

2949818701317 9

Form 990

## Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public  
InspectionDepartment of the Treasury  
Internal Revenue Service

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

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

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

A For the 2017 calendar year, or tax year beginning

07/01/2017, and ending

06/30, 2018

B Check if applicable

Address change
X Name change
Initial return
Final return/terminated
Amended return
Application pending

C Name of organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

D Employer identification number

81-4322087

Doing business as

Number and street (or P O box if mail is not delivered to street address)  
6600 S. YALE AVENUE, SUITE 400

Room/suite

E Telephone number  
(918) 494-8430City or town, state or province, country, and ZIP or foreign postal code  
TULSA, OK 74136-3319

G Gross receipts \$ 146,422,294.

F Name and address of principal officer ERIC E. SCHICK  
6600 S. YALE AVENUE, SUITE 400 TULSA, OK 74136-3319H(a) Is this a group return for subordinates?  Yes  NoH(b) Are all subordinates included?  Yes  No

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

H(c) Group exemption number I Tax-exempt status  501(c)(3)  501(c)( ) (insert no) 4947(a)(1) or 527J Website ► [HTTPS://WWW.SAINTRFRANCIS.COM/MUSKOGEE](https://www.saintfrancis.com/muskogee)K Form of organization  Corporation  Trust  Association  Other ► L Year of formation 2016 M State of legal domicile OK

## Part I Summary

1	Briefly describe the organization's mission or most significant activities MINISTRY OF CHRIST IN ALL WE DO.	TO EXTEND THE PRESENCE AND HEALING
2	Check this box ► <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets	
3	Number of voting members of the governing body (Part VI, line 1a)	3 3.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4 1.
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5 912.
6	Total number of volunteers (estimate if necessary)	6 79.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a 0.
b	Net unrelated business taxable income from Form 990-T, line 34	7b 0.
Revenue	Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	0. 0.
9	Program service revenue (Part VIII, line 2g)	34,071,679. 145,181,334.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1. -57,993.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	264,981. 952,979.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	34,336,661. 146,076,320.
Expenses	Prior Year	Current Year
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0. 0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0. 0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	14,382,549. 50,810,667.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0. 0.
b	Total fundraising expenses (Part IX, column (D), line 25) ► 0.	
17	Other expenses (Part IX, column (A), lines 11a-11d, 17-24a)	22,879,213. 99,120,303.
18	Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	37,261,762. 149,930,970.
19	Revenue less expenses Subtract line 18 from line 12	-2,925,101. -3,854,650.
Net Assets or Fund Balances	Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	128,325,857. 130,695,468.
21	Total liabilities (Part X, line 26)	10,600,191. 13,280,051.
22	Net assets or fund balances Subtract line 21 from line 20	117,725,666. 117,415,417.

## 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	► <i>Eric Schick</i>	Date 5/12/19
	Signature of officer ERIC E. SCHICK	
	Type or print name and title TREASURER/CFO	

Paid Preparer Use Only	Print/Type preparer's name KATHLEEN MOSELEY	Preparer's signature <i>Kathleen Moseley</i>	Date 05/08/19	Check <input type="checkbox"/> if self-employed	PTIN P00116760
	Firm's name ► ERNST & YOUNG U.S. LLP			Firm's EIN ► 34-6565596	
	Firm's address ► 425 HOUSTON STREET, STE 600 FORT WORTH, TX 76102			Phone no 817-335-1900	

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

For Paperwork Reduction Act Notice, see the separate instructions.

JSA  
7E1010 1 000

5929MP 3987

V 17-7.10

H

907 Form 990 (2017)

066  
383

14532018 2020 JUN 2020

SCANNED AUG 28 2018

16

**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  X

---

**1 Briefly describe the organization's mission**

TO EXTEND THE PRESENCE AND HEALING MINISTRY OF CHRIST IN ALL WE DO.

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 \$ 130,427,337 including grants of \$ 0. ) (Revenue \$ 145,181,334 )  
SEE SCHEDULE Q

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

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

**4d Other program services (Describe in Schedule O )**

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

4e Total program service expenses ► 130,427,337.

ADH JRD

**Part IV Checklist of Required Schedules**

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

## Part IV Checklist of Required Schedules (continued)

		Yes	No
20a	Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H. . . . .	20a	X
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	20b	X
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II. . . . .	21	X
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III. . . . .	22	X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J . . . . .	23	X
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a. . . . .	24a	X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	24b	
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	24c	
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	24d	
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I . . . . .	25a	X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I . . . . .	25b	X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II . . . . .	26	X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III. . . . .	27	X
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)	28a	X
a	A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . .	28b	X
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV. . . . .	28c	X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV. . . . .	29	X
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M. . . . .	30	X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M . . . . .	31	X
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I. . . . .	32	X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II . . . . .	33	X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? If "Yes," complete Schedule R, Part I . . . . .	34	X
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 . . . . .	35a	X
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)? . . . . .	35b	X
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 . . . . .	36	X
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 . . . . .	37	X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI . . . . .	38	X
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		

Part V Statements Regarding Other IRS Filings and Tax Compliance		
Check if Schedule O contains a response or note to any line in this Part V . . . . . <input checked="" type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. . . . .	1a <input type="text"/> 236
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. . . . .	1b <input type="text"/> 0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	1c <input checked="" type="checkbox"/>
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. . . . .	2a <input type="text"/> 912
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) . . . . .	2b <input checked="" type="checkbox"/>
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	3a <input checked="" type="checkbox"/>
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O. . . . .	3b <input type="checkbox"/>
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .	4a <input type="checkbox"/>
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)	<input type="text"/>
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	5a <input checked="" type="checkbox"/>
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .	5b <input checked="" type="checkbox"/>
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T? . . . . .	5c <input type="checkbox"/>
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .	6a <input checked="" type="checkbox"/>
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	6b <input type="checkbox"/>
7	Organizations that may receive deductible contributions under section 170(c).	<input type="checkbox"/>
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .	7a <input type="checkbox"/>
b	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	7b <input type="checkbox"/>
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	7c <input checked="" type="checkbox"/>
d	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	7d <input type="text"/>
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . .	7e <input checked="" type="checkbox"/>
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .	7f <input checked="" type="checkbox"/>
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	7g <input type="checkbox"/>
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	7h <input type="checkbox"/>
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .	8 <input type="checkbox"/>
9	Sponsoring organizations maintaining donor advised funds.	<input type="checkbox"/>
a	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	9a <input type="checkbox"/>
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .	9b <input type="checkbox"/>
10	Section 501(c)(7) organizations. Enter	<input type="checkbox"/>
a	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	10a <input type="checkbox"/>
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. . . . .	10b <input type="checkbox"/>
11	Section 501(c)(12) organizations. Enter	<input type="checkbox"/>
a	Gross income from members or shareholders. . . . .	11a <input type="checkbox"/>
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) . . . . .	11b <input type="checkbox"/>
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? . . . . .	12a <input type="checkbox"/>
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year. . . . .	12b <input type="checkbox"/>
13	Section 501(c)(29) qualified nonprofit health insurance issuers.	<input type="checkbox"/>
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . .	13a <input type="checkbox"/>
Note. See the instructions for additional information the organization must report on Schedule O		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .	13b <input type="checkbox"/>
c	Enter the amount of reserves on hand . . . . .	13c <input type="checkbox"/>
14a	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	14a <input checked="" type="checkbox"/>
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .	14b <input type="checkbox"/>

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

### 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	3
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O		
1b Enter the number of voting members included in line 1a, above, who are independent . . . . .	1b	1
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	X
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . . . . .	3	X
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . .	4	X
5 Did the organization become aware during the year of a significant diversion of the organization's assets? . . . . .	5	X
6 Did the organization have members or stockholders? . . . . .	6	X
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . . . .	7a	X
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . .	7b	X
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
a The governing body? . . . . .	8a	X
b Each committee with authority to act on behalf of the governing body? . . . . .	8b	X
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O . . . . .	9	X

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

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

### Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ►OK,

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ►  
ERIC E. SCHICK 6161 S. YALE AVENUE TULSA, OK 74136-3319 918-494-8430

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

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

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

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

• List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid

• List all of the organization's **current** key employees, if any See instructions for definition of "key employee"

• List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

• List all of the organization's **former** officers key employees and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations

• List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated			
(1) JAKE HENRY JR PRESIDENT/CEO/DIRECTOR	1.00 39.00	X	X				0.	5,273,282.	81,823.
(2) BARRY L STEICHEN VICE PRESIDENT/COO/DIRECTOR	1.00 39.00	X	X				0.	997,892.	154,074.
(3) WILLIAM R LISSAU DIRECTOR	1.00 0.	X					0.	0.	0.
(4) THOMAS G NEFF SECRETARY	1.00 39.00		X				0.	491,368.	60,041.
(5) ERIC E SCHICK TREASURER/CFO	1.00 39.00		X				0.	781,206.	135,089.
(6) JEFFREY C SACRA ASST SECRETARY (UNTIL 6/1/18)	1.00 39.00		X				0.	319,217.	60,841.
(7) ANTHONY YOUNG ADMINISTRATOR	40.00 0.			X			245,310.	0.	53,299.
(8) MARVIN PADNICK MD PHYSICIAN	1.00 39.00				X		26,333.	444,466.	429.
(9) EDGAR BOYD JR MD PHYSICIAN	1.00 39.00				X		10,000.	364,237.	5,263.
(10) SELAMAWIT NEGUSSE MD PHYSICIAN	1.00 39.00				X		18,501.	353,396.	12,785.
(11) JONATHAN BALDWIN MD PHYSICIAN	1.00 39.00				X		7,867.	260,511.	15,109.
(12) CALEB HARRIS MD PHYSICIAN	1.00 39.00				X		14,500.	210,112.	8,709.
(13)									
(14)									

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

**1b Sub-total** ► 322,511. 9,495,687. 587,462.

c Total from continuation sheets to Part VII, Section A . . . . . ► 0. 0. 0.

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 ► 2

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

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

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

**Section B. Independent Contractors**

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

	Yes	No
3		X
4	X	
E		X

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ► 33

**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
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>					
1a	Federated campaigns . . . . .	1a			
1b	Membership dues . . . . .	1b			
1c	Fundraising events . . . . .	1c			
1d	Related organizations . . . . .	1d			
1e	Government grants (contributions) . . . . .	1e			
1f	All other contributions, gifts, grants, and similar amounts not included above . . . . .	1f			
g	Noncash contributions included in lines 1a-1f \$				
h	Total Add lines 1a-1f . . . . . ►	0			
<b>Program Service Revenue</b>		<b>Business Code</b>			
2a	PATIENT SVCS, NET OF CONTRACTUAL ADJUST	621110	145,181,334	145,181,334	
b					
c					
d					
e					
f	All other program service revenue . . . . .				
g	Total Add lines 2a-2f . . . . . ►	145,181,334			
3	Investment income (including dividends, interest, and other similar amounts). . . . . ►		5,447		5,447
4	Income from investment of tax-exempt bond proceeds . ►		0.		
5	Royalties . . . . . ►		0		
6a	Gross rents . . . . .	(i) Real 543,574			
b	Less rental expenses . . . . .	(ii) Personal 250,468.			
c	Rental income or (loss) . . . . .	293,106			
d	Net rental income or (loss) . . . . . ►	293,106			293,106.
7a	Gross amount from sales of assets other than inventory	(i) Securities 32,066			
b	Less cost or other basis and sales expenses . . . . .	(ii) Other 95,506			
c	Gain or (loss) . . . . .	-63,440			
d	Net gain or (loss) . . . . . ►	-63,440			-63,440
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . . a				
b	Less direct expenses . . . . . b		0		
c	Net income or (loss) from fundraising events . . . . . ►	0			
9a	Gross income from gaming activities See Part IV, line 19 . . . . . a				
b	Less direct expenses . . . . . b		0.		
c	Net income or (loss) from gaming activities . . . . . ►	0.			
10a	Gross sales of inventory, less returns and allowances . . . . . a				
b	Less cost of goods sold . . . . . b		0		
c	Net income or (loss) from sales of inventory. . . . . ►	0			
<b>Miscellaneous Revenue</b>		<b>Business Code</b>			
11a	CAFETERIA SALES	722210	439,550		439,550
b	SALES TAX REFUND	900099	200,000		200,000
c	OTHER	900099	20,323		20,323
d	All other revenue . . . . .				
e	Total. Add lines 11a-11d . . . . . ►	659,873			
12	Total revenue See instructions . . . . . ►	146,076,320.	145,181,334		894,986

**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 

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A) Total expenses</b>	<b>(B) Program service expenses</b>	<b>(C) Management and general expenses</b>	<b>(D) Fundraising expenses</b>
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 . . . . .	0.			
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, lines 15 and 16 . . . . .	0.			
4 Benefits paid to or for members . . . . .	0.			
5 Compensation of current officers, directors, trustees, and key employees . . . . .	310,052.		310,052.	
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 . . . . .	43,973,751.	41,518,912.	2,454,839.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	170,428.	170,428.		
9 Other employee benefits . . . . .	3,699,923.	3,522,524.	177,399.	
10 Payroll taxes . . . . .	2,656,513.	2,656,513.		
11 Fees for services (non-employees)				
a Management . . . . .	0.			
b Legal . . . . .	39,654.	3,610.	36,044.	
c Accounting . . . . .	202,639.		202,639.	
d Lobbying . . . . .	0.			
e Professional fundraising services See Part IV, line 17. . . . .	0.			
f Investment management fees . . . . .	0.			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) . . . . .	11,218,032.	11,248,171.	-30,139.	
12 Advertising and promotion . . . . .	24,243.	3,574.	20,669.	
13 Office expenses . . . . .	2,422,669.	2,229,338.	193,331.	
14 Information technology . . . . .	135,296.	142,276.	-6,980.	
15 Royalties . . . . .	0.			
16 Occupancy . . . . .	2,185,235.	2,014,975.	170,260.	
17 Travel . . . . .	32,875.	25,243.	7,632.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0.			
19 Conferences, conventions, and meetings . . . . .	14,511.	8,387.	6,124.	
20 Interest . . . . .	0.			
21 Payments to affiliates . . . . .	0.			
22 Depreciation, depletion, and amortization . . . . .	6,674,234.	5,632,386.	1,041,848.	
23 Insurance . . . . .	1,275,060.	45.	1,275,015.	
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 . . . . .	32,812,671.	25,961,911.	6,850,760.	
b BAD DEBT EXPENSE . . . . .	23,661,300.	23,661,300.		
c MAINTENANCE . . . . .	8,804,619.	8,780,894.	23,725.	
d MEDICAID SHOPP FEE . . . . .	3,862,154.		3,862,154.	
e All other expenses . . . . .	5,755,111.	2,846,850.	2,908,261.	
25 Total functional expenses Add lines 1 through 24e	149,930,970.	130,427,337.	19,503,633.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ► <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0.			

## Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>				
1	Cash - non-interest-bearing . . . . .	8,795,819.	1	7,173,682.
2	Savings and temporary cash investments . . . . .	0.	2	0.
3	Pledges and grants receivable, net . . . . .	0.	3	0.
4	Accounts receivable, net . . . . .	23,514,277.	4	17,247,859.
5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L . . . . .			
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.	5	0.
7	Notes and loans receivable, net . . . . .	0.	6	0.
8	Inventories for sale or use . . . . .	0.	7	0.
9	Prepaid expenses and deferred charges . . . . .	5,249,779.	8	5,616,005.
10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 109,651,518.		
b	Less accumulated depreciation . . . . .	10b 11,209,716.	10c	88,289,672. 98,441,802.
11	Investments - publicly traded securities . . . . .	0.	11	0.
12	Investments - other securities See Part IV, line 11 . . . . .	0.	12	0.
13	Investments - program-related See Part IV, line 11 . . . . .	0.	13	0.
14	Intangible assets . . . . .	0.	14	0.
15	Other assets See Part IV, line 11 . . . . .	326,976.	15	959,526.
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	128,325,857.	16	130,695,468.
<b>Liabilities</b>				
17	Accounts payable and accrued expenses . . . . .	10,167,691.	17	11,892,829.
18	Grants payable . . . . .	0.	18	0.
19	Deferred revenue . . . . .	0.	19	0.
20	Tax-exempt bond liabilities . . . . .	0.	20	0.
21	Escrow or custodial account liability Complete Part IV of Schedule D . . . . .	0.	21	0.
22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L . . . . .			
23	Secured mortgages and notes payable to unrelated third parties . . . . .	0.	22	0.
24	Unsecured notes and loans payable to unrelated third parties . . . . .	0.	23	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 . . . . .	0.	24	0.
26	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .	432,500.	25	1,387,222.
<b>Net Assets or Fund Balances</b>				
	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 . . . . .	117,725,666.	27	117,415,417.
28	Temporarily restricted net assets . . . . .	0.	28	0.
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	<b>Total net assets or fund balances</b> . . . . .	117,725,666.	33	117,415,417.
34	<b>Total liabilities and net assets/fund balances</b> . . . . .	128,325,857.	34	130,695,468.

Form 990 (2017)

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI. 

1	Total revenue (must equal Part VIII, column (A), line 12) . . . . .	1	146,076,320.
2	Total expenses (must equal Part IX, column (A), line 25) . . . . .	2	149,930,970.
3	Revenue less expenses Subtract line 2 from line 1 . . . . .	3	-3,854,650.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	4	117,725,666.
5	Net unrealized gains (losses) on investments . . . . .	5	0.
6	Donated services and use of facilities . . . . .	6	0.
7	Investment expenses . . . . .	7	0.
8	Prior period adjustments . . . . .	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O) . . . . .	9	3,544,401.
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) . . . . .	10	117,415,417.

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII. 

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

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

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

c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? . . . . .  
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O

3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .

b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a	X	
2b	X	
2c	X	
3a		X
3b		

Form 990 (2017)

**SCHEDULE A**  
(Form 990 or 990-EZ)

## Public Charity Status and Public Support

OMB No 1545-0047

2017

Open to Public  
Inspection

Department of the Treasury  
Internal Revenue Service

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

► Attach to Form 990 or Form 990-EZ.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

---

**Name of the organization**

**Employer identification number**

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

81-4322087

**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.)

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

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

---

Schedule A (Form 990 or 990-EZ) 2017

JSA  
7E1210 1 000

5929MP 3987

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►

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

**Section C. Computation of Public Support Percentage**

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

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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

**Section C. Computation of Public Support Percentage**

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

**Section D. Computation of Investment Income Percentage**

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

19a 33 1/3% support tests - 2017. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>
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 ► <input type="checkbox"/>
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ► <input type="checkbox"/>

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in **Part VI** how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain

2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in **Part VI** how the organization determined that the supported organization was described in section 509(a)(1) or (2)

3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below

b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in **Part VI** when and how the organization made the determination

c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in **Part VI** what controls the organization put in place to ensure such use

4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below

b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in **Part VI** how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations

c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in **Part VI** what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes

5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in **Part VI**, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document)

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?

c Substitutions only. Was the substitution the result of an event beyond the organization's control?

6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in **Part VI**.

7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)

8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)

9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in **Part VI**.

b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in **Part VI**.

c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in **Part VI**.

10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer 10b below

b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings)

	Yes	No
1		
2		
3a		
3b		
3c		
4a		
4b		
4c		
5a		
5b		
5c		
6		
7		
8		
9a		
9b		
9c		
10a		
10b		

Schedule A (Form 990 or 990-EZ) 2017

**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?	11a	
b A family member of a person described in (a) above?	11b	
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in <b>Part VI</b> .	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? If "No," describe in <b>Part VI</b> how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year	1	
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in <b>Part VI</b> how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization	2	

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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? If "No," explain in <b>Part VI</b> how the organization maintained a close and continuous working relationship with the supported organization(s)	2	
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in <b>Part VI</b> the role the organization's supported organizations played in this regard	3	

**Section E. Type III Functionally Integrated Supporting Organizations**

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

Schedule A (Form 990 or 990-EZ) 2017

**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

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

Schedule A (Form 990 or 990-EZ) 2017

Schedule A (Form 990 or 990-EZ) 2017

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

	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
<b>7 Total annual distributions.</b> 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	
<b>10 Line 8 amount divided by Line 9 amount</b>	

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

Schedule A (Form 990 or 990-EZ) 2017

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

**SCHEDULE D**  
**(Form 990)**Department of the Treasury  
Internal Revenue Service**Supplemental Financial Statements**► Complete if the organization answered "Yes" on Form 990,  
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

► Attach to Form 990.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2017****Open to Public  
Inspection**

Name of the organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

Employer identification number

81-4322087

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

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

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

**Part II Conservation Easements.**

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)	<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education) <input type="checkbox"/> Preservation of a historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year	<input type="checkbox"/> Held at the End of the Tax Year
a Total number of conservation easements . . . . .	2a
b Total acreage restricted by conservation easements . . . . .	2b
c Number of conservation easements on a certified historic structure included in (a) . . . . .	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register . . . . .	2d
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►	
4 Number of states where property subject to conservation easement is located ►	
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►	
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$	
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements	

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items
(i) Revenue included on Form 990, Part VIII, line 1. . . . . ► \$
(ii) Assets included in Form 990, Part X. . . . . ► \$
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items
a Revenue included on Form 990, Part VIII, line 1. . . . . ► \$
b Assets included in Form 990, Part X. . . . . ► \$

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

JSA

7E1268 2 000

5929MP 3987

Schedule D (Form 990) 2017

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

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

a  Public exhibition      d  Loan or exchange programs  
 b  Scholarly research      e  Other \_\_\_\_\_  
 c  Preservation for future generations

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . . . .  Yes  No

**Part IV Escrow and Custodial Arrangements.**

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

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

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

	Amount
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 on 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

Yes	No
3a(i)	
3a(ii)	

(i) unrelated organizations . . . . .  
 (ii) related organizations . . . . .

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

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

**Part VI Land, Buildings, and Equipment.**

Complete if the organization answered "Yes" 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 . . . . .		9,280,000.			9,280,000.
b Buildings . . . . .		64,781,784.	2,805,491.		61,976,293.
c Leasehold improvements . . . . .		2,480,000.	495,190.		1,984,810.
d Equipment . . . . .		18,163,376.	7,909,035.		10,254,341.
e Other . . . . .		14,946,358.			14,946,358.
<b>Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10c.) . . . . .</b>				►	<b>98,441,802.</b>

Schedule D (Form 990) 2017

**Part VII Investments - Other Securities.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		

Total (Column (b) must equal Form 990, Part X, col (B) line 12) ►

**Part VIII Investments - Program Related.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		

Total (Column (b) must equal Form 990, Part X, col (B) line 13) ►

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	

Total. (Column (b) must equal Form 990, Part X, col (B) line 15). . . . . ►

**Part X Other Liabilities.**

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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO MEDTCARE	870,976.
(3) PROFESSIONAL LIABILITY RESERVE	516,246.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	

Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ► 1,387,222.

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

SEE PAGE 5

**Part XIII Supplemental Information (continued)**

SCHEDULE D, PART X, LINE 2

ACCOUNTING STANDARDS CODIFICATION TOPIC (ASC) 740, INCOME TAXES, PROVIDES GUIDANCE REGARDING RECOGNITION, DE-RECOGNITION, MEASUREMENT, AND DISCLOSURE OF ALL TAX POSITIONS. IN ACCORDANCE WITH THE REQUIREMENTS OF ASC 740, SAINT FRANCIS HOSPITAL MUSKOGEE, INC. IDENTIFIES AND DOCUMENTS UNCERTAIN TAX POSITIONS FOR ALL OPEN TAX YEARS. IF UNCERTAIN TAX POSITIONS ARE IDENTIFIED, THEY ARE ANALYZED TO DETERMINE THE PROPER UNIT OF ACCOUNT. NEXT THEY ARE TESTED TO DETERMINE WHETHER A TAX ASSET OR A TAX LIABILITY SHOULD BE RECOGNIZED. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. HAS ASSESSED ITS UNCERTAIN TAX POSITIONS AND DETERMINED THEY ARE MORE LIKELY THAN NOT TO BE FULLY SUSTAINED UPON EXAMINATION. THEREFORE, NO LIABILITY OR ASSET FOR UNCERTAIN TAX POSITIONS NEEDS TO BE RECORDED.

**SCHEDULE H**  
**(Form 990)**

**Hospitals**

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

Employer identification number

81-4322087

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

► Attach to Form 990.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .

b If "Yes," was it a written policy? . . . . .

2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year

Applied uniformly to all hospital facilities  Applied uniformly to most hospital facilities

Generally failed to individual hospital facilities

3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year

a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care

100%  150%  200%  Other 225.0000 %

b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care . . . . .

200%  250%  300%  350%  400%  Other %

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"? . . . . .

5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?

b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .

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? . . . . .

6a Did the organization prepare a community benefit report during the tax year? . . . . .

b If "Yes," did the organization make it available to the public? . . . . .

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

	Yes	No
1a	X	
1b	X	
3a	X	
3b		X
4	X	
5a	X	
5b	X	
5c		X
6a	X	
6b	X	

**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) . . . . .			3,902,158.		3,902,158.	3.09
b Medicaid (from Worksheet 3, column a) . . . . .			23,688,697.	15,487,513.	8,201,184.	6.49
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d Total Financial Assistance and Means-Tested Government Programs . . . . .			27,590,855.	15,487,513.	12,103,342.	9.58
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4) . . . . .						
f Health professions education (from Worksheet 5) . . . . .						
g Subsidized health services (from Worksheet 6) . . . . .			23,558,325.	17,119,118.	6,439,207.	5.10
h Research (from Worksheet 7) . . . . .						
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .						
j Total Other Benefits . . . . .			23,558,325.	17,119,118.	6,439,207.	5.10
k Total Add lines 7d and 7j. . . . .			51,149,180.	32,606,631.	18,542,549.	14.68

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

JSA 7E1284 1000

5929MP 3987

Schedule H (Form 990) 2017

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			341,212.		341,212.	.27
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			341,212.		341,212.	.27

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

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

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. . . . .

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 . . . . .

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) . . . . .

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

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

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used

Cost accounting system  Cost to charge ratio  Other

**Section C. Collection Practices**

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

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 . . . . .

Yes No

1

X

9a

X

9b

X

<b>Part IV Management Companies and Joint Ventures</b> (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)				
(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Schedule H (Form 990) 2017

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

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

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

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

1 SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

300 ROCKEFELLER DRIVE

MUSKOGEE OK 74401

HTTPS://WWW.SAINTFRANCIS.COM/MUSKOGEE

2177

2

3

4

5

6

7

8

9

10

**Part V Facility Information (continued)**

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

PART V, SECTION B, LINE 2

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. RECEIVED THE TRANSFER OF OWNERSHIP  
AND THE STATE HOSPITAL LICENSE FROM EASTAR HEALTH SYSTEM AND COMMENCED  
OPERATIONS ON APRIL 1, 2017.

PART V, SECTION B, LINE 3

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. RECEIVED THE TRANSFER OF OWNERSHIP  
AND THE STATE HOSPITAL LICENSE FROM EASTAR HEALTH SYSTEM AND COMMENCED  
OPERATIONS ON APRIL 1, 2017. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. WILL  
COMPLETE ITS INITIAL COMMUNITY HEALTH NEEDS ASSESSMENT DURING THE FISCAL  
YEAR ENDING JUNE 30, 2019.

PART V, SECTION B, LINE 13A

PATIENTS WHO HAVE BEEN EVALUATED AND IDENTIFIED TO BE FINANCIAL  
ASSISTANCE PLAN ELIGIBLE AND MEET THE CRITERIA ESTABLISHED BY SAINT  
FRANCIS HOSPITAL MUSKOGEE, INC. ACCORDING TO RELEVANT CIRCUMSTANCES  
REGARDING INCOME, ASSETS, OR OTHER RESOURCES AVAILABLE TO THE PATIENT OR  
PATIENT'S FAMILY, ARE CONSIDERED CHARITY AND THEREFORE, BY HOSPITAL  
POLICY, ARE NOT BILLED FOR ANY SERVICES.

PART V, SECTION B, LINES 16A, B AND C

[HTTPS://WWW.SAINTRFRANCIS.COM/PATIENTS-AND-GUESTS/FOR-PATIENTS/BILLING-AND-  
INSURANCE/](https://www.saintfrancis.com/patients-and-guests/for-patients/billing-and-insurance/)

**Part V Facility Information (continued)**

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

PART V, SECTION B, LINE 16J

THE BILLING STATEMENT INCLUDES INFORMATION REGARDING FINANCIAL ASSISTANCE  
AVAILABILITY.

PART V, SECTION B, LINE 20E

PROACTIVE PHONE CALLS AND STATEMENTS ARE SENT BEFORE COLLECTION ACTIONS  
ARE TAKEN.

PART V, SECTION B, LINE 22D

AMOUNTS GENERALLY BILLED (AGB) ARE DETERMINED UNDER THE PROSPECTIVE  
METHOD USING MEDICAID REIMBURSEMENT RATES. ADDITIONALLY, A SELF-PAY  
DISCOUNT OF 20 PERCENT IS PROVIDED ON ALL CHARGES FOR UNINSURED PATIENTS.

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

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

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

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

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

Name of hospital facility or letter of facility reporting group SAINT FRANCIS HOSPITAL MUSKOGEE, INC.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**

1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....

2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....

3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....

If "Yes," indicate what the CHNA report describes (check all that apply)

a  A definition of the community served by the hospital facility

b  Demographics of the community

c  Existing health care facilities and resources within the community that are available to respond to the health needs of the community

d  How data was obtained

e  The significant health needs of the community

f  Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

g  The process for identifying and prioritizing community health needs and services to meet the community health needs

h  The process for consulting with persons representing the community's interests

i  The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)

j  Other (describe in Section C)

4 Indicate the tax year the hospital facility last conducted a CHNA 20 .....

5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....

6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....

b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....

7 Did the hospital facility make its CHNA report widely available to the public? .....

If "Yes," indicate how the CHNA report was made widely available (check all that apply)

a  Hospital facility's website (list url) \_\_\_\_\_

b  Other website (list url) \_\_\_\_\_

c  Made a paper copy available for public inspection without charge at the hospital facility

d  Other (describe in Section C)

8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....

9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 .....

10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....

a If "Yes," (list url) \_\_\_\_\_

b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....

11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed

12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....

b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....

c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ \_\_\_\_\_

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

## Part V Facility Information (continued)

## Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that	13	X
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	14	X
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 225 000 % and FPG family income limit for eligibility for discounted care of 000 %	15	X
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients? . . . . .		
15 Explained the method for applying for financial assistance? . . . . .		
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application	16	X
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? . . . . .		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE SCHEDULE H, PART V, SECTION C		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE SCHEDULE H, PART V,		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE SCH H, PART		
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**

Name of hospital facility or letter of facility reporting group SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

	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	X
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP	18	
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged	19	X
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input type="checkbox"/> Made presumptive eligibility determinations		
e <input checked="" type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . . If "No," indicate why	21	X
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)**Name of hospital facility or letter of facility reporting group SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

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

	Yes	No
22		
23		X
24		X

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

**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

PART I, LINE 3C

INCOME BASED CRITERIA IS USED AS THE BASIS IN DETERMINING ELIGIBILITY FOR  
FREE HEALTH SERVICES.

PART I, LINE 6A

SAINT FRANCIS HEALTH SYSTEM, INC. 73-1501972, THE PARENT ORGANIZATION OF  
SAINT FRANCIS HOSPITAL MUSKOGEE, INC. PRODUCES A CONSOLIDATED COMMUNITY  
BENEFIT REPORT INCLUDED IN THE SPRING ISSUE OF THE SAINT FRANCIS HEALTH  
SYSTEM MAGAZINE "PRESENCE" THAT IS MADE AVAILABLE TO THE PUBLIC THROUGH  
THE ORGANIZATION'S WEBSITE AT

[HTTPS://WWW.SAINTFRANCIS.COM/ABOUT-US/COMMITMENT-TO-COMMUNITY](https://www.saintfrancis.com/about-us/commitment-to-community)

PART I, LINE 7

COSTING METHODOLOGY: A RATIO OF PATIENT CARE COST TO CHARGES, AS  
DETERMINED IN WORKSHEET 2, WAS USED TO REPORT THE AMOUNTS IN PART I,  
LINES 7A - 7C. FOR AMOUNTS REPORTED ON LINES 7E - 7I, ACTUAL EXPENSES  
FOR EACH COMMUNITY BENEFIT ACTIVITY ARE TRACKED AND REPORTED USING THE  
ORGANIZATION'S ACCOUNTING GENERAL LEDGER AND ARE NOT BASED ON A COST TO

**Part VI Supplemental Information**

Provide the following information

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

CHARGE RATIO. THE NUMBER REFLECTED ON LINE 7, COLUMN (F) EXCLUDES BAD

DEBT EXPENSE.

THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) WAS CREATED AND IMPLEMENTED IN CALENDAR YEAR 2011 FOR THE PURPOSE OF ASSURING ACCESS TO QUALITY CARE FOR OKLAHOMA MEDICAID MEMBERS. THE PROGRAM IS DESIGNED TO ASSESS OKLAHOMA HOSPITALS, UNLESS EXEMPT, A SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM FEE. THE COLLECTED FEES ARE PLACED IN POOLS AND THEN ALLOCATED TO HOSPITALS BASED ON MEDICAID REVENUES AS DIRECTED BY LEGISLATION. THE OKLAHOMA HEALTH CARE AUTHORITY (OHCA) DOES NOT GUARANTEE THAT ALLOCATION WILL EQUAL OR EXCEED THE AMOUNT OF THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM FEES THAT WERE PAID BY SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

**PART II: COMMUNITY BUILDING ACTIVITIES**

COMMUNITY BUILDING ACTIVITIES IMPROVE THE COMMUNITY'S HEALTH AND SAFETY BY ADDRESSING THE ROOT CAUSE OF HEALTH PROBLEMS. THESE ACTIVITIES STRENGTHEN THE COMMUNITY'S CAPACITY TO PROMOTE THE HEALTH AND WELL-BEING

**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

OF ITS RESIDENTS BY OFFERING THE EXPERTISE AND RESOURCES OF THE  
HEALTHCARE ORGANIZATION. COSTS FOR THESE ACTIVITIES INCLUDE CASH  
DONATIONS AND EXPENSES FOR THE DEVELOPMENT OF A VARIETY OF  
COMMUNITY-BUILDING PROGRAMS AND PARTNERSHIPS.

SAINT FRANCIS CHILD DEVELOPMENT CENTER IN MUSKOGEE, MANAGED BY BRIGHT  
HORIZONS, PROVIDES A SAFE, NURTURING AND ENGAGING ENVIRONMENT FOR  
CHILDREN TO LEARN AND DEVELOP TO THEIR FULL POTENTIAL. IN THE FISCAL YEAR  
2018, THE CHILD CENTER SERVED APPROXIMATELY 27 COMMUNITY FAMILIES IN THE  
AREA WHICH RESULTED IN APPROXIMATELY \$341,200 IN SUBSIDIZED CARE BY SAINT  
FRANCIS HOSPITAL MUSKOGEE, INC.

**PART III, SECTION A, LINE 2**

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. HAS AN ESTABLISHED PROCESS TO  
DETERMINE THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTABLE RECEIVABLES  
THAT RELIES ON A NUMBER OF ANALYTICAL TOOLS AND BENCHMARKS TO ARRIVE AT A  
REASONABLE ALLOWANCE. NO SINGLE STATISTIC OR MEASUREMENT DETERMINES THE  
ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTABLE RECEIVABLES. SOME OF THE

**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

ANALYTICAL TOOLS THAT SAINT FRANCIS HOSPITAL MUSKOGEE, INC. UTILIZES INCLUDE, BUT ARE NOT LIMITED TO, HISTORICAL CASH COLLECTION EXPERIENCE, REVENUE TRENDS BY PAYER CLASSIFICATION, AND REVENUE DAYS IN ACCOUNTS RECEIVABLE. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S POLICIES.

PART III, SECTION A, LINE 3

THE PROVISION FOR BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IS CALCULATED FROM A SAMPLE REVIEW OF ALL BAD DEBT ACCOUNTS AND SUBSEQUENT INFORMATION.

PART III, SECTION A, LINE 4

THE SAINT FRANCIS HEALTH SYSTEM, INC. AUDITED CONSOLIDATED FINANCIAL STATEMENTS, WHICH INCLUDES SAINT FRANCIS HOSPITAL MUSKOGEE, INC., PROVIDE A SEPARATE FOOTNOTE ADDRESSING THE ORGANIZATION'S ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS ON PAGES 5, 6 AND 7. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. REPORTS BAD DEBT IN ACCORDANCE WITH GENERALLY

**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

ACCEPTED ACCOUNTING PRINCIPLES (GAAP). HEALTHCARE FINANCIAL MANAGEMENT

ASSOCIATE STATEMENT 15 IS FOLLOWED TO THE EXTENT THAT THE PROVISION FOR BAD DEBT AT COST IS DETERMINED USING THE SAME COST TO CHARGE RATIO THAT IS USED TO CALCULATE CHARITY CARE AND MEDICAID SHORTFALLS. DISCOUNTS AND ALLOWANCES ARE ACCOUNTED FOR SEPARATELY FROM THE PROVISION FOR BAD DEBT. ACCOUNTS RECEIVABLE ARE VALUED AT NET REALIZABLE VALUE. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. ESTIMATES THE ALLOWANCES FOR UNCOLLECTABLE RECEIVABLES BASED ON HISTORIC WRITE-OFFS AND THE AGING OF THE ACCOUNTS.

PART III, SECTION B, LINE 8

COSTING METHODOLOGY: MEDICARE ALLOWABLE COSTS WERE CALCULATED USING A COST-TO-CHARGE RATIO AND THE MEDICARE FILED COST REPORT.

THE SHORTFALL ON SCHEDULE H, PART III, SECTION B, LINE 7 IS CONSIDERED COMMUNITY BENEFIT. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. PROVIDES SERVICES TO MANY LOW-INCOME MEDICARE RECIPIENTS. THE MEDICARE LOSSES SUSTAINED AT THE HOSPITAL ARE A RESULT OF MEDICARE REIMBURSING AT LESS THAN OPERATING COSTS.

**Part VI Supplemental Information**

Provide the following information

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

THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) WAS CREATED AND IMPLEMENTED IN CALENDAR YEAR 2011 FOR THE PURPOSE OF ASSURING ACCESS TO QUALITY CARE FOR OKLAHOMA MEDICAID MEMBERS. THE PROGRAM IS DESIGNED TO ASSESS OKLAHOMA HOSPITALS, UNLESS EXEMPT, A SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM FEE. THE COLLECTED FEES ARE PLACED IN POOLS AND THEN ALLOCATED TO HOSPITALS BASED ON MEDICAID REVENUES AS DIRECTED BY LEGISLATION. THE OKLAHOMA HEALTH CARE AUTHORITY (OHCA) DOES NOT GUARANTEE THAT ALLOCATION WILL EQUAL OR EXCEED THE AMOUNT OF THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM FEES THAT WERE PAID BY SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

IRS REV. RUL. 69-545 ESTABLISHED THE COMMUNITY BENEFIT STANDARD FOR HOSPITALS AND CONSIDERS A HOSPITAL THAT SERVES PATIENTS COVERED BY GOVERNMENTAL HEALTH BENEFITS (INCLUDING MEDICARE) AS OPERATING TO PROMOTE THE HEALTH OF THE COMMUNITY AND FURTHERANCE OF ITS EXEMPT PURPOSES. ACCORDINGLY, TREATING MEDICARE PATIENTS IS CONSIDERED A COMMUNITY BENEFIT.

**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

**PART III, SECTION C, LINE 9B**

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S DEBT COLLECTION POLICY IS TO PURSUE COLLECTIONS OF PATIENT BALANCES FROM PATIENTS WHO HAVE THE ABILITY TO PAY FOR THE SERVICES. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. APPLIES ITS COLLECTIONS EFFORTS CONSISTENTLY AND FAIRLY TO ALL PATIENTS REGARDLESS OF INSURANCE. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. WORKS WITH THOSE INDIVIDUALS WHO DO NOT HAVE THE FINANCIAL RESOURCES TO PAY OUTSTANDING BALANCES TO QUALIFY FOR SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S FINANCIAL ASSISTANCE POLICY. CHARGES TO PATIENTS QUALIFYING FOR CHARITY CARE UNDER THE SAINT FRANCIS HOSPITAL MUSKOGEE, INC. FINANCIAL ASSISTANCE POLICY ARE WRITTEN-OFF 100 PERCENT.

**PART VI, LINE 2**

ONE OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S FUNDAMENTAL OPERATIONAL GOALS IS TO IDENTIFY AND ADDRESS THE NEEDS OF THE DEFINED COMMUNITY THAT IT SERVES. JUSTICE IS ONE OF THE CORE VALUES OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC. AND SAINT FRANCIS HEALTH SYSTEM, INC. IT CALLS FOR THE ORGANIZATION TO ADVOCATE FOR SYSTEMS AND STRUCTURES THAT ARE ATTUNED TO

**Part VI Supplemental Information**

Provide the following information

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

THE NEEDS OF THE VULNERABLE AND DISADVANTAGED AND TO PROMOTE A SENSE OF  
COMMUNITY AMONG ALL PERSONS.

TO EFFECTIVELY DO THIS REQUIRES THAT SAINT FRANCIS HEALTH SYSTEM, INC.:.

1. GATHERS AND OBTAINS INFORMATION IDENTIFYING THOSE NEEDS; AND
2. DEVELOPS PROGRAMS AND SERVICES THAT ADDRESS AND PROVIDES ACCESS TO  
THOSE IN GREATEST NEED OF HEALTHCARE SERVICES.

HISTORICALLY, SAINT FRANCIS HEALTH SYSTEM, INC. AND ITS ENTITIES FOCUS  
HAVE BEEN CARING FOR THOSE WHO ARE SICK OR VULNERABLE. IN ORDER TO MAKE  
INFORMED DECISIONS ON HOW TO CARE FOR THE SICK, AT-RISK AND MINORITY  
POPULATIONS, SAINT FRANCIS HEALTH SYSTEM, INC. MUST FIRST IDENTIFY  
PRIORITY HEALTH NEEDS. DURING THE FISCAL YEAR 2016, SAINT FRANCIS HEALTH  
SYSTEM, INC. CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) TO  
ADDRESS THE HEALTHCARE NEEDS OF THE COMMUNITY FOR EACH OF ITS LICENSED  
HOSPITAL FACILITIES, WHICH AT THE TIME INCLUDED SAINT FRANCIS HOSPITAL,  
INC., SAINT FRANCIS HOSPITAL SOUTH, LLC, AND LAUREATE PSYCHIATRIC CLINIC  
AND HOSPITAL, INC., AND DEVELOPED AN IMPLEMENTATION STRATEGY TO ADDRESS

**Part VI Supplemental Information**

Provide the following information

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

THE NEEDS IDENTIFIED IN THE CHNA. THE ASSESSMENT IS A COMPILATION OF NATIONAL SURVEY RESULTS, HEALTH INFORMATION DATABASES, GOVERNMENT DATA, AND ANALYTICAL FEEDBACK FROM STATE AND LOCAL PARTNERS. THIS DATA IS USED TO IDENTIFY POTENTIAL COURSES OF ACTION BASED ON EXISTING HEALTHCARE FACILITIES, AVAILABLE RESOURCES WITHIN THE COMMUNITY, AND CAPABILITIES OF THE COMMUNITY IN TERMS OF BOTH SOCIOECONOMIC AND EDUCATION STATUS. PROVIDING ACCESS TO COMPREHENSIVE, QUALITY HEALTH SERVICES; PROVIDING EFFECTIVE TREATMENTS AND SERVICES IN THE COMMUNITY FOR SUBSTANCE ABUSE DISORDERS AND MENTAL HEALTH DISORDERS; PROMOTING THE PREVENTION OF DISEASE; REDUCING OBESITY AND PROMOTING HEALTHY EATING; CESSATION OF TOBACCO USE; AND PROMOTING THE HEALTH OF LOW-INCOME AND AT-RISK COMMUNITIES ARE AMONG THE PUBLIC HEALTH ISSUES THAT THE ASSESSMENT SEEKS TO PRIORITIZE. THE CHNA AND IMPLEMENTATION STRATEGIES FOR SAINT FRANCIS HOSPITAL, INC., SAINT FRANCIS HOSPITAL SOUTH, LLC, AND LAUREATE PSYCHIATRIC CLINIC AND HOSPITAL, INC. ARE AVAILABLE TO THE PUBLIC ON SAINT FRANCIS HEALTH SYSTEM, INC.'S WEBSITE:  
[HTTPS://WWW.SAINTFRANCIS.COM/DOCUMENTS/CHNA.PDF](https://www.saintfrancis.com/documents/chna.pdf).

**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

SAINT FRANCIS HEALTH SYSTEM, INC. WILL COMPLETE ITS CHNA AND  
IMPLEMENTATION STRATEGY FOR SAINT FRANCIS HOSPITAL MUSKOGEE, INC. DURING  
FISCAL YEAR 2019.

PART VI, LINE 3

SAINT FRANCIS HEALTH SYSTEM, INC. AND ITS ENTITIES ARE COMMITTED TO  
PROMOTING HEALTH IN THE COMMUNITY INCLUDING PROVIDING OR FINDING  
FINANCIAL ASSISTANCE PROGRAMS TO ASSIST PATIENTS. SAINT FRANCIS HEALTH  
SYSTEM, INC. USES A MULTI-FACETED APPROACH TO EDUCATE ITS PATIENTS ON THE  
AVAILABILITY OF CHARITY, AS WELL AS STATE AND FEDERAL FINANCIAL  
ASSISTANCE. THIS INCLUDES SEVERAL WAYS INCLUDING, BUT NOT LIMITED TO,  
THE FOLLOWING:

- A BROCHURE TITLED "PATIENT FINANCIAL POLICY" ON FINANCIAL RIGHTS AND  
RESPONSIBILITY IS PROVIDED TO EVERY PATIENT AT THE TIME OF THEIR  
REGISTRATION AND IS AVAILABLE ON THE SAINT FRANCIS HEALTH SYSTEM, INC.  
AND SAINT FRANCIS HOSPITAL MUSKOGEE, INC. WEBSITES. THE BROCHURE  
PROVIDES FINANCIAL ASSISTANCE PROGRAM DETAILS.
- THE FINANCIAL ASSISTANCE POLICY, PLAIN LANGUAGE SUMMARY, AND

**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

APPLICATION ARE POSTED ON THE SAINT FRANCIS HEALTH SYSTEM, INC. AND SAINT FRANCIS HOSPITAL MUSKOGEE, INC. WEBSITES IN ENGLISH AND THE LIMITED ENGLISH PROFICIENCY LANGUAGES OF THE PRIMARY SERVICE AREA (PSA).

- SAINT FRANCIS HEALTH SYSTEM, INC. PRINTS A PHONE NUMBER WHERE PATIENTS CAN OBTAIN INFORMATION ABOUT FINANCIAL ASSISTANCE ON THE BACK OF THE BILLING INVOICES.
- SELF-PAY PATIENTS ARE VISITED BY A FINANCIAL COUNSELOR UPON ADMISSION TO VERIFY THEIR SELF-PAY STATUS. THE FINANCIAL COUNSELOR WORKS WITH THE SELF-PAY PATIENTS TO DETERMINE IF THE PATIENT MAY QUALIFY FOR ASSISTANCE UNDER A GOVERNMENT SPONSORED PLAN. IF THE PATIENT DOES NOT QUALIFY FOR A GOVERNMENT SPONSORED PLAN THEN THE FINANCIAL COUNSELOR WORKS WITH THE PATIENT TO DETERMINE IF THEY QUALIFY FOR CHARITY BASED ON THE SAINT FRANCIS HEALTH SYSTEM, INC.'S FINANCIAL ASSISTANCE POLICY.
- SAINT FRANCIS HEALTH SYSTEM, INC. OFFERS THE FINANCIAL ASSISTANCE POLICY, AS WELL AS PAYMENT OPTIONS AS PART OF THE PATIENT RESPONSIBILITY DURING THE FOLLOW UP COLLECTION CALLS.

**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

**PART VI, LINE 4**

THE PRIMARY SERVICE AREA (PSA) OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

CONSISTS OF MUSKOGEE, CHEROKEE, HASKELL, MCINTOSH, OKMULGEE, SEQUOYAH AND

WAGONER COUNTIES, WHERE A SIGNIFICANT MAJORITY OF INPATIENT ADMISSIONS

ORIGINATE. THE MOST RECENT 2016 US CENSUS BUREAU REPORT IDENTIFIED

APPROXIMATELY 309,000 PEOPLE IN THE PSA. THE PSA IS COMPRISED OF THE

FOLLOWING REPRESENTATION:

- 64% CAUCASIAN
- 20% NATIVE-AMERICAN
- 8% TWO OR MORE RACES
- 5% HISPANIC OR LATINO
- 2% AFRICAN-AMERICAN
- 1% ASIAN

IN 2018, THE MEDIAN HOUSEHOLD INCOME FOR THE PSA WAS \$40,490, (ABOUT 42

PERCENT BELOW THE US MEDIAN) AND IN 2017 THE MEAN HOUSEHOLD INCOME WAS

\$51,700 (ABOUT 57 PERCENT BELOW THE US AVERAGE OF \$81,283).

**Part VI Supplemental Information**

Provide the following information

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

THE PER CAPITAL INCOME FOR THE PSA IS 44 PERCENT BELOW THE NATIONAL MEDIAN AND 22 PERCENT LOWER THAN THE AVERAGE FOR OKLAHOMA. IN 2017, APPROXIMATELY 19 PERCENT OF THE PSA'S POPULATION LIVES IN POVERTY, WITH THE NUMBER CLIMBING TO ALMOST 27 PERCENT FOR THOSE UNDER 18. NEARLY 18 PERCENT OF HOUSEHOLDS IN THE PSA RECEIVED FOOD STAMPS/SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS IN 2017.

THE UNINSURED RATE IN THE PSA WAS APPROXIMATELY 23 PERCENT. OF THOSE IN THE PSA THAT DO HAVE INSURANCE, 74 PERCENT OF HOLD PRIVATE INSURANCE POLICIES. WHEN NARROWING FOCUS TO THE PSA CIVILIAN POPULATION AGE 19 TO 64 THAT PARTICIPATES IN THE LABOR FORCE, THE UNINSURED RATE DECREASES TO 20 PERCENT.

DURING OKLAHOMA'S 2018 FISCAL YEAR, THERE WERE 1,020,726 UNDuplicated MEDICAID ENROLLEES; MEANING OVER 25 PERCENT OF THE STATE'S POPULATION WAS ENROLLED IN THE MEDICAID PROGRAM AT SOME POINT IN TIME. THE PSA WAS HOME TO 90,559 OF THOSE UNDuplicated ENROLLEES, OR APPROXIMATELY 29 PERCENT OF THE PSA'S POPULATION.

**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

**PART VI, LINE 5**

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. IS PART OF AN INTEGRATED HEALTHCARE DELIVERY SYSTEM WITH THE MISSION OF EXTENDING THE PRESENCE AND HEALING MINISTRY OF CHRIST IN ALL WE DO. SAINT FRANCIS HEALTH SYSTEM, INC., AS A CATHOLIC ORGANIZATION, SEEKS TO REFLECT THE PRESENCE OF CHRIST IN EVERY PERSONAL AND CORPORATE ENCOUNTER. SAINT FRANCIS HOSPITAL MUSKOGEE, INC. IS DEDICATED TO GIVING BACK TO THE COMMUNITY IN WHICH ITS EMPLOYEES LIVE AND WORK.

SAINT FRANCIS HEALTH SYSTEM, INC. AND SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S GOVERNING BODY IS COMPRISED OF COMMUNITY REPRESENTATIVES ON THE BOARD OF DIRECTORS THAT PROVIDE LEADERSHIP AND GOVERNANCE FOR THE ORGANIZATION. THE BOARD OF DIRECTORS HAS THE OVERALL RESPONSIBILITY FOR THE CHARITABLE, THE CLINICAL AND THE OPERATIONAL ENDEAVORS OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC. AND THE OTHER ENTITIES THAT ARE PART OF THE SAINT FRANCIS HEALTH SYSTEM, INC.'S INTEGRATED HEALTH SYSTEM. THE MEMBERS OF THE BOARD OF DIRECTORS ARE SELECTED BASED ON THEIR AREAS OF EXPERTISE AND EXPERIENCE INCLUDING SUCH AREAS AS EDUCATION, RESEARCH,

**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

BUSINESS AND GOVERNMENT. THE MEMBERS OF THE GOVERNING BODY CONTRIBUTE THEIR WISDOM, INSIGHTS, AND EXPERTISE TO ENSURE THE ORGANIZATION IS FULFILLING ITS MISSION AND CHARITABLE PURPOSE WHILE PROVIDING EFFICIENT ADMINISTRATIVE SUPPORT SERVICES AND DIRECTION FOR SAINT FRANCIS HEALTH SYSTEM, INC.

THE GOAL OF SAINT FRANCIS HEALTH SYSTEM, INC. IS TO SUSTAIN AND GROW ITS TECHNOLOGY, TO ATTRACT TALENTED HEALTHCARE PROFESSIONALS FROM ACROSS THE COUNTRY AND TO PROVIDE HIGH QUALITY PATIENT CARE TO ALL THE RESIDENTS OF NORTHEASTERN OKLAHOMA AND THE NEIGHBORING STATES WE SERVE.

PART VI, LINE 6

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. IS PART OF SAINT FRANCIS HEALTH SYSTEM, INC. ANNUALLY, SAINT FRANCIS HOSPITAL MUSKOGEE, INC. ADMITS APPROXIMATELY 7,500 PATIENTS AND PROVIDES APPROXIMATELY 40,500 OUTPATIENT AND 31,600 EMERGENCY ROOM VISITS. SEE SCHEDULE O FOR ADDITIONAL INFORMATION REGARDING SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S ROLE WITHIN SAINT FRANCIS HEALTH SYSTEM, INC.

**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

**PART VI, LINE 7**

SAINT FRANCIS HEALTH SYSTEM, INC., WHICH INCLUDES SAINT FRANCIS HOSPITAL MUSKOGEE, INC., PUBLISHES A COMMUNITY BENEFIT REPORT IN OKLAHOMA. A WRITTEN REPORT THAT IS INCLUDED IN THE SPRING ISSUE OF THE SAINT FRANCIS HEALTH SYSTEM, INC. MAGAZINE "PRESENCE" IS DISTRIBUTED TO 40,000 HOUSEHOLDS ACROSS EASTERN OKLAHOMA AND TO ALL SAINT FRANCIS HEALTH SYSTEM, INC. LOCATIONS FOR DISPLAY AND PICK UP TO HELP EDUCATE THE COMMUNITY ON THE BENEFITS THAT SAINT FRANCIS HOSPITAL MUSKOGEE, INC. AND SAINT FRANCIS HEALTH SYSTEM, INC. PROVIDE TO THE COMMUNITIES WE SERVE IN RETURN FOR OUR NOT-FOR-PROFIT STATUS.

**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?
  - a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity . . . . .
  - b Gift, grant, or capital contribution to related organization(s) . . . . .
  - c Gift, grant, or capital contribution from related organization(s) . . . . .
  - d Loans or loan guarantees to or for related organization(s) . . . . .
  - e Loans or loan guarantees by related organization(s) . . . . .
  - f Dividends from related organization(s) . . . . .
  - g Sale of assets to related organization(s) . . . . .
  - h Purchase of assets from related organization(s) . . . . .
  - i Exchange of assets with related organization(s) . . . . .
  - j Lease of facilities, equipment, or other assets to related organization(s) . . . . .
  - k Lease of facilities, equipment, or other assets from related organization(s) . . . . .
  - l Performance of services or membership or fundraising solicitations for related organization(s) . . . . .
  - m Performance of services or membership or fundraising solicitations by related organization(s) . . . . .
  - n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .
  - o Sharing of paid employees with related organization(s) . . . . .
  - p Reimbursement paid to related organization(s) for expenses . . . . .
  - q Reimbursement paid by related organization(s) for expenses . . . . .
  - r Other transfer of cash or property to related organization(s) . . . . .
  - s Other transfer of cash or property from related organization(s) . . . . .

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) SAINT FRANCIS HOSPITAL, INC.	M	309,594.	TRANS REVIEW
(2) SAINT FRANCIS HOSPITAL, INC.	P	122,643,912.	TRANS REVIEW
(3) SAINT FRANCIS HOSPITAL, INC.	Q	8,653,312.	TRANS REVIEW
(4) SAINT FRANCIS HOSPITAL, INC.	R	123,867.	TRANS REVIEW
(5) WARREN CLINIC, INC.	J	230,422.	TRANS REVIEW
(6) WARREN CLINIC, INC.	K	131,441.	TRANS REVIEW

**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?  
 a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity. . . . .  
 b Gift, grant, or capital contribution to related organization(s). . . . .  
 c Gift, grant, or capital contribution from related organization(s). . . . .  
 d Loans or loan guarantees to or for related organization(s). . . . .  
 e Loans or loan guarantees by related organization(s) . . . . .  
 f Dividends from related organization(s). . . . .  
 g Sale of assets to related organization(s). . . . .  
 h Purchase of assets from related organization(s). . . . .  
 i Exchange of assets with related organization(s). . . . .  
 j Lease of facilities, equipment, or other assets to related organization(s). . . . .  
 k Lease of facilities, equipment, or other assets from related organization(s) . . . . .  
 l Performance of services or membership or fundraising solicitations for related organization(s) . . . . .  
 m Performance of services or membership or fundraising solicitations by related organization(s) . . . . .  
 n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .  
 o Sharing of paid employees with related organization(s) . . . . .  
 p Reimbursement paid to related organization(s) for expenses . . . . .  
 q Reimbursement paid by related organization(s) for expenses . . . . .  
 r Other transfer of cash or property to related organization(s) . . . . .  
 s Other transfer of cash or property from related organization(s) . . . . .

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) WARREN CLINIC, INC.	P	416,111.	TRANS REVIEW
(2) WARREN CLINIC, INC.	Q	595,511.	TRANS REVIEW
(3) LAUREATE PSYCHIATRIC CLINIC & HOSPITAL, INC.	Q	137,793.	TRANS REVIEW
(4)			
(5)			
(6)			

**SCHEDULE J  
(Form 990)**Department of the Treasury  
Internal Revenue Service**Compensation Information**For certain Officers, Directors, Trustees, Key Employees, and Highest  
Compensated Employees

► Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

► Attach to Form 990.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2017**Open to Public  
Inspection

Name of the organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

Employer identification number

81-4322087

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items

<input type="checkbox"/>	First-class or charter travel	<input type="checkbox"/>	Housing allowance or residence for personal use
<input checked="" type="checkbox"/>	Travel for companions	<input type="checkbox"/>	Payments for business use of personal residence
<input checked="" type="checkbox"/>	Tax indemnification and gross-up payments	<input type="checkbox"/>	Health or social club dues or initiation fees
	Discretionary spending account	<input type="checkbox"/>	Personal services (such as, maid, chauffeur, chef)

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

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

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

<input checked="" type="checkbox"/>	Compensation committee	<input type="checkbox"/>	Written employment contract
<input checked="" type="checkbox"/>	Independent compensation consultant	<input checked="" type="checkbox"/>	Compensation survey or study
	Form 990 of other organizations	<input checked="" 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? . . . . .  
**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? . . . . .  
**c** Participate in, or receive payment from, an equity-based compensation arrangement? . . . . .

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

**5** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

**a** The organization? . . . . .  
**b** Any related organization? . . . . .

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

**6** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of

**a** The organization? . . . . .  
**b** Any related organization? . . . . .

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

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

**8** Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III. . . . .

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

	Yes	No
1b	X	
2	X	
4a	X	
4b	X	
4c	X	
5a	X	
5b	X	
6a	X	
6b	X	
7	X	
8	X	
9		

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

Schedule J (Form 990) 2017

## Schedule J (Form 990) 2017

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(I) Base compensation	(II) Bonus & incentive compensation	(III) Other reportable compensation				
1 JAKE HENRY JR PRESIDENT/CEO/DIRECTOR	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 1,255,548.	(ii) 3,950,000.	(ii) 67,734.	35,140.	46,683.	5,355,105.	0.
2 BARRY L STEICHEN VICE PRESIDENT/COO/DIRECTOR	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 763,321.	(ii) 224,646.	(ii) 9,925.	131,417.	22,657.	1,151,966.	0.
3 THOMAS G NEFF SECRETARY	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 366,175.	(ii) 106,266.	(ii) 18,927.	35,140.	24,901.	551,409.	0.
4 ERIC E SCHICK TREASURER/CFO	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 576,921.	(ii) 193,737.	(ii) 10,548.	113,370.	21,719.	916,295.	0.
5 JEFFREY C SACRA ASST SECRETARY (UNTIL 6/1/18)	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
	(ii) 248,645.	(ii) 66,120.	(ii) 4,452.	50,399.	10,442.	380,058.	0.
6 ANTHONY YOUNG ADMINISTRATOR	(i) 245,310.	(i) 0.	(i) 0.	39,000.	14,299.	298,609.	0.
	(ii) 0.	(ii) 0.	(ii) 0.	0.	0.	0.	0.
7 MARVIN PADNICK MD PHYSICIAN	(i) 26,333.	(i) 0.	(i) 0.	0.	0.	26,333.	0.
	(ii) 326,299.	(ii) 118,167.	(ii) 0.	0.	429.	444,895.	0.
8 EDGAR BOYD JR MD PHYSICIAN	(i) 10,000.	(i) 0.	(i) 0.	0.	0.	10,000.	0.
	(ii) 280,905.	(ii) 83,332.	(ii) 0.	0.	5,263.	369,500.	0.
9 SELAMAWIT NEGUSSE MD PHYSICIAN	(i) 18,501.	(i) 0.	(i) 0.	0.	0.	18,501.	0.
	(ii) 333,403.	(ii) 19,993.	(ii) 0.	0.	12,785.	366,181.	0.
10 JONATHAN BALDWIN MD PHYSICIAN	(i) 7,867.	(i) 0.	(i) 0.	0.	0.	7,867.	0.
	(ii) 189,419.	(ii) 54,892.	(ii) 16,200.	0.	15,109.	275,620.	0.
11 CALEB HARRIS MD PHYSICIAN	(i) 14,500.	(i) 0.	(i) 0.	0.	0.	14,500.	0.
	(ii) 210,112.	(ii) 0.	(ii) 0.	0.	8,709.	218,821.	0.
12	(i) 0.	(i) 0.	(i) 0.	0.	0.	0.	0.
13	(i) 0.	(i) 0.	(i) 0.	0.	0.	0.	0.
14	(i) 0.	(i) 0.	(i) 0.	0.	0.	0.	0.
15	(i) 0.	(i) 0.	(i) 0.	0.	0.	0.	0.
16	(i) 0.	(i) 0.	(i) 0.	0.	0.	0.	0.

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.

**PART I, LINE 1A**

CERTAIN INDIVIDUALS INCLUDED IN SCHEDULE J, PART II PARTICIPATED IN KEY BUSINESS ACTIVITIES ACCCOMPANIED BY THEIR SPOUSE. ADDITIONALLY, THESE SAME INDIVIDUALS MAY HAVE INCURRED PERSONAL EXPENSES RELATED TO THESE KEY BUSINESS ACTIVITIES. WITH PROPER DOCUMENTATION AND APPROVAL, SAINT FRANCIS HEALTH SYSTEM, INC., INCLUDES THESE REIMBURSEMENTS AS W-2 WAGES FOR THE EMPLOYEE. THESE WAGES ARE GROSSED UP TO PROVIDE TAX INDEMNIFICATION TO THE EMPLOYEE.

**PART I, LINE 4B**

A SELECT GROUP OF HIGHLY COMPENSATED EMPLOYEES OF SAINT FRANCIS HEALTH SYSTEM, INC., AND ITS RELATED ENTITIES, SAINT FRANCIS HOSPITAL, INC.,, LAUREATE PSYCHIATRIC CLINIC AND HOSPITAL, INC., WARREN CLINIC, INC.,, SAINT FRANCIS HOSPITAL SOUTH, LLC, SAINT FRANCIS HOME HEALTH, INC., THE CHILDREN'S HOSPITAL FOUNDATION AT SAINT FRANCIS, SAINT FRANCIS HOSPITAL VINITA, INC., AND SAINT FRANCIS HOSPITAL MUSKOGEE, INC., ARE ELIGIBLE TO PARTICIPATE IN A NONQUALIFIED DEFERRED COMPENSATION PLAN UNDER SECTION 457 (B) AND 457 (F) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED UNDER THE ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT OF 2001.

**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**

NOTE: NONE OF THE INDIVIDUALS LISTED ON SCHEDULE J ARE COMPENSATED AS BOARD MEMBERS OF THE REPORTING ENTITY. THE REPORTED COMPENSATION IS FOR SERVICES AS EMPLOYEES OF THE REPORTING ENTITY OR RELATED ORGANIZATION.

PART II, COLUMN B (II)

THE FOLLOWING INDIVIDUAL RECEIVED A ONE-TIME RETENTION BONUS DURING THE YEAR. THESE PAYMENTS ARE INCLUDED IN SCHEDULE J, PART II, COLUMN B (II):

JAKE HENRY JR. \$3,000,000

**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

**Supplemental Information to Form 990 or 990-EZ**

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

► Attach to Form 990 or 990-EZ

► Information about Schedule O (Form 990 or 990-EZ) and its Instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

Employer identification number

81-4322087

FORM 990, PART III, LINE 4A

SAINT FRANCIS HOSPITAL MUSKOGEE, INC. IS A MEMBER OF SAINT FRANCIS HEALTH SYSTEM, INC. SAINT FRANCIS HEALTH SYSTEM, INC. IS A CATHOLIC, NOT-FOR-PROFIT HEALTH SYSTEM WHOSE MISSION IS TO EXTEND THE PRESENCE AND HEALING MINISTRY OF CHRIST IN ALL WE DO.

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.'S ACCOMPLISHMENTS INCLUDES OPERATING AN ACUTE CARE HOSPITAL WHERE ADMITTING PHYSICIANS, WHO ARE PRIMARILY PRACTITIONERS IN THE LOCAL AREA, PROVIDE INPATIENT/OUTPATIENT AND EMERGENCY CARE SERVICES TO RESIDENTS OF MUSKOGEE AND THE SURROUNDING AREAS. IN FISCAL YEAR 2018, SAINT FRANCIS HOSPITAL MUSKOGEE, INC. PROVIDED APPROXIMATELY \$3,902,000 OF CHARITY CARE (MEASURED AT ESTABLISHED RATES) AND \$23,689,000 IN UNREIMBURSED MEDICAID SERVICES (MEASURED AT ESTABLISHED RATES).

FORM 990, PART V, LINE 2B

SAINT FRANCIS PAYROLL SERVICES, LLC, EIN 45-0470422, HAS BEEN AUTHORIZED TO ACT AS A COMMON PAY AGENT UNDER SECTION 3504 OF THE INTERNAL REVENUE CODE FOR SAINT FRANCIS HEALTH SYSTEM, INC. EFFECTIVE JULY 1, 2002, IN ACCORDANCE WITH REVENUE PROCEDURE 70-6, 1970-1 C.B. 420. SAINT FRANCIS PAYROLL SERVICES, LLC ASSUMED REPORTING OBLIGATIONS FOR FEDERAL INCOME TAX, SOCIAL SECURITY AND MEDICARE WITHHOLDING TAX PURPOSES FOR SAINT FRANCIS HEALTH SYSTEM, INC. AND YEAR-END REPORTING EFFECTIVE JULY 1, 2002.

Name of the organization <b>SAINT FRANCIS HOSPITAL MUSKOGEE, INC.</b>	Employer identification number <b>81-4322087</b>
--	---

FORM 990, PART VI, SECTION A, LINE 2

DESCRIPTION OF RELATIONSHIPS

MANY OF THE PERSONS LISTED ON PART VII HAVE A "BUSINESS RELATIONSHIP" WITH EACH OTHER BY VIRTUE OF SERVING ON RELATED SAINT FRANCIS HEALTH SYSTEM, INC. ENTITY BOARDS AND OTHER CORPORATION BOARDS. THE ORGANIZATION HAS DETERMINED THESE ASSOCIATIONS DO NOT PRESENT A CONFLICT OF INTEREST.

JAKE HENRY JR., AN OFFICER AND DIRECTOR, SERVES ON OTHER BOARDS OUTSIDE OF SAINT FRANCIS HEALTH SYSTEM, INC. WITH BARRY STEICHEN, AN OFFICER AND DIRECTOR, AND ERIC SCHICK, AN OFFICER.

FORM 990, PART VI, SECTION A, LINE 3

THE DIRECTOR FUNCTIONS ARE DELEGATED TO THE SAINT FRANCIS HEALTH SYSTEM, INC. BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION A, LINE 4

THE ORGANIZATION AMENDED ITS ARTICLES OF INCORPORATION TO CHANGE ITS NAME FROM SAINT FRANCIS REGIONAL SERVICES, INC. TO SAINT FRANCIS HOSPITAL MUSKOGEE, INC. ON 3/1/18.

FORM 990, PART VI, SECTION A, LINE 6

SAINT FRANCIS HEALTH SYSTEM, INC., IS THE SOLE MEMBER OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

FORM 990, PART VI, SECTION A, LINE 7A

SAINT FRANCIS HEALTH SYSTEM, INC., THE SOLE MEMBER OF SAINT FRANCIS HOSPITAL MUSKOGEE, INC. ELECTS THE GOVERNING BODY.

Name of the organization SAINT FRANCIS HOSPITAL MUSKOGEE, INC.	Employer identification number 81-4322087
---	--

FORM 990, PART VI, SECTION A, LINE 7B

THE BOARD OF DIRECTORS AND A MAJORITY OF THE TRUSTEES APPROVE THE SALE OF  
CORPORATE ASSETS VALUED AT \$10,000,000 OR MORE.

THE MEMBER HAS SOLE AUTHORITY TO:

- AMEND THE CERTIFICATE OF INCORPORATION
- APPROVE MERGERS OR CONSOLIDATIONS
- APPROVE THE SALE, LEASE OR TRANSFER OF ALL, OR SUBSTANTIALLY ALL, OF  
THE ASSETS OF THE CORPORATION
- THE DISSOLUTION OF CORPORATION
- THE AMENDMENT OF BYLAWS

FORM 990, PART VI, SECTION B, LINE 11B

THE FINANCE COMMITTEE, A SUB-COMMITTEE OF THE BOARD OF DIRECTORS OF SAINT  
FRANCIS HEALTH SYSTEM, INC. HAS ACCESS TO THE PASSWORD PROTECTED FORM 990  
ONLINE PRIOR TO FILING WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C

THE ORGANIZATION USES THE CONFLICT OF INTEREST, WHISTLEBLOWER AND RECORD  
RETENTION POLICIES OF SAINT FRANCIS HEALTH SYSTEM, INC. A REQUEST FOR  
INFORMATION ON POTENTIAL CONFLICTS IS SOLICITED ANNUALLY FROM DIRECTORS,  
TRUSTEES AND ALL EMPLOYEES AT MANAGER LEVEL AND ABOVE TO MONITOR FOR  
PROPOSED OR ONGOING TRANSACTIONS FOR CONFLICTS OF INTEREST AND DEALING  
WITH POTENTIAL OR ACTUAL CONFLICTS. THERE ARE NO CONFLICTS REPORTED  
SPECIFIC TO THIS ORGANIZATION. CONFLICTS ARE REGULARLY DISCLOSED AND  
ADDRESSED.

Name of the organization SAINT FRANCIS HOSPITAL MUSKOGEE, INC.	Employer identification number 81-4322087
---	--

FORM 990, PART VI, SECTION B, LINES 15A AND 15B  
 COMPENSATION OF OFFICIALS AND KEY EMPLOYEES IS ANNUALLY REVIEWED AND  
 APPROVED BY THE COMPENSATION COMMITTEE WITH GUIDANCE FROM INDEPENDENT  
 CONSULTANTS AND USE OF COMPARATIVE DATA.

FORM 990, PART VI, SECTION C, LINE 19  
 THESE REQUESTS ARE DETERMINED ON A CASE-BY-CASE BASIS.

FORM 990, PART VII, SECTION A  
 THE HOURS PER WEEK REPORTED ON FORM 990, PART VII FOR OFFICERS AND  
 DIRECTORS ARE THE HOURS SPENT ON THE FILING ENTITY ONLY. THE REMAINING  
 PORTION OF THE 40 HOURS PER WEEK OF THE OFFICERS AND DIRECTORS WITH  
 RELATED COMPENSATION IS ALLOCATED AMONG THE ENTITIES REPORTED ON SCHEDULE  
 R.

FORM 990, PART XI, LINE 9  
 THE CHANGE IN FUND BALANCE OF \$3,544,401 WAS A NET EQUITY TRANSFER OF  
 \$3,541,560 AND \$2,841 WAS AN EQUIPMENT TRANSFER.

ATTACHMENT 1

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
REHABCARE GROUP MANAGEMENT 7733 FORSYTH BLVD, STE 1400 ST LOUIS, MO 53105	REHABILITATION SVCS	1,744,070.
SHIFTWISE INC. 200 SW MARKET ST., STE 700 PORTLAND, OR 97201	VENDOR MGMT SERVICES	2,935,764.
GREEN COUNTRY EMERGENCY PHYSICIANS GROUP 1145 S UTICA AVE, STE 365 TULSA, OK 74104-1050	PHYSICIAN SVCS	1,102,654.

Name of the organization	Employer identification number
SAINT FRANCIS HOSPITAL MUSKOGEE, INC.	81-4322087
<u>ATTACHMENT 1 (CONT'D)</u>	

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
GREEN COUNTRY HOSPITALIST, PC 5908 S 298TH EAST AVE BROKEN ARROW, OK 74014	PHYSICIAN SVCS	699,300.
NORTHSTAR ANESTHESIA 6225 N STATE HWY 161, STE 200 IRVING, TX 75038	HEALTHCARE SVCS	1,468,526.

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

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

► Attach to Form 990.

► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.Department of the Treasury  
Internal Revenue Service**2017**Open to Public  
Inspection

Name of the organization

SAINT FRANCIS HOSPITAL MUSKOGEE, INC.

Name of the organization

81-4322087

Employer identification number

Name of the organization

81-4322087

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
(1) SAINT FRANCIS HOSPITAL, INC 6600 S YALE AVE., STE 400 TULSA, OK 74136	73-0700090 HEALTH SVCS	OK	501 (C) (3)	3	SFHS	X
(2) LAUREATE PSYCHIATRIC CLINIC & HOSP INC 6600 S. YALE AVE , STE 400 TULSA, OK 74136	73-1308273 HEALTH SVCS	OK	501 (C) (3)	3	SFHS	X
(3) WARREN CLINIC, INC 6600 S. YALE AVE., STE 400 TULSA, OK 74136	73-1310891 HEALTH SVCS	OK	501 (C) (3)	3	SFHS	X
(4) SAINT FRANCIS HEALTH SYSTEM, INC 6600 S. YALE AVE , STE 400 TULSA, OK 74136	73-1501972 HEALTH SVCS	OK	501 (C) (3)	12B TYPE II N/A		X
(5) THE CHILDREN'S HOSP FDN AT SAINT FRANCIS 6600 S. YALE AVE , STE 400 TULSA, OK 74136	20-2843418 HEALTH SVCS	OK	501 (C) (3)	12A TYPE I	SFHS	X
(6) SAINT FRANCIS HOSPITAL VINTA, INC 6600 S. YALE AVE , STE 400 TULSA, OK 74136	81-3747248 HEALTH SVCS	OK	501 (C) (3)	12A TYPE I	SFHS	X
(7) SAINT FRANCIS HOSPITAL SOUTH, LLC 6600 S. YALE AVE , STE 400 TULSA, OK 74136	01-0603214 HEALTH SVCS	OK	501 (C) (3)	3	SFHS	X

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

Schedule R (Form 990) 2017

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate interests?	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										

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

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

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

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

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

**Part VII Supplemental Information**

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