effect of income tax positions only if those positions are more likely than not of being sustained Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized Changes in recognition or measurement are reflected in the period in which the change in judgement occurs No reserves for uncertain tax positions have been recorded "

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2017

Open to Public Inspection

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

Department of the Treasury

Internal Revenue Service

Name of the organization

ST FRANCIS MEDICAL CENTER

Employer identification number

72-0408970

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			355,277	355,277	0	0 %
b Medicaid (from Worksheet 3, column a)			51,743,733	44,995,791	6,747,942	2 420 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			52,099,010	45,351,068	6,747,942	2 420 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			12,366		12,366	
f Health professions education (from Worksheet 5)			49,818		49,818	0 020 %
g Subsidized health services (from Worksheet 6)			1,766,828	681,375	1,085,453	0 390 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			45,670		45,670	0 020 %
j Total. Other Benefits			1,874,682	681,375	1,193,307	0 430 %
k Total. Add lines 7d and 7j			53,973,692	46,032,443	7,941,249	2 850 %

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			48,465		48,465	0.020 %
2 Economic development						
3 Community support			12,730		12,730	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			3,587		3,587	
9 Other						
10 Total			64,782		64,782	0.020 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	10,851,354	
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	65,299,141
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	74,999,629
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-9,700,488
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input checked="" 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	Yes	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI.	9b	Yes	

Part IV Management Companies and Joint Ventures

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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 P&S SURGICAL HOSPITA	MEDICAL SERVICES	50 %	3.89 %	37.48 %
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

2

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

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

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
ST FRANCIS MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____	10	No
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b Yes	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

ST FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input checked="" type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> Other (describe in Section C)			

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

ST FRANCIS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

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

ST FRANCIS MEDICAL CENTER

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
P&S SURGERY CENTER LLC**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

2

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____	10	No
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b Yes	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

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

P&S SURGERY CENTER LLC

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150</u> % and FPG family income limit for eligibility for discounted care of <u>0</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input type="checkbox"/> The FAP was widely available on a website (list url) _____			
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 type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, 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 type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> Other (describe in Section C)			

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

P&S SURGERY CENTER LLC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

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

P&S SURGERY CENTER LLC

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

[illegible]

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 4

Name and address	Type of Facility (describe)
1 COMMUNITY HEALTH CENTER 2600 TOWER DRIVE MONROE, LA 71201	VARIOUS OUTPATIENT SERVICES
2 NORTHEAST LA CANCER INSTITUTE 411 CALYPSO STREET MONROE, LA 71210	CANCER TREATMENT AND IMAGING CENTER
3 Monroe MRI Center 501 Catalpa Street Monroe, LA 71201	MRI SERVICES
4 ST FRANCIS PET IMAGING OF MONROE PO BOX 1851 Monroe, LA 71201	PET IMAGING SERVICES
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C	FINANCIAL ASSISTANCE IS AVAILABLE FOR INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR ANY GOVERNMENT HEALTH CARE BENEFIT PROGRAM, AND WHO ARE UNABLE TO PAY FOR THEIR CARE FULL AND PARTIAL DISCOUNTED CARE IS AVAILABLE IF INCOME AND ASSETS MEET CERTAIN FEDERAL POVERTY GUIDELINE LEVELS DISCOUNTED CARE IS ALSO AVAILABLE FOR THOSE PATIENTS WITH CATASTROPHIC MEDICAL BILLS AND IS AVAILABLE IF MEDICAL BILLS EXCEED A CERTAIN PERCENTAGE OF INCOME AND ASSETS FULLY DISCOUNTED CARE IS ALSO AVAILABLE WHERE THE PATIENT OR OTHER SOURCES CAN PROVIDE SUFFICIENT EVIDENCE OF PRESUMPTIVE ELIGIBILITY PRESUMPTIVE ELIGIBILITY MAY BE DETERMINED ON THE BASIS OF INDIVIDUAL LIFE CIRCUMSTANCES THAT MAY INCLUDE 1) PATIENT RECEIVING FREE CARE FROM A COMMUNITY CLINIC AND IS REFERRED TO THE HOSPITAL, 2) STATE-FUNDED PRESCRIPTION PROGRAMS, 3) HOMELESS, INDIGENT, OR HOMELESS CLINIC PATIENT, 4) PATIENT'S CHILDREN WHO QUALIFY FOR OTHER FINANCIAL ASSISTANCE PROGRAMS, 5) PATIENT ELIGIBLE FOR FOOD STAMPS, 6) MEDICAID ELIGIBLE PATIENT, 7) PATIENT IS DECEASED WITH NO KNOWN RESPONSIBLE PARTY, 8) PATIENT IS INCARCERATED AND HAS NO OTHER RESPONSIBLE PARTY
PART I, LINE 7G	ST FRANCIS MEDICAL CENTER PROVIDES SUBSIDIZED HEALTH SERVICES, INCLUDING SERVICES THAT PROVIDE PEDIATRIC NEUROLOGY, PEDIATRIC NEUROSURGERY, AND ADULT NEUROLOGY THESE SPECIALIZED SERVICES ARE SUBSIDIZED BY ST FRANCIS MEDICAL CENTER SINCE THESE ARE UNDER-SERVED SPECIALTY AREAS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	THE COST-TO-CHARGE RATIO IS UTILIZED AS THE COSTING METHODOLOGY TO CALCULATE THE AMOUNTS REPORTED IN PART I LINES 7A-7D AND IS BASED ON THE JUNE 30, 2018 MEDICARE COST REPORT DATA FOR PART I LINES 7E, 7F, 7G, 7H AND 7I, DIRECT COSTS WERE CAPTURED FROM THE HOSPITAL'S AUDITED FINANCIAL STATEMENT AND THE MEDICARE COST REPORT WHERE APPLICABLE
PART III, LINE 4	THE BAD DEBT FOOTNOTE IS ON PAGE 15 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	THE COSTING METHODOLOGY USED TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE MEDICARE COST REPORT IS BASED ON REGULATORY REQUIREMENTS AND GUIDELINES THE ORGANIZATION CURRENTLY DOES NOT BELIEVE THAT ANY SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT
PART III, LINE 9B	PATIENTS WITH NO MEANS OF PAYMENT MAY APPLY FOR FINANCIAL ASSISTANCE APPROVAL WILL BE BASED ON INCOME, ASSETS, AND MEDICAL EXPENSES AS SET FORTH IN THE FINANCIAL ASSISTANCE POLICY ACCOUNTS MAY ALSO BE FULLY DISCOUNTED BASED ON A PRESUMPTIVE CHARITY SCORING SYSTEM WHICH IS SIMILAR TO CREDIT SCORING TO THE EXTENT APPROPRIATE AND PERMITTED BY LAW, FINANCIAL COUNSELING AND SCREENINGS ARE CONDUCTED AT THE TIME OF ENCOUNTER TO ASSIST IN IDENTIFYING PATIENTS WHO WOULD LIKELY QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S POLICY THESE PROCESSES HELP IDENTIFY (EARLY IN THE PROCESS) PATIENTS WHO QUALIFY FOR FINANCIAL ASSISTANCE THIS HELPS KEEP QUALIFYING PATIENTS OUT OF THE HOSPITAL'S COLLECTION PROCESSES BECAUSE AMOUNTS COVERED BY FINANCIAL ASSISTANCE ARE NOT SUBJECT TO THE HOSPITAL'S COLLECTION PRACTICES HOWEVER, IF IT IS DETERMINED THAT A PATIENT QUALIFIES FOR CHARITY CARE AFTER THE INDIVIDUAL'S ACCOUNT HAS BEEN SENT TO COLLECTIONS, THE DISCOUNTED AMOUNT IS IMMEDIATELY REMOVED FROM THE COLLECTIONS PROCESS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	NEEDS ASSESSMENT Responding to the health needs of our community, especially to those most in need, is primary to the hospital's mission As such, St Francis Medical Center, Inc works to conduct health care needs assessments They work closely with Families helping Families, The Wellspring, The Children's Coalition, YMCA and many other organizations to define community needs and to consolidate efforts to meet those community needs For example, a school-based health center and a diabetes and nutrition center was initiated after a health care assessment identified the need The hospital conducted an updated community based needs assessment in tax year 2015 and will continue to use community based data to support decisions for outreach in the community
PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE Patients are informed through a patient handbook that contains information on the financial policies of St Francis Medical Center Additionally, signs are posted in the Admissions areas that Financial Counseling is available upon request Systems and tools are utilized to conduct high level financial screening to assist in identifying patients eligible for financial assistance Financial counselors work closely with patients to assist with enrollment for those who are eligible for Medicaid as well as assist those who are eligible for HOSPITAL FINANCIAL ASSISTANCE in determining eligibility

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	<p>COMMUNITY INFORMATION ST FRANCIS MEDICAL CENTER (SFMC) IS A COMMUNITY-BASED, NOT-FOR-PROFIT HOSPITAL LOCATED IN MONROE, LOUISIANA THAT SERVES OUACHITA PARISH AND PORTIONS OF THE SURROUNDING PARISHES PURSUANT TO THE HOSPITAL'S LAST CHNA, SFMC'S PRIMARY SERVICE AREA HAS A POPULATION OF APPROXIMATELY 205,192 AND THE SENIOR POPULATION COMPRISES ABOUT 13.48% OF THE TOTAL POPULATION THE MEDIAN HOUSEHOLD INCOME IS \$39,309 AND 20.09% OF THE PARISH'S RESIDENTS LIVE BELOW THE POVERTY LEVEL ST FRANCIS MEDICAL CENTER PRIMARY SERVICE AREA INCLUDES THE FOLLOWING PARISH OUACHITA PARISH LINCOLN PARISH ST FRANCIS MEDICAL CENTER SECONDARY SERVICE AREA INCLUDES THE FOLLOWING PARISHES CALDWELL PARISH EAST CARROLL PARISH FRANKLIN PARISH JACKSON PARISH MADISON PARISH MOREHOUSE PARISH RICHLAND PARISH TENSAS PARISH UNION PARISH WEST CARROLL PARISH</p>
PART VI, LINE 5	<p>PROMOTION OF COMMUNITY HEALTH St Francis Medical Center participates in community improvement activities because it understands that improvements to a community have a direct link to the improved health of community residents Community improvement activities include the following SFMC provides occupancy and utilities free of charge to St Vincent DePaul charitable pharmacy so that the poorest individuals in the community have access to prescription drugs SFMC also provides occupancy free of charge to a primary health care clinic located in one of the poorest areas of Monroe These activities allow the recipient organizations to spend their available funds on activities that have more direct impact on those in need SFMC provides management oversight of community programs and activities, including Meals on Wheels, taxi and medication provided to the needy, and community benefit salary dollars SMFC proudly serves as the designated regional hospital for Region 8 and provides leadership and coordination for emergency preparedness activities SFMC provides leadership development and training for Roman Catholic Priests to serve in the SFMC Community SFMC improves access to public health through its financial support of an adult day health care facility and a school based health center SFMC has many programs designed to promote leadership development and provide exposure to various careers in health care Such programs include health information management, sports medicine program, AHEC (area health education center) program, Carroll High School Housekeeping Program and the Jr Volunteer Program A majority of the governing body of SFMC is comprised of individuals from a broad cross-section of the community who reside in the primary service area and who are neither employees nor contractors of the organization SFMC extends medical staff privileges to all qualified physicians in the community for some or all of the departments, as needed SFMC applies surplus funds to improvements in patient care through investment in clinical technology, medical information technology, and continued training of clinical staff</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	St Francis Medical Center is a not-for-profit hospital, non-stock member corporation of which Franciscan Missionaries of Our Lady Health System, Inc (FMOL Health System) is the sole member St Francis Medical Center is part of the FMOL Health System which includes several hospitals and tax-exempt affiliates throughout the state of Louisiana St Francis Medical Center serves the community in Northeastern Louisiana and Southern Arkansas Other related hospitals in Louisiana include Our Lady of Lourdes Regional Medical Center Our Lady of the Lake Hospital St Elizabeth Hospital Our Lady of the Lake Assumption Hospital OUR LADY OF THE ANGELS HOSPITAL
PART III, SECTION A, LINE 2	THE HOSPITAL ACCOUNTS FOR BAD DEBTS BASED ON THE AGING OF THE ACCOUNTS AND BASED ON THE HISTORICAL COLLECTION ASSOCIATED WITH THE VARIOUS AGING CATEGORIES ON A PERIODIC BASIS, THE ORGANIZATION CONDUCTS A RETROSPECTIVE REVIEW TO DETERMINE THE APPROPRIATENESS OF THE COLLECTION PERCENTAGES UTILIZED IN ESTIMATED BAD DEBT EXPENSE CHARITY AND DISCOUNTS ARE NOT INCLUDED IN BAD DEBT EXPENSE PAYMENTS RECEIVED ON ACCOUNTS SUBSEQUENT TO BEING CONSIDERED BAD DEBT ARE RECORDED AS A REDUCTION OF BAD DEBT EXPENSE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7F	FOR THE PURPOSE OF CALCULATING THE PERCENTAGE IN PART I, LINE 7, COLUMN F, FUNCTIONAL EXPENSES WERE USED WHICH DID NOT INCLUDE BAD DEBT EXPENSE

Schedule H (Form 990) 2017

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 2		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	ST FRANCIS MEDICAL CENTER PO BOX 1901 MONROE, LA 71210 www.fmolhs.org/stfran	X	X					X			
2	P&S SURGERY CENTER LLC 312 GRAMMONT STREET MONROE, LA 71201 www.pssurgery.com	X	X								

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5	ST FRANCIS MEDICAL CENTER (SFMC) AND P&S SURGICAL HOSPITAL THE ORGANIZATIONS ENGAGED KEY COMMUNITY PARTNERS THROUGH PERSONAL INTERVIEWS SFMC TOOK INTO ACCOUNT INPUT FROM THOSE WITH SPECIALIZED KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH BY INTERVIEWING DR SHELLEY JONES, WHO IS THE REGIONAL MEDICAL DIRECTOR/ADMINISTRATOR WITH THE OFFICE OF PUBLIC HEALTH ADDITIONALLY, SFMC ALSO TOOK INTO ACCOUNT INPUT FROM THOSE WHO REPRESENT A BROAD INTEREST IN THE COMMUNITY BY ATTENDING A PRIORITY AREA PRESENTATION BY DR MONTEIC SIZER, EXECUTIVE DIRECTOR OF NORTHEAST DELTA HUMAN SERVICES AUTHORITY, WHERE THERE WAS A DISCUSSION REGARDING EMERGING THEMES IN BEHAVIORAL HEALTH, MENTAL HEALTH, AND SUBSTANCE ABUSE

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 7A	ST FRANCIS MEDICAL CENTER THE CHNA CAN BE FOUND AT HTTPS //STFRAN COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT P&S SURGERY CENTER, LLC THE CHNA CAN BE FOUND AT HTTPS //STFRAN COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	<p>DURING THE CURRENT YEAR, SFMC FOCUSED ON IDENTIFIED COMMUNITY NEEDS OF OBESITY/SEDENTARY L IFESTYLES, HEART ATTACK/STROKE, CHRONIC DISEASE MANAGEMENT, AND TOBACCO USE (SUBSTANCE ABU SE) WHILE IT IDENTIFIED NINE HEALTH NEEDS, IT CHOSE NOT TO FOCUS ON ACCESS TO CARE, CARE FOR THE ELDERLY, MENTAL HEALTH, COMMUNICABLE/INFECTIOUS DISEASE, AND NUTRITION/HEALTHY EAT ING HOWEVER, SINCE THERE ARE LINKAGES AMONG ALL OF THESE AREAS, SFMC ANTICIPATES THAT THE OUTCOMES OF THE NON FOCUS AREAS WILL IMPROVE DUE TO THE TIE-INS THAT EXIST FOR EXAMPLE, WHILE WE DID NOT CHOOSE TO FOCUS ON NUTRITION/HEALTHY EATING, WE DID SELECT OBESITY/SEDENT ARY LIFESTYLES WHICH WILL HAVE TIE-INS TO HOW PEOPLE EAT ADDITIONALLY CARE FOR THE ELDERL Y WILL BE IMPROVED AS A COMPONENT OF IMPROVING HEALTH IN OUR FOCUS AREAS THE OTHER UNSELE CTED HeaIth NEEDS WILL NOT GO UNADDRESSED SINCE WORK IS CURRENTLY BEING DONE BY OUR OWN RE SOURCES AND/OR BY THE PROGRAMMING OF OTHER COMMUNITY ORGANIZATIONS ST FRANCIS MEDICAL CE NTER DID THE FOLLOWING OBESITY/SEDENTARY LIFESTYLES SFMC ESTABLISHED GOALS REGARDING THE NUMBER OF PATIENTS RECEIVING LACTATION COUNSELING, THE IMPLEMENTATION OF A SCREENING TOOL TO GAUGE UNDERSTANDING OF MATERIALS AND INITIATION OF BREASTFEEDING, AND THE DISTRIBUTION OF INFORMATION TO PROVIDERS AND NEW PARENTS SHOWING BREASTFEEDING AS AN EVIDENCE-BASED ST RATEGY TO COMBAT OBESITY THE HOSPITAL MET OR EXCEEDED ALL OF THESE GOALS THE HOSPITAL AL SO INCREASED THE PERCENTAGE OF PATIENTS RECEIVING BREASTFEEDING EDUCATION AS THEIR PRIMARY SOURCE OF INFORMATION ABOUT NEWBORN NUTRITION THE HOSPITAL ALSO HAS FOCUSED ON RETAINING TWO CERTIFIED LACTATION COUNSELORS THE HOSPITAL IS FOCUSING ON BETTER TRACKING OF ADULTS RECEIVING BMI SCREEINGS AND FOLLOW-UP EDUCATION HEART ATTACK/STROKE THE HOSPITAL MET IT S GOALS DURING THE FISCAL YEAR WITH REGARDS TO INCREASING THE PERCENTAGE OF ST FRANCIS ME DICAL GROUP PATIENTS RECEIVING EFFECTIVE CLINICAL CARE FOR CORONARY ARTERY DISEASE THROUGH ANTIPLATELET THERAPY, PRESENTING INFORMATION TO AT LEAST ONE OF EACH OF THE FOLLOWING FI RST RESPONDER, WOMEN'S GROUPS, COMMUNITY ORGANIZATION, SCHOOL, BUSINESS, HEALTHCARE PROFES SIONALS, IMPROVING TIME FROM HOSPITAL ARRIVAL TO PERCUTANEOUS INTERVENTION (PCI) FOR ELIGI BLE PATIENTS WITH HEART ATTACKS, AND PROVIDING EDUCATION TO AT LEAST 90% OF SFMC ORIENTATI ON SESSIONS CHRONIC DISEASE MANAGEMENT THE HOSPITAL HAS FOCUSED ON DEVELOPING A BUSINESS PLAN WITH GOALS AND STRATEGIES FOR REDUCING READMISSIONS WORK HAS ALSO BEEN DONE TOWARD CREATING A SPEAKERS' BUREAU TO HELP POSITION ST FRANCIS MEDICAL CENTER AS A RESOURCE IN T HE COMMUNITY THAT CAN BE CALLED UPON WHEN COMMUNITY PARTNERS NEED EDUCATION ABOUT A TOPIC RELATED TO CHRONIC DISEASE MANAGEMENT SUBSTANCE ABUSE/TOBACCO USE THE HOSPITAL MET ITS G OALS REGARDING INCREASING THE NUMBER OF NEW PATIENTS WHO ATTEND AN INTAKE SESSION AND AT L EAST ONE GROUP SESSION, AND ESTABLISHING TOBACCO CESSATION SUPPORT GROUPS P&S SURGICAL HO SPITAL (P&S) DURING THE CURRE</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	NT YEAR, P&S FOCUSED ON IDENTIFIED COMMUNITY NEEDS OF ACCESS TO DENTAL CARE AND OBESITY W HILE IT IDENTIFIED NINE HEALTH NEEDS DURING ITS LAST CHNA, IT CHOSE NOT TO FOCUS ON CHRONI C DISEASE MANAGEMENT, CARE FOR THE ELDERLY, SUBSTANCE ABUSE, MENTAL HEALTH, HEART ATTACK/S TROKE, COMMUNICABLE/INFECTIOUS DISEASE, AND NUTRITION/HEALTHY EATING EACH NEED NOT ADDRES SED IS EITHER BEING ADDRESSED BY OTHER ORGANIZATIONS IN THE COMMUNITY OR P&S IS NOT EQUIPP ED TO ADDRESS THE NEED P&S DID THE FOLLOWING ACCESS TO DENTAL CARE P&S IS PROVIDING DEN TAL CARE TO INDIVIDUALS WHO MIGHT NOT OTHERWISE HAVE ACCESS TO SUCH CARE LAST YEAR, 270 C ASES WERE HANDLED IN THE CURRENT YEAR, 320 CASES WERE HANDLED OBESITY P&S HAS MET ALL I TS GOALS RELATED TO OBESITY EMPLOYMENT/RETENTION OF ONE DIETITION, RETAINING CENTER OF EX CELLENCE DESIGNATION, RETAINING CENTER OF DISTINCTION DESIGNATION, PROVIDING A SUPPORT GRO UP

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
PART V, SECTION B, LINE 16J	St Francis Medical Center and P&S SURGERY CENTER, LLC Registration personnel refer patients that may have difficulty paying for their medical care to financial counselors to discuss qualifications for fully discounted care

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 13H	St Francis Medical Center Presumptive eligibility may be determined on the basis of individual life circumstances that may include 1 The patient receiving free care from a community clinic and is referred to the hospital, 2 State-funded prescription programs, 3 Homeless, indigent, or homeless clinic patient, 4 Patients children who qualify for other financial assistance programs, 5 Patient eligible for food stamps, 6 Medicaid eligible patient, 7 Patient is deceased with no known responsible party, 8 Patient is incarcerated and has no other responsible party

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16	PART V, SECTION B, LINE 16A, 16B 16C IT WAS DISCOVERED IN MAY 2018 THAT WHILE P&S DID HAVE ITS FAP, PLAIN LANGUAGE SUMMARY AND FINANCIAL ASSISTANCE APPLICATION AVAILABLE TO PATIENTS, IT ONLY HAD ITS FINANCIAL ASSISTANCE APPLICATION POSTED ON THE WEBSITE THE HOSPITAL FACILITY HAS SINCE BEEN FULLY ACQUIRED BY SFMC AS SUCH IT HAS BEEN FULLY INTEGRATED INTO SFMC'S FULLY COMPLIANT 501(R) POLICIES, PLS, AND WEBSITE POSTINGS ST FRANCIS MEDICAL CENTER THE FINANCIAL ASSISTANCE POLICY, FAP APPLICATION FORM, AND A PLAIN LANGUAGE SUMMARY ARE AVAILABLE AT HTTPS //FMOLHS ORG/FINANCIAL-ASSISTANCE-POLICY/ P&S SURGERY CENTER, LLC THE FINANCIAL ASSISTANCE POLICY, FAP APPLICATION FORM, AND A PLAIN LANGUAGE SUMMARY ARE AVAILABLE AT HTTPS //FMOLHS ORG/FINANCIAL-ASSISTANCE-POLICY/ PART V, SECTION B, LINE 16I ST FRANCIS MEDICAL CENTER WIDELY PUBLICIZES ITS FAP, IN PART, BY INCLUDING ON ITS WEBSITE LANGUAGE TRANSLATIONS OF ITS FINANCIAL ASSISTANCE POLICY AND ASSOCIATED DOCUMENTS P&S SURGICAL HOSPITAL, A SMALLER ASSOCIATED HOSPITAL, ALSO WIDELY PUBLICIZES THE FAP IN MANY WAYS HOWEVER, IT WAS DISCOVERED IN MAY 2018 THAT P&S WAS MISSING THE NEEDED TRANSLATIONS OF THE FINANCIAL ASSISTANCE POLICIES AND ASSOCIATED DOCUMENTS ON ITS WEBSITE P&S WAS FULLY ACQUIRED BY ST FRANCIS MEDICAL CENTER AND HAS NOW ADOPTED ALL OF ST FRANCIS'S POLICES SINCE P&S NO LONGER EXISTS AS A SEPARATE HOSPITAL FACILITY, THE NEEDED TRANSLATIONS AS POSTED ON ST FRANCIS'S WEBSITE WILL SERVE TO MEET 501(R) REQUIREMENTS THE WEBSITE CONTINUES TO BE ROUTINELY MONITORED TO ENSURE THE NEEDED TRANSLATED DOCUMENTS REMAIN AVAILABLE TO THE PUBLIC

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 21	WHILE ST FRANCIS MEDICAL CENTER HAS A COMPLIANT EMERGENCY CARE POLICY, IT WAS DISCOVERED THAT ITS SMALL AFFILIATED HOSPITAL, P&S SURGICAL HOSPITAL, HAD AN EMERGENCY CARE POLICY THAT WAS NOT FULLY IN COMPLIANCE WITH IRC REGULATION 1 501(R)-(C) DUE TO A SMALL AMOUNT OF MISSING LANGUAGE P&S DOES NOT HAVE AN EMERGENCY DEPARTMENT, BUT OTHERWISE OPERATED IN COMPLIANCE WITH EMTALA REGULATIONS P&S DID NOT DISCRIMINATE AGAINST ANY PATIENT WITH AN EMERGENCY CONDITION P&S WAS FULLY ACQUIRED BY ST FRANCIS AND HAS ADOPTED ST FRANCIS'S EMERGENCY CARE POLICY THAT INCLUDES ALL REQUIRED LANGUAGE

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 20A	ST FRANCIS MEDICAL CENTER SFMC HAS A FINANCIAL ASSISTANCE POLICES DESIGNED TO ASSIST PATIENTS WITH LOW INCOME AND NO HEALTH INSURANCE FOR THOSE WHO FALL OUTSIDE OF THIS FINANCIAL ASSISTANCE POLICY, SFMC WILL INITIATE EXTRAORDINARY COLLECTION ACTIONS (ECAS) IN AN EFFORT TO COLLECT PAYMENT FOR SERVICES PROVIDED IRC REGULATION 1 501(R)-6(C)(4)(A) REQUIRES THAT SFMC SEND TO ALL PATIENTS (EVEN NON-QUALIFYING PATIENTS WITH HEALTH INSURANCE) A PLAIN LANGUAGE SUMMARY OF THE FAP AND A COMPLIANT LETTER PRIOR TO INITIATING THE ECA IT WAS DISCOVERED IN MAY 2018 THAT TWO COLLECTION VENDORS OF SFMC DID NOT FULLY COMPLY WITH MAKING REASONABLE EFFORTS IN ACCORDANCE WITH IRC 1 501(R)-6 (C)(4) DESPITE THE HOSPITAL GIVING THEM DETAILED INSTRUCTIONS TO DO SO UPON DISCOVERY, THE HOSPITAL TOOK IMMEDIATE ACTION AND CORRECTED THE COLLECTION VENDORS' PROCESSES FOR PATIENTS POTENTIALLY AFFECTED, THE COLLECTION VENDORS WILL NOT PERFORM ECAS AND WILL PROCESS FINANCIAL ASSISTANCE APPLICATIONS REGARDLESS OF TIMEFRAMES BEFORE THE FISCAL YEAR ENDED, THE HOSPITAL INSTITUTED NEW PROCEDURES AND NEW TECHNOLOGY TO PREVENT THIS FROM REOCCURRING P&S SURGERY CENTER, LLC P&S SURGERY CENTER LLC INITIATES VERY FEW ECAS OF THOSE INITIATED, P&S WAITED MORE THAN 240 DAYS BEFORE INITIATING ECAS IN COMPLIANCE WITH THE IRC 501(R) REGULATIONS P&S ALSO SENT LETTERS NOTIFYING THE PATIENTS OF THE UPCOMING ECA HOWEVER, THE LANGUAGE IN SUCH LETTER WAS NOT FULLY COMPLIANT WITH IRC 501(R) REGULATIONS AND P&S CANNOT PROVE WHETHER ORAL NOTIFICATIONS WERE OR WERE NOT MADE WITHIN REGULATION TIMEFRAMES SHORTLY AFTER DISCOVERY OF THIS PROBLEM IN MAY, 2018, P&S SURGERY CENTER LLC WAS FULLY ACQUIRED BY ST FRANCIS MEDICAL CENTER UPON ACQUISITION, BILLING AND COLLECTION PRACTICES WERE FULLY INTEGRATED INTO ST FRANCIS MEDICAL CENTER'S PRACTICES

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

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

Form and Line Reference	Explanation
SUPPLEMENTAL INFORMATION	P&S SURGERY CENTER WAS ACQUIRED BY ST FRANCIS MEDICAL CENTER IN SEPTEMBER OF 2018, SO ALL LINKS TO P&S DOCUMENTS WILL BE TO ST FRANCIS MEDICAL CENTER'S WEBSITE

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization ST FRANCIS MEDICAL CENTER	Employer identification number 72-0408970
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Part I Questions Regarding Compensation

	Yes	No								
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input checked="" type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input checked="" type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input checked="" type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.	1b									
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2									
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> 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?	4a	Yes								
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes								
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No								
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.										
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.										
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:										
a The organization?	5a	No								
b Any related organization?	5b	No								
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?	6a	No								
b Any related organization?	6b	No								
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 in lines 5 and 6? If "Yes," describe in Part III.	7	No								
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.	8	No								
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9									

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

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

See Additional Data Table

Schedule J (Form 990) 2017

Part III Supplemental Information

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

Return Reference	Explanation
PART I, QUESTION 3	THE CEO IS PAID BY FMOL HEALTH SYSTEM, A RELATED TAX EXEMPT ORGANIZATION. THE FMOLHS BOARD OF DIRECTORS DESIGNATES A COMPENSATION COMMITTEE, MADE UP OF INDEPENDENT BOARD MEMBERS, TO REVIEW AND SET THE CEO'S COMPENSATION ANNUALLY. THE COMPENSATION COMMITTEE OBTAINS AND RELIES UPON COMPARABLE DATA INCLUDING A COMPENSATION STUDY/SURVEY FROM AN INDEPENDENT COMPENSATION CONSULTANT. THE COMPENSATION COMMITTEE REVIEWS COMPENSATION PACKAGES AND APPROPRIATE COMPENSATION IS DETERMINED AND APPROVED. THE BASIS FOR DETERMINATION IS THEN DOCUMENTED BY THE COMPENSATION COMMITTEE. THE CEO ALSO SIGNS A WRITTEN EMPLOYMENT AGREEMENT.
PART I, QUESTION 4B	FMOLHS maintains three unfunded deferred compensation plans which meet the requirements of IRC Section 457(f) and IRC Section 409A. The plans provide for compensation to be deferred and paid upon the occurrence of certain events such as termination without cause, disability, death or attainment of a specific payment date. Participation in the plans is limited to certain executives and is subject to approval of FMOLHS board of directors or a designated committee of such board. No one listed on Part VII, Section A received a payment from the plans in the current year.
PART I, QUESTION 4A	Two officers are entitled to a severance benefit. The payout of such benefit is remote as it is effective only for a termination of employment without cause, for good reason or due to change of control. If triggered, the employee would be paid his/her base salary and provided retirement and welfare benefits for an entitlement period. The entitlement period is 12 months. No payments were made under the plan in the current year. Ronald Hogan received a severance payment of \$210,339 during the current year.
PART I, QUESTION 1A	TWO OFFICERS LISTED ON PART VII RECEIVED A HOUSING ALLOWANCE DURING THE YEAR. THE HOUSING ALLOWANCES WERE INCLUDED AS TAXABLE COMPENSATION TO THE INDIVIDUALS.

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(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				
1R KEITH WHITE MD DIRECTOR/PHYSICIAN	(i)	651,846	203,720	3,418	6,750	24,203	889,937	0
	(ii)	0	0	0	0	0	0	0
1THOMAS J GULLATT MD DIRECTOR/PHYSICIAN	(i)	456,938	62,000	3,418	42,495	18,538	583,389	0
	(ii)	0	0	0	0	0	0	0
2KRISTIN WOLKART President/CEO	(i)	0	0	0	0	0	0	0
	(ii)	325,831	73,413	14,575	47,765	24,143	485,727	0
3RONALD E HOGAN FORMER Regional CFO	(i)	0	0	0	0	0	0	0
	(ii)	0	0	210,339	0	0	210,339	0
4KEVIN M MEYER Physician	(i)	369,252	83,093	2,868	6,750	18,097	480,060	0
	(ii)	0	0	0	0	0	0	0
5KAYLA JOHNSON VP Patient Care Services	(i)	195,378	31,912	1,334	35,039	23,914	287,577	0
	(ii)	0	0	0	0	0	0	0
6FRANK B SARTOR Physician	(i)	438,435	39,243	4,108	6,750	18,538	507,074	0
	(ii)	0	0	0	0	0	0	0
7SABRINA HOGAN VP Physician Services	(i)	209,420	32,217	815	42,495	25,407	310,354	0
	(ii)	0	0	0	0	0	0	0
8MICHAEL LANGIULLI PHYSICIAN	(i)	594,732	178,863	2,428	6,750	16,965	799,738	0
	(ii)	0	0	0	0	0	0	0
9John Califano Physician	(i)	462,001	40,453	2,029	6,750	20,859	532,092	0
	(ii)	0	0	0	0	0	0	0
10JEFF LIMBOCKER REGIONAL CFO	(i)	0	0	0	0	0	0	0
	(ii)	427,364	110,390	14,575	107,606	24,017	683,952	0
11JOHN D BRUCHHAUS PHYSICIAN	(i)	379,933	62,000	14,322	0	25,552	481,807	0
	(ii)	0	0	0	0	0	0	0

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
ST FRANCIS MEDICAL CENTER

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

72-0408970

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section A, Question 6	FMOL Health System, Inc (an IRC Section 501(C)(3) organization) is the sole member of the medical center

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION A, QUESTION 7A	FMOL HEALTH SYSTEM, INC AS THE SOLE MEMBER OF THE MEDICAL CENTER, RETAINS THE POWER TO AP POINT AND REMOVE THE MEMBERS OF THE BOARD OF TRUSTEES AND OFFICERS OF ST FRANCIS MEDICAL CENTER

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION A, QUESTION 7B	<p>THE RESERVED POWERS TO FMOL HEALTH SYSTEM, INC ARE AS FOLLOWS</p> <ul style="list-style-type: none">i To change philosophy, objectives and purposes of corporationii To appoint or remove the Members of the Board of Trustees and Officers of the corporationiii To amend, alter, modify or repeal the Articles of Incorporation and Bylaws of the corporationiv To authorize merger, consolidation, or affiliation, or participate in joint venturesv To dissolve and to distribute assets of the corporationvi To appoint and/or terminate with or without cause the Chief Executive Officer of the corporationvii To acquire, purchase, sell, lease, transfer, or encumber any immovable property on behalf of the corporationviii To add to or incur long-term debt in excess of \$5 million by the Corporationix To appoint the fiscal auditor for the corporationx To approve any increment or addition to the capital debt or efforts to renegotiate, modify or change the existing capital debt obligations of the corporationxi To approve the annual operating and capital budgets of the corporationxii To approve a strategic business plan of the corporation

990 Schedule O, Supplemental Information

Return Reference	Explanation
Part VI, Section A, Question 11A	AFTER PREPARATION AND REVIEW OF FORM 990 BY KPMG LLP, THE TAXPAYER'S TAX ADVISORS, ONE OR MORE MEMBERS OF SENIOR MANAGEMENT REVIEWS THE RETURN ST FRANCIS MEDICAL CENTER'S GOVERNING BODY IS PROVIDED A COPY OF THE RETURN ELECTRONICALLY PRIOR TO THE FILING DATE AND IS GIVEN AN OPPORTUNITY TO REVIEW AND PROVIDE COMMENTS TO MANAGEMENT

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION B, QUESTION 12C	<p>St Francis Medical Center has a comprehensive conflict of interest policy that requires each officer, trustee, board committee member and employee to complete a conflict of interest disclosure statement annually. Completed disclosure forms are reviewed and maintained by the Chief Compliance Officer. If any trustee, Board committee member or senior manager has as a potential conflict, the Executive Committee of the Board determines whether action needs to be taken and communicates any such action to the individual. A potential conflict of any other employee is reviewed by the CEO or his designee. The Executive Committee, CEO or designee, as applicable, determines if a conflict of interest exists or creates the appearance of impropriety. If such a determination is made, the individual will be excused from participating in the business decision. During the year, any change to the information in the disclosure statement must be disclosed promptly to the Chief Compliance Officer, who takes appropriate action. The process also requires affirmation from each individual that she/he (a) has received a copy of the conflict of interest policy, (b) has read and understands the policy, (c) has agreed to comply with the policy, and (d) understands that St Francis Medical Center is a charitable organization and that, in order to maintain its Federal tax exemption, it must engage primarily in activities which accomplish one or more of its tax-exempt purposes. In addition to the above, St Francis Medical Center provides mechanisms for confidential reporting of compliance issues. These mechanisms include an anonymous hotline and Web site where individuals may raise issues, seek clarification, and report possible conflicts of interest or other concerns. These reports, including reports of possible conflicts of interest, are reviewed and investigated by the Corporate Compliance Department and appropriate action is taken.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION B, QUESTION 15A & 15B	<p>Our Board of Directors designates an executive committee made up of independent board members to review and set the compensation annually of our officers and key employees. The executive committee obtains and relies upon comparable data including industry-wide compensation information provided by an outside consulting firm. The executive committee reviews compensation packages and appropriate compensation is determined and approved. The basis for determination is then documented by the executive committee. The compensation for the CEO of St. Francis Medical Center is set by the compensation committee of FMOL Health System (a related tax-exempt organization) according to their pay practices which are similar to those described above.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
GOVERNING DOCUMENTS	PART VI, SECTION C, QUESTION 19 The organization makes its governing documents, conflict of interest policy and financial statements available upon request

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART XI, QUESTION 9	CAPITAL TRANSFERS \$(24,420,628)

990 Schedule O, Supplemental Information

Return Reference	Explanation
SECTION 1 263(A)-3(N) ELECTION- BOOK CONFORMITY ELECTION	ST FRANCIS MEDICAL CENTER is making the election under Treas Reg 1 263(a)-3(n) to capitalize those repair and maintenance costs that it treats as capital improvements on its books and records for the tax year ended JUNE 30, 2018

990 Schedule O, Supplemental Information

Return Reference	Explanation
SECTION 1 263 (A)-1 (F)- ELECTION- DE MINIMIS SAFE HARBOR ELECTION	ST FRANCIS MEDICAL CENTER hereby makes the de minimis safe harbor election under Section 1 263(a)-1(f) of the Treasury Regulations, effective only for the tax year ending June 30, 2018 Taxpayer has an Applicable Financial Statement for the year of the election This election permits the taxpayer to deduct for tax purposes any item deducted under its book policy that does not exceed \$5,000 per invoice (or per item, as substantiated by the invoice) or items having an economic useful life of twelve months or less as described in Section 1 263(a)-1(f)(1)(i)

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION A, QUESTION 3	SUMMIT TALENT GROUP, LLC WAS HIRED TO PROVIDE CFO SERVICES DURING AN INTERIM PERIOD FOR ST FRANCIS MEDICAL CENTER

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ST FRANCIS MEDICAL CENTER

Employer identification number
72-0408970

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) ST FRANCIS MEDICAL GROUP PO BOX 1901 MONROE, LA 71210	HEALTHCARE	LA	20,329,764	-4,418,680	SFMC

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 BERNARD HEALTH FUND 4200 ESSEN LANE BATON ROUGE, LA 70809 20-4685614	HEALTHCARE	LA	501(C)(3)	11 TYPE 1	FMOL		No
(2)HEALTH CARE CENTERS IN SCHOOLS 5000 HENNESSY BLVD BATON ROUGE, LA 70808 72-1443935	HEALTHCARE	LA	501(C)(3)	7	OLOL	Yes	
(3)ST FRANCIS AMBULATORY SERVICES PO BOX 1901 MONROE, LA 71210 72-1206096	HEALTHCARE	LA	501(C)(3)	3	SFMC	Yes	

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

See Additional Data Table

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

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) ST FRANCIS INSURANCE AGENCY 309 JACKSON STREET MONROE, LA 71201 72-1435136	INSURANCE	LA	SFMC	C CORP	3,497	0	100 000 %	Yes	
(2) HOSPITAL ASSISTANCE SERVICES PO BOX 4027-C LAFAYETTE, LA 70502 72-1073486	HEALTHCARE	LA	LOURDES	C CORP					
(3) LOUISE INSURANCE COMPANY PO BOX 1051 CAYMAN ISLANDS KY1-1102 CJ	INSURANCE	CJ	FMOL	C CORP					
(4) MONROE HEALTH SERVICES PO BOX 3187 MONROE, LA 71210 72-1057820	HEALTHCARE	LA	AMBULATORY	C CORP					
(5) NORTHEAST LA HEALTH NETWORK 309 JACKSON STREET MONROE, LA 71201 72-1294587	HEALTHCARE	LA	AMBULATORY	C CORP					
(6) FRANCISCAN HEALTH & WELLNESS SERVICES I 4200 ESSEN LANE BATON ROUGE, LA 70809 45-5492379	HEALTHCARE	LA	FMOL	C CORP					
(7) FMOL HEALTH SYSTEM HOLDINGS INC 4200 ESSEN LANE BATON ROUGE, LA 70809 45-4405024	INVESTMENT	LA	FMOL	C CORP					

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

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a Yes	
b Gift, grant, or capital contribution to related organization(s)	1b	No
c Gift, grant, or capital contribution from related organization(s)	1c	No
d Loans or loan guarantees to or for related organization(s)	1d	No
e Loans or loan guarantees by related organization(s)	1e	No
f Dividends from related organization(s)	1f	
g Sale of assets to related organization(s)	1g	No
h Purchase of assets from related organization(s)	1h	No
i Exchange of assets with related organization(s)	1i	No
j Lease of facilities, equipment, or other assets to related organization(s)	1j Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	No
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	No
o Sharing of paid employees with related organization(s)	1o	No
p Reimbursement paid to related organization(s) for expenses	1p Yes	
q Reimbursement paid by related organization(s) for expenses	1q	No
r Other transfer of cash or property to related organization(s)	1r Yes	
s Other transfer of cash or property from related organization(s)	1s Yes	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) P&S SURGERY CENTER	a	901,105	FMV
(2) P&S SURGERY CENTER	l	226,020	FMV

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

[illegible]

Part VII **Supplemental Information**

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

Additional Data

Software ID:
Software Version:
EIN: 72-0408970
Name: ST FRANCIS MEDICAL CENTER

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
HEART HOSPITAL OF ACADIANA LLC 1105 KALISTE SALOOM ROAD LAFAYETTE, LA 70508 30-0442368	HEALTHCARE	LA	LOURDES	N/A								
PERKINS PLAZA IMAGING DEVELOPMENT LLC 5000 HENNESSY BLVD BATON ROUGE, LA 70808 20-3894521	REAL ESTATE	LA	OLOL	N/A								
P&S SURGERY CENTER LLC 312 GRAMMONT STREET MONROE, LA 71201 72-1387870	HEALTHCARE	LA	SFMC	RELATED	-110,367	9,263,178		No	0	Yes		50 000 %
LOURDES IMAGING DEVELOPMENT LLC 4801 AMBASSADOR CAFFERY PKWY LAFAYETTE, LA 70508 20-8326287	REAL ESTATE	LA	LOURDES	N/A								
PARK PLACE SURGERY CENTER LLC 4811 AMBASSADOR CAFFERY PKWY LAFAYETTE, LA 70508 72-1404092	HEALTHCARE	LA	LOURDES	N/A								
BRPT LAKE REHABILITATION CENTERS LLC 5222 BRITTANY DRIVE BATON ROUGE, LA 70808 72-1506100	HEALTHCARE	LA	OLOL	N/A								
CONVENIENT CARE LLC 10319 JEFFERSON HIGHWAY BATON ROUGE, LA 70809 72-1439481	HEALTHCARE	LA	OLOL	N/A								
SURGICAL SPECIALTY CENTER OF BATON ROUGE 8080 BLUEBONNET BLVD BATON ROUGE, LA 70810 26-3160962	HEALTHCARE	LA	OLOL	N/A								
ST ELIZABETH-MARY BIRD PERKINS CANCER C 4950 ESSEN LANE BATON ROUGE, LA 70809 26-0628752	HEALTHCARE	LA	STEH	N/A								
ST MARYS IMAGING CENTER II LLC 4801 AMBASSADOR CAFFERY PKWY LAFAYETTE, LA 70508 72-1329499	HEALTHCARE	LA	LOURDES IMAGING	N/A								
NORTHEAST LA CANCER INSTITUTE LLC 411 CALYPSO STREET MONROE, LA 71201 72-1329499	HEALTHCARE	LA	SFMC	RELATED	621,795	5,715,404		No	0	Yes		50 000 %
LHCG-XIII LLC 901 S HUGH WALLIS ROAD LAFAYETTE, LA 70508 20-8068308	HEALTHCARE	LA	LOURDES	N/A								
LOURDES AFTER HOURS LLC 7777 HENNESSY BLVD SUITE 1004-202 BATON ROUGE, LA 70809 20-1367299	HEALTHCARE	LA	LOURDES	N/A								
LAKE URGENT CARE ASCENSION LLC 10319 JEFFERSON HIGHWAY BATON ROUGE, LA 70809 35-2463092	HEALTHCARE	LA	STEH	N/A								
LAKE URGENT CARE ASCENSION LLC 10319 JEFFERSON HIGHWAY BATON ROUGE, LA 70809 35-2463092	HEALTHCARE	LA	OLOL	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Dispropportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
OLOLUSP SURGERY CENTER LLC 15305 DALLAS PKWY STE 1600 LB 28 ADDISON, TX 75001 35-2457810	HEALTHCARE	TX	LOL	N/A								
ST FRANCIS URGENT CARE LLC 10319 JEFFERSON HIGHWAY BATON ROUGE, LA 70809 47-4013731	HEALTHCARE	LA	SFMC	RELATED	2,102,593	640,046		No	0	Yes		50 000 %
GAMMA KNIFE OF LOUISIANA LLC 4950 ESSEN LANE BATON ROUGE, LA 70809 81-1827194	HEALTHCARE	LA	LOL	N/A								
LHCG LXVII LLC 901 S HUGH WALLIS ROAD LAFAYETTE, LA 70508 72-0423635	HEALTHCARE	LA	LOURDES	N/A								
PREMIER HEALTH HOLDINGS LLC 10319 JEFFERSON HIGHWAY BATON ROUGE, LA 70809 47-2665226	HEALTHCARE	LA	LOL	N/A								
PINNACLE CARE HOLDINGS LLC 5627 S SHERWOOD FOREST BLVD BATON ROUGE, LA 70816 72-0423651	HEALTHCARE	LA	LOURDES	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
ST FRANCIS INSURANCE AGENCY 309 JACKSON STREET MONROE, LA 71201 72-1435136	INSURANCE	LA	SFMC	C CORP	3,497	0	100 000 %	Yes	
HOSPITAL ASSISTANCE SERVICES PO BOX 4027-C LAFAYETTE, LA 70502 72-1073486	HEALTHCARE	LA	LOURDES	C CORP					
LOUISE INSURANCE COMPANY PO BOX 1051 CAYMAN ISLANDS KY1-1102 CJ	INSURANCE	CJ	FMOL	C CORP					
MONROE HEALTH SERVICES PO BOX 3187 MONROE, LA 71210 72-1057820	HEALTHCARE	LA	AMBULATORY	C CORP					
NORTHEAST LA HEALTH NETWORK 309 JACKSON STREET MONROE, LA 71201 72-1294587	HEALTHCARE	LA	AMBULATORY	C CORP					
FRANCISCAN HEALTH & WELLNESS SERVICES I 4200 ESSEN LANE BATON ROUGE, LA 70809 45-5492379	HEALTHCARE	LA	FMOL	C CORP					
FMOL HEALTH SYSTEM HOLDINGS INC 4200 ESSEN LANE BATON ROUGE, LA 70809 45-4405024	INVESTMENT	LA	FMOL	C CORP					