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Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

▶ Do not enter social security numbers on this form as it may be made public
▶ Information about Form 990 and its instructions is at *www IRS gov/form990*

OMB No 1545-0047

**2017**

**Open to Public Inspection**

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

**B** Check if applicable
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

**C** Name of organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

Doing business as
SEE SCHEDULE O

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1055 NORTH CURTIS ROAD

City or town, state or province, country, and ZIP or foreign postal code
BOISE, ID 83706

**D Employer identification number**
82-0200895

E Telephone number
(208) 367-2121

**G** Gross receipts $ 706,155,906

**F** Name and address of principal officer
ANDREW COSENTINO
1055 NORTH CURTIS ROAD
BOISE, ID 83706

**H(a)** Is this a group return for subordinates? ☐ Yes ☑ No

**H(b)** Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

**H(c)** Group exemption number ▶ 0928

**I** Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no ) ☐ 4947(a)(1) or ☐ 527

**J Website:** ▶ WWW SAINTALPHONSUS ORG

**K** Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

**L** Year of formation 1958

**M** State of legal domicile ID

## Part I Summary

**Activities & Governance**

1 Briefly describe the organization's mission or most significant activities
TO PROVIDE HEALTH CARE AND HOSPITAL SERVICES

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

| | | | |
|---|---|---|---|
| 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 | 17 |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 14 |
| 5 | Total number of individuals employed in calendar year 2017 (Part V, line 2a) | 5 | 0 |
| 6 | Total number of volunteers (estimate if necessary) | 6 | 2,351 |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 2,967,360 |
| 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) | 4,866,697 | 2,802,670 |
| 9 | Program service revenue (Part VIII, line 2g) | 612,584,532 | 672,901,588 |
| 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 6,254,324 | 8,745,774 |
| 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 15,109,001 | 20,878,440 |
| 12 | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 638,814,554 | 705,328,472 |

**Expenses**

| | | | |
|---|---|---|---|
| 13 | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 71,089,765 | 1,394,963 |
| 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) | 292,790,557 | 300,409,850 |
| 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| b | Total fundraising expenses (Part IX, column (D), line 25) ▶750,179 | | |
| 17 | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 330,274,389 | 367,266,774 |
| 18 | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 694,154,711 | 669,071,587 |
| 19 | Revenue less expenses Subtract line 18 from line 12 | -55,340,157 | 36,256,885 |

**Net Assets or Fund Balances**

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| 20 | Total assets (Part X, line 16) | 676,207,025 | 699,604,228 |
| 21 | Total liabilities (Part X, line 26) | 259,682,831 | 257,184,277 |
| 22 | Net assets or fund balances Subtract line 21 from line 20 | 416,524,194 | 442,419,951 |

## 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**

****** 2019-05-14
Signature of officer Date

B LANNIE CHECKETTS TREASURER
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| | | | | |

Firm's name ▶ | Firm's EIN ▶

Firm's address ▶ | Phone no

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

## Part III Statement of Program Service Accomplishments

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

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

WE, SAINT ALPHONSUS HEALTH SYSTEM AND TRINITY HEALTH, SERVE TOGETHER IN THE SPIRIT OF THE GOSPEL AS A COMPASSIONATE AND TRANSFORMING HEALING PRESENCE WITHIN OUR COMMUNITIES SAINT ALPHONSUS REGIONAL MEDICAL CENTER IS A MEMBER OF SAINT ALPHONSUS HEALTH SYSTEM AND TRINITY HEALTH

**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 $ 571,528,697 including grants of $ 1,394,963 ) (Revenue $ 687,343,710 )

See Additional Data

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

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

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

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

**4e** **Total program service expenses** ▶ 571,528,697

**Part IV Checklist of Required Schedules**

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

**Part IV** **Checklist of Required Schedules** *(continued)*

| | | | Yes | No |
|---|---|---|---|---|
| **20a** | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | **20a** | Yes | |
| **b** | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | **20b** | Yes | |
| **21** | Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II* | **21** | Yes | |
| **22** | Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III* | **22** | Yes | |
| **23** | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J* | **23** | Yes | |
| **24a** | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a* | **24a** | | No |
| **b** | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | **24b** | | |
| **c** | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | **24c** | | |
| **d** | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | **24d** | | |
| **25a** | **Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I* | **25a** | | No |
| **b** | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I* | **25b** | | No |
| **26** | Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II* | **26** | | No |
| **27** | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III* | **27** | | No |
| **28** | Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) | | | |
| **a** | A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28a** | | No |
| **b** | A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28b** | Yes | |
| **c** | An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV* | **28c** | Yes | |
| **29** | Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M* | **29** | Yes | |
| **30** | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M* | **30** | | No |
| **31** | Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I* | **31** | | No |
| **32** | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II* | **32** | | No |
| **33** | Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I* | **33** | | No |
| **34** | Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1* | **34** | Yes | |
| **35a** | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | **35a** | Yes | |
| **b** | If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* | **35b** | Yes | |
| **36** | **Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2* | **36** | | No |
| **37** | Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI* | **37** | | No |
| **38** | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O | **38** | Yes | |

**Part V** **Statements Regarding Other IRS Filings and Tax Compliance**

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

| | | | | Yes | No |
|---|---|---|---|---|---|
| **1a** | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . | **1a** | 706 | | |
| **b** | Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable | **1b** | 0 | | |
| **c** | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . . | **1c** | | Yes | |
| **2a** | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . . | **2a** | 0 | | |
| **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** | | | |
| **3a** | Did the organization have unrelated business gross income of $1,000 or more during the year? . . . | **3a** | | Yes | |
| **b** | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . . | **3b** | | Yes | |
| **4a** | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . | **4a** | | | No |
| **b** | If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | | | |
| **5a** | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . | **5a** | | | No |
| **b** | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | **5b** | | | No |
| **c** | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . . | **5c** | | | |
| **6a** | Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . | **6a** | | | No |
| **b** | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . . | **6b** | | | |
| **7** | **Organizations that may receive deductible contributions under section 170(c).** | | | | |
| **a** | Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor? . . . . . | **7a** | | Yes | |
| **b** | If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . . | **7b** | | Yes | |
| **c** | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . . | **7c** | | | No |
| **d** | If "Yes," indicate the number of Forms 8282 filed during the year . . . . | **7d** | | | |
| **e** | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | **7e** | | | No |
| **f** | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . | **7f** | | | No |
| **g** | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . . | **7g** | | | |
| **h** | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . . | **7h** | | | |
| **8** | **Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . . | **8** | | | |
| **9a** | Did the sponsoring organization make any taxable distributions under section 4966? . . . | **9a** | | | |
| **b** | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . | **9b** | | | |
| **10** | **Section 501(c)(7) organizations.** Enter | | | | |
| **a** | Initiation fees and capital contributions included on Part VIII, line 12 . . . | **10a** | | | |
| **b** | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | **10b** | | | |
| **11** | **Section 501(c)(12) organizations.** Enter | | | | |
| **a** | Gross income from members or shareholders . . . . . | **11a** | | | |
| **b** | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . . | **11b** | | | |
| **12a** | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | **12a** | | | |
| **b** | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | **12b** | | | |
| **13** | **Section 501(c)(29) qualified nonprofit health insurance issuers.** | | | | |
| **a** | Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O | **13a** | | | |
| **b** | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . | **13b** | | | |
| **c** | Enter the amount of reserves on hand . . . . . | **13c** | | | |
| **14a** | Did the organization receive any payments for indoor tanning services during the tax year? . . . . . | **14a** | | | No |
| **b** | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . . | **14b** | | | |

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

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

## Section A. Governing Body and Management

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1a | Enter the number of voting members of the governing body at the end of the tax year | 1a | 17 | | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 1b | 14 | | |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | | 2 | | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | | 3 | | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | | 4 | Yes | |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | | 5 | | No |
| 6 | Did the organization have members or stockholders? | | 6 | Yes | |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | | 7a | Yes | |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | | 7b | Yes | |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | | |
| a | The governing body? | | 8a | Yes | |
| b | Each committee with authority to act on behalf of the governing body? | | 8b | Yes | |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* | | 9 | | No |

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

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

## Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶STEPHANIE PLISCHKE 6301 EMERALD BOISE, ID 83706 (208) 367-4504

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

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

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

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

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

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| See Additional Data Table | | | | | | | | | | |
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**Part VII** **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| See Additional Data Table | | | | | | | | | | |
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| | | | | | | | | | | |
| **1b Sub-Total** ▶ | | | | | | | | | | |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | 0 | 11,109,861 | 631,384 |

**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 ▶ 0

| | | | Yes | No |
|---|---|---|---|---|
| **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* | **3** | Yes | |
| **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* | **4** | Yes | |
| **5** | Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person* | **5** | | No |

## Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| REHABILITATION MANAGEMENT ASSOCIATES INC<br>901 N CURTIS<br>BOISE, ID 83706 | REHABILITATION SERVICES | 10,523,685 |
| INTERMOUNTAIN MEDICAL IMAGING LLC<br>877 WEST MAIN ST<br>BOISE, ID 83706 | RADIOLOGY SERVICES | 5,919,825 |
| ANDERSEN CONSTRUCTION COMPANY<br>6712 N CUTTER CIRCLE<br>PORTLAND, OR 97217 | CONSTRUCTION SERVICES | 3,372,046 |
| ORTHOPAEDIC SPECIALISTS OF IDAHO<br>6225 N MEEKER STE 210<br>BOISE, ID 83713 | MEDICAL SERVICES | 3,278,609 |
| TREASURE VALLEY LABORATORY<br>PO BOX 2693<br>SPOKANE, WA 99220 | LABORATORY SERVICES | 2,182,404 |

**2** Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 73

**Part VIII Statement of Revenue**

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

| | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|---|---|---|---|---|
| **Contributions, Gifts, Grants and Other Similar Amounts** | **1a** Federated campaigns . . **1a** | | | | |
| | **b** Membership dues . . **1b** | | | | |
| | **c** Fundraising events . . **1c** 607,700 | | | | |
| | **d** Related organizations **1d** 609,723 | | | | |
| | **e** Government grants (contributions) **1e** 488,680 | | | | |
| | **f** All other contributions, gifts, grants, and similar amounts not included above **1f** 1,096,567 | | | | |
| | **g** Noncash contributions included in lines 1a-1f $ 250,356 | | | | |
| | **h Total.** Add lines 1a-1f . . . . . ▶ | 2,802,670 | | | |
| **Program Service Revenue** | | Business Code | | | |
| | **2a** NET PATIENT SERVICE REVENUE | 622110 672,901,588 | 669,945,989 | 2,955,599 | |
| | **b** | | | | |
| | **c** | | | | |
| | **d** | | | | |
| | **e** | | | | |
| | **f** All other program service revenue | | | | |
| | **g Total.** Add lines 2a–2f . . . . ▶ | 672,901,588 | | | |
| **Other Revenue** | **3** Investment income (including dividends, interest, and other similar amounts) . . . . . ▶ | 3,441,872 | | | 3,441,872 |
| | **4** Income from investment of tax-exempt bond proceeds ▶ | | | | |
| | **5** Royalties . . . . . ▶ | | | | |
| | | (i) Real / (ii) Personal | | | |
| | **6a** Gross rents 495,720 | | | | |
| | **b** Less rental expenses 0 | | | | |
| | **c** Rental income or (loss) 495,720 | | | | |
| | **d** Net rental income or (loss) . . . . . ▶ | 495,720 | | | 495,720 |
| | | (i) Securities / (ii) Other | | | |
| | **7a** Gross amount from sales of assets other than inventory 5,726,959 | | | | |
| | **b** Less cost or other basis and sales expenses 0 / 423,057 | | | | |
| | **c** Gain or (loss) 5,726,959 / -423,057 | | | | |
| | **d** Net gain or (loss) . . . . . ▶ | 5,303,902 | | | 5,303,902 |
| | **8a** Gross income from fundraising events (not including $ 607,700 of contributions reported on line 1c) See Part IV, line 18 . . . . **a** 394,332 | | | | |
| | **b** Less direct expenses . . . **b** 394,257 | | | | |
| | **c** Net income or (loss) from fundraising events . . ▶ | 75 | | | 75 |
| | **9a** Gross income from gaming activities See Part IV, line 19 . . . **a** 31,093 | | | | |
| | **b** Less direct expenses . . . **b** 10,120 | | | | |
| | **c** Net income or (loss) from gaming activities . . ▶ | 20,973 | | | 20,973 |
| | **10a** Gross sales of inventory, less returns and allowances . . **a** | | | | |
| | **b** Less cost of goods sold . . **b** | | | | |
| | **c** Net income or (loss) from sales of inventory . . ▶ | | | | |
| | Miscellaneous Revenue / Business Code | | | | |
| | **11a** OTHER RELATED REVENUE 622110 | 17,409,482 | 17,397,721 | 11,761 | |
| | **b** CAFETERIA REVENUE 722514 | 2,763,502 | | | 2,763,502 |
| | **c** PARKING 812930 | 126,883 | | | 126,883 |
| | **d** All other revenue . . . . | 61,805 | | | 61,805 |
| | **e Total.** Add lines 11a–11d . . . . . ▶ | 20,361,672 | | | |
| | **12 Total revenue.** See Instructions . . . . . ▶ | 705,328,472 | 687,343,710 | 2,967,360 | 12,214,732 |

**Part IX Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns All other organizations must complete column (A)

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraisingexpenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | 1,287,862 | 1,287,862 | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 107,101 | 107,101 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees . . . . | 918,401 | | 918,401 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . | 39,114 | 39,114 | | |
| 7 Other salaries and wages | 260,477,997 | 251,830,718 | 8,307,483 | 339,796 |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . | 8,059,325 | 7,784,215 | 264,605 | 10,505 |
| 9 Other employee benefits . . . . . | 14,504,251 | 14,007,475 | 477,878 | 18,898 |
| 10 Payroll taxes . . . . . | 16,410,762 | 15,804,256 | 585,184 | 21,322 |
| 11 Fees for services (non-employees) | | | | |
| a Management . . . . . | 1,207,071 | 1,207,071 | | |
| b Legal . . . . . | 134,495 | | 134,495 | |
| c Accounting . . . . . | 23,178 | | 23,178 | |
| d Lobbying . . . . . | 61,041 | | 61,041 | |
| e Professional fundraising services See Part IV, line 17 | | | | |
| f Investment management fees . . . . . | 335,693 | | 335,693 | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 53,348,534 | 51,186,488 | 2,021,047 | 140,999 |
| 12 Advertising and promotion . . . . | 1,953,327 | 1,827,768 | 17,722 | 107,837 |
| 13 Office expenses . . . . . | 3,310,204 | 2,615,061 | 628,939 | 66,204 |
| 14 Information technology . . . . . | 26,022,931 | 603,145 | 25,394,390 | 25,396 |
| 15 Royalties . . | | | | |
| 16 Occupancy . . . . . | 18,182,721 | 15,637,140 | 2,545,581 | |
| 17 Travel . . . . . | 389,189 | 361,945 | 15,568 | 11,676 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials . | | | | |
| 19 Conferences, conventions, and meetings . . . . | 984,731 | 984,731 | | |
| 20 Interest . . . . . | 7,451,780 | 7,451,780 | | |
| 21 Payments to affiliates . . . . . | | | | |
| 22 Depreciation, depletion, and amortization . . | 32,820,791 | 31,507,959 | 1,312,832 | |
| 23 Insurance . . . | 4,149,489 | 1,203,352 | 2,946,137 | |
| 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 | 121,524,086 | 121,524,086 | | |
| b INTERCO PURCHASED SVCS | 51,064,644 | 510,646 | 50,553,998 | |
| c BAD DEBT | 34,423,038 | 34,423,038 | | |
| d EQUIPMENT MAINTENANCE | 7,022,652 | 6,952,425 | 70,227 | |
| e All other expenses | 2,857,179 | 2,671,321 | 178,312 | 7,546 |
| 25 **Total functional expenses.** Add lines 1 through 24e | 669,071,587 | 571,528,697 | 96,792,711 | 750,179 |
| 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 ▶ ☐ if following SOP 98-2 (ASC 958-720) | | | | |

**Part X Balance Sheet**

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

| | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | 3,266,353 | 1 | 5,359,650 |
| | 2 | Savings and temporary cash investments | | 2 | |
| | 3 | Pledges and grants receivable, net | 1,617,298 | 3 | 1,422,167 |
| | 4 | Accounts receivable, net | 104,994,283 | 4 | 123,932,320 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 5 | |
| | 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 | | 6 | |
| | 7 | Notes and loans receivable, net | 444,365 | 7 | 396,565 |
| | 8 | Inventories for sale or use | 9,253,808 | 8 | 10,619,211 |
| | 9 | Prepaid expenses and deferred charges | 1,350,530 | 9 | 800,495 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 580,310,607 | | | |
| | b | Less accumulated depreciation — 10b: 310,729,619 | 266,097,451 | 10c | 269,580,988 |
| | 11 | Investments—publicly traded securities | 126,410,502 | 11 | 143,193,817 |
| | 12 | Investments—other securities See Part IV, line 11 | 105,522,370 | 12 | 86,438,505 |
| | 13 | Investments—program-related See Part IV, line 11 | | 13 | |
| | 14 | Intangible assets | 1,096,667 | 14 | 816,667 |
| | 15 | Other assets See Part IV, line 11 | 56,153,398 | 15 | 57,043,843 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | 676,207,025 | 16 | 699,604,228 |
| Liabilities | 17 | Accounts payable and accrued expenses | 55,524,010 | 17 | 56,512,005 |
| | 18 | Grants payable | | 18 | |
| | 19 | Deferred revenue | | 19 | |
| | 20 | Tax-exempt bond liabilities | | 20 | |
| | 21 | Escrow or custodial account liability Complete Part IV of Schedule D | | 21 | |
| | 22 | Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | 3,553,610 | 23 | 3,647,471 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | 200,605,211 | 25 | 197,024,801 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | 259,682,831 | 26 | 257,184,277 |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.** | | | |
| | 27 | Unrestricted net assets | 412,586,831 | 27 | 438,530,243 |
| | 28 | Temporarily restricted net assets | 3,937,363 | 28 | 3,889,708 |
| | 29 | Permanently restricted net assets | | 29 | |
| | | **Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.** | | | |
| | 30 | Capital stock or trust principal, or current funds | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 | Total net assets or fund balances | 416,524,194 | 33 | 442,419,951 |
| | 34 | Total liabilities and net assets/fund balances | 676,207,025 | 34 | 699,604,228 |

## Part XI Reconcilliation 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 | 705,328,472 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 669,071,587 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 36,256,885 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 416,524,194 |
| 5 | Net unrealized gains (losses) on investments | 5 | 5,364,321 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -15,725,449 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 442,419,951 |

## Part XII Financial Statements and Reporting

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

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Accounting method used to prepare the Form 990 ☐ 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? | 2a | | No |
| | If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis | | | |
| b | Were the organization's financial statements audited by an independent accountant? | 2b | Yes | |
| | 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? | 2c | Yes | |
| | 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? | 3a | Yes | |
| b | If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits | 3b | Yes | |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 82-0200895

**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER



**Form 990, Part III, Line 4a:**

SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) IS A MEDICAL-SURGICAL/ACUTE CARE HOSPITAL LOCATED IN BOISE, IDAHO, WHOSE HISTORY STARTS OVER 100 YEARS AGO SARMC SERVES RESIDENTS THROUGHOUT SOUTHWEST IDAHO, EASTERN OREGON AND NORTHERN NEVADA SARMC OFFERS A FULL RANGE OF SERVICES IN AN INPATIENT AND OUTPATIENT SETTING AS WELL AS 24 HOUR EMERGENCY CARE, SURGICAL SERVICES, CANCER CARE, BREAST CARE, BRAIN INJURY PROGRAM, PEDIATRICS, SPINE CARE, AND STROKE CENTER AS WELL AS MANY OTHER SERVICES SARMC OFFERS CONVENIENT ACCESS TO HEALTH CARE SERVICES WITH NUMEROUS HEALTH PLAZAS AND CLINIC LOCATIONS PLEASE VISIT SCHEDULE H AND OUR WEBSITE FOR ADDITIONAL INFORMATION ABOUT SERVICES, RECOGNITIONS AND AWARDS WWW SAINTALPHONSUS ORG/LOCATION/SAINT-ALPHONSUS-REGIONAL-MEDICAL-CENTER

**Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| ODETTE BOLANO<br>DIRECTOR, PRESIDENT | 54 00<br>1 00 | X | | X | | | | 0 | 641,826 | 106,004 |
| DARREL ANDERSON<br>DIRECTOR, CHAIR | 1 00<br>4 00 | X | | X | | | | 0 | 0 | 0 |
| GARY DYER<br>DIRECTOR, VICE CHAIR | 1 00<br>4 00 | X | | X | | | | 0 | 0 | 0 |
| KENT BAILEY<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| VICKEN GARABEDIAN MD<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| RONALD GRAVES<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| STUART HARTLEY<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| MICHAEL HOLPER<br>DIRECTOR, TRINITY SVP INTEG/AUDIT SVC | 1 00<br>49 00 | X | | | | | | 0 | 738,740 | 47,562 |
| GERALDINE HOYLER CSC<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| GEORGE JUETTEN<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |

**Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| JOHN KIRBY<br>DIRECTOR AS OF 1/18 | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| MAUREEN KIM LYNCH MD<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| KAYE O'RIORDAN<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| MIRIAM NOHEMI ARIZPE<br>PARADES, CSC, DIRECTOR AS OF 1/18 | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| STACY PEARSON<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| RODNEY REIDER<br>DIRECTOR, SAHS PRESIDENT AND CEO | 1 00<br>54 00 | X | | | | | | 0 | 880,747 | 44,969 |
| MIKE REULING<br>DIRECTOR | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| DON ROUMAGOUX<br>DIRECTOR THROUGH 12/17 | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| SHARLET WAGNER CSC<br>DIRECTOR THROUGH 12/17 | 1 00<br>4 00 | X | | | | | | 0 | 0 | 0 |
| STEPHANIE WESTERMEIER<br>SECRETARY, SAHS VP & GENERAL COUNSEL | 15 00<br>35 00 | | | X | | | | 0 | 388,722 | 41,288 |

**Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| B LANNIE CHECKETTS<br>TREASURER, SAHS CFO | 15 00<br>35 00 | | | X | | | | 0 | 515,287 | 43,903 |
| BRENT CHERNE<br>VP OF FINANCE THRU 5/18 | 50 00<br>0 00 | | | | X | | | 0 | 225,184 | 25,518 |
| JEAN BASOM<br>REGIONAL DIRECTOR SUPPLY CHAIN | 15 00<br>35 00 | | | | X | | | 0 | 176,756 | 31,396 |
| JAMES LEDERER MD<br>SAHS CMO/CHIEF QUALITY OFFICER | 15 00<br>35 00 | | | | X | | | 0 | 502,755 | 32,212 |
| CHRISTIAN ZIMMERMAN MD<br>PHYSICIAN | 50 00<br>0 00 | | | | | X | | 0 | 1,249,099 | 35,004 |
| JOSEPH BROOKS MD<br>PHYSICIAN | 50 00<br>0 00 | | | | | X | | 0 | 1,062,022 | 41,354 |
| MARGOT VLOKA MD<br>PHYSICIAN | 50 00<br>0 00 | | | | | X | | 0 | 820,005 | 34,792 |
| LINDSAY SALES MD<br>PHYSICIAN | 50 00<br>0 00 | | | | | X | | 0 | 807,976 | 32,627 |
| STEPHEN JONES MD<br>PHYSICIAN | 50 00<br>0 00 | | | | | X | | 0 | 784,937 | 33,035 |
| BLAINE PETERSEN<br>FORMER OFFICER, LOYOLA UNIV CFO | 0 00<br>50 00 | | | | | | X | 0 | 798,148 | 38,275 |

**Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| SALLY JEFFCOAT<br>FORMER OFFICER, TRINITY HEALTH EVP | 0 00<br>55 00 | | | | | | X | 0 | 1,517,657 | 43,445 |

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# SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

## Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

f Enter the number of supported organizations _____

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

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

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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

12 Gross receipts from related activities, etc (see instructions) **12**

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

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

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2016 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

**Part III** **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

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

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

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

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

## Part IV Supporting Organizations

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

### Section A. All Supporting Organizations

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year* | 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* ***Part VI*** *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* ***Part VI*** *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* ***Part VI*** *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* ***Part VI*** *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 ☐ The organization satisfied the Activities Test Complete **line 2** below
- b ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- c ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

| | | | Yes | No |
|---|---|---|---|---|
| 2 | Activities Test **Answer (a) and (b) below.** | | | |
| a | Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities* | 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* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement* | 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* ***Part VI.*** | 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* ***Part VI.*** *the role played by the organization in this regard* | 3b | | |

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

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

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

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

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

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

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

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

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

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 82-0200895

**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER



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

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

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

Department of the Treasury
Internal Revenue Service

# Political Campaign and Lobbying Activities

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

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** ***www.irs.gov/form990*****.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**
- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

**If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

**If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then**
- Section 501(c)(4), (5), or (6) organizations Complete Part III

| Name of the organization | **Employer identification number** |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | 82-0200895 |

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

| | **(a)** Name | **(b)** Address | **(c)** EIN | **(d)** Amount paid from filing organization's funds If none, enter -0- | **(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0- |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |

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

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

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

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | (a) Filing organization's totals | (b) Affiliated group totals |
|---|---|---|
| **1a** Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| **b** Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| **c** Total lobbying expenditures (add lines 1a and 1b) | | |
| **d** Other exempt purpose expenditures | | |
| **e** Total exempt purpose expenditures (add lines 1c and 1d) | | |
| **f** Lobbying nontaxable amount Enter the amount from the following table in both columns | | |
| **g** Grassroots nontaxable amount (enter 25% of line 1f) | | |
| **h** Subtract line 1g from line 1a If zero or less, enter -0- | | |
| **i** Subtract line 1f from line 1c If zero or less, enter -0- | | |

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

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

**Lobbying Expenditures During 4-Year Averaging Period**

| Calendar year (or fiscal year beginning in) | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) Total |
|---|---|---|---|---|---|
| **2a** Lobbying nontaxable amount | | | | | |
| **b** Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| **c** Total lobbying expenditures | | | | | |
| **d** Grassroots nontaxable amount | | | | | |
| **e** Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| **f** Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity* | | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|---|
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | Yes | | 56,201 |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | Yes | | 62,924 |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | | No | |
| j | Total Add lines 1c through 1i | | | 119,125 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

**Part IV** **Supplemental Information**

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

| Return Reference | Explanation |
|---|---|
| PART II-B, LINE 1 | LOBBYING ACTIVITIES PERFORMED BY SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) INCLUDED THE RETENTION OF AN INDIVIDUAL WHO WAS PAID A RETAINER TO PERFORM THE FOLLOWING 1 MONITOR AND REPORT ON ALL SIGNIFICANT DEVELOPMENTS IN IDAHO STATE LEGAL, LEGISLATIVE, POLICY AND REGULATORY MATTERS AFFECTING SARMC 2 REGULARLY MEET IDAHO STATE OFFICIALS ON ISSUES OF CONTINUING CONCERN AND INTEREST TO SARMC AND REPORT THE RESULTS OF SUCH MEETINGS 3 MONITOR ALL LEGISLATION INTRODUCED DURING EACH LEGISLATIVE SESSION, LOBBY AGAINST LEGISLATION DETERMINED TO BE ADVERSE TO SARMC AND LOBBY IN FAVOR OF ALL MATTERS OF INTEREST AND CONCERN TO SARMC DURING THE SAME LEGISLATIVE SESSION SARMC HAS ALSO MADE GRANTS TO OTHER ORGANIZATIONS FOR LOBBYING PURPOSES THESE GRANTS HAVE BEEN IN THE FORM OF MEMBERSHIP DUES PAID TO REGIONAL AND NATIONAL HEALTH CARE ORGANIZATIONS, WHERE THE ORGANIZATIONS HAVE PROVIDED SARMC WITH AN ESTIMATED PERCENTAGE OF DUES PAYMENTS WHICH ARE USED FOR LOBBYING ACTIVITIES ORGANIZATION EMPLOYEES ALSO ENGAGE IN ADVOCACY ON ISSUES RELATED TO HEALTH CARE AND HEALTH CARE PROVIDERS SUCH ACTIVITIES CONSIST OF WRITTEN AND VERBAL COMMUNICATIONS WITH FEDERAL, STATE AND LOCAL ELECTED OFFICIALS AND GOVERNMENT AGENCIES |

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

## 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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)

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

| | | Held at the End of the Year |
|---|---|---|
| a | Total number of conservation easements | 2a |
| b | Total acreage restricted by conservation easements | 2b |
| c | Number of conservation easements on a certified historic structure included in (a) | 2c |
| d | Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2d |

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

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

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

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

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

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

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

## Part IV Escrow and Custodial Arrangements.

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

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

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

| | Amount |
|---|---|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

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

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|
| 1a Beginning of year balance | 15,805,236 | 14,494,409 | 15,264,825 | 15,343,853 | 13,279,888 |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | 1,064,733 | 1,821,364 | -409,988 | 260,023 | 2,537,609 |
| d Grants or scholarships | | 119,896 | 117,059 | 107,588 | 473,644 |
| e Other expenditures for facilities and programs | 11,250 | 390,641 | 243,369 | 231,463 | |
| f Administrative expenses | 443,936 | | | | |
| g End of year balance | 16,414,783 | 15,805,236 | 14,494,409 | 15,264,825 | 15,343,853 |

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

- a Board designated or quasi-endowment ▶ 100 000 %
- 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 |
|---|---|---|
| (i) unrelated organizations . . . . . | 3a(i) | No |
| (ii) related organizations . . . . . | 3a(ii) | No |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . | 3b | |

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

## Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|---|---|---|---|
| 1a Land | | 8,559,490 | | 8,559,490 |
| b Buildings | | 372,171,294 | 174,386,399 | 197,784,895 |
| c Leasehold improvements | | | | |
| d Equipment | | 178,918,468 | 136,343,220 | 42,575,248 |
| e Other | | 20,661,355 | | 20,661,355 |
| **Total.** Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c) )* ▶ | | | | 269,580,988 |

**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) COMMINGLED FUNDS DIRECTLY HOLDING SECURITIES | 31,029,207 | F |
| (B) EQUITY METHOD INVESTMENTS | 37,678,323 | C |
| (C) HEDGE FUNDS | 17,730,975 | F |
| (D) | | |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 12 )* ▶ | 86,438,505 | |

**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) MISCELLANEOUS RECEIVABLES | 134,867 |
| (2) INTERCOMPANY OTHER LT ASSETS | 36,978,214 |
| (3) INTERCOMPANY ACCOUNTS RECEIVABLE | 19,924,821 |
| (4) OTHER CURRENT ASSETS | 5,941 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 15 )* ▶ | 57,043,843 |

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

| 1. (a) Description of liability | (b) Book value |
|---|---|
| (1) Federal income taxes | |
| INTERCOMPANY ACCOUNTS PAYABLE | 5,411,902 |
| DEFERRED COMPENSATION LIABILITY | 8,380,752 |
| ASSET RETIREMENT OBLIGATION (FIN 47) | 980,152 |
| INTERCOMPANY NOTES PAYABLE | 181,767,576 |
| OTHER CURRENT LIABILITIES | 480,151 |
| OTHER LONG TERM LIABILITIES | 4,268 |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 25 )* ▶ | 197,024,801 |

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

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

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

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

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

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

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

## Part XIII Supplemental Information

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

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

**Part XIII Supplemental Information *(continued)***

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

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 82-0200895
**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Supplemental Information**

| Return Reference | Explanation |
|---|---|
| PART V, LINE 4 | THE INTENDED USES OF THE ORGANIZATION'S ENDOWMENT FUNDS ARE FOR - PROJECTS DESIGNED TO EL EVATE THE QUALITY OF HEALTH CARE (INTERNAL GRANTS) - PROJECTS TO MEET IMMEDIATE NEEDS RELA TED TO PATIENT CARE QUALITY (OPPORTUNITY GRANTS) - PROJECTS FOR HEALTH AND WELFARE-RELATED COMMUNITY BENEFIT PROJECTS THAT MEET THE NEEDS OF THE POOR AND UNDERSERVED |

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Supplemental Information Regarding Fundraising or Gaming Activities

**Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a**

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

**Part I** **Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

**1** Indicate whether the organization raised funds through any of the following activities Check all that apply

**a** ☐ Mail solicitations
**b** ☐ Internet and email solicitations
**c** ☐ Phone solicitations
**d** ☐ In-person solicitations
**e** ☐ Solicitation of non-government grants
**f** ☐ Solicitation of government grants
**g** ☐ Special fundraising events

**2a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

**b** If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization

| | **(i)** Name and address of individual or entity (fundraiser) | **(ii)** Activity | **(iii)** Did fundraiser have custody or control of contributions? **Yes** | **No** | **(iv)** Gross receipts from activity | **(v)** Amount paid to (or retained by) fundraiser listed in col **(i)** | **(vi)** Amount paid to (or retained by) organization |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| **Total** | | ▶ | | | | | |

**3** List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing

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

| | | (a) Event #1 FESTIVAL OF TREES (event type) | (b) Event #2 WINE WOMEN AND WELLNESS (event type) | (c) Other events 1 (total number) | (d) Total events (add col (a) through col (c)) |
|---|---|---|---|---|---|
| Revenue | 1 Gross receipts | 983,928 | 9,141 | 8,963 | 1,002,032 |
| | 2 Less Contributions | 597,317 | 1,995 | 8,388 | 607,700 |
| | 3 Gross income (line 1 minus line 2) | 386,611 | 7,146 | 575 | 394,332 |
| Direct Expenses | 4 Cash prizes | | | | |
| | 5 Noncash prizes | 8,980 | | | 8,980 |
| | 6 Rent/facility costs | | | | |
| | 7 Food and beverages | 100,000 | 5,204 | 312 | 105,516 |
| | 8 Entertainment | | | | |
| | 9 Other direct expenses | 278,000 | 1,276 | 485 | 279,761 |
| | 10 Direct expense summary Add lines 4 through 9 in column (d) ▶ | | | | 394,257 |
| | 11 Net income summary Subtract line 10 from line 3, column (d) ▶ | | | | 75 |

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

| | | (a) Bingo | (b) Pull tabs/Instant bingo/progressive bingo | (c) Other gaming | (d) Total gaming (add col (a) through col (c)) |
|---|---|---|---|---|---|
| Revenue | 1 Gross revenue | | | 31,093 | 31,093 |
| Direct Expenses | 2 Cash prizes | | | | |
| | 3 Noncash prizes | | | 10,120 | 10,120 |
| | 4 Rent/facility costs | | | | |
| | 5 Other direct expenses | | | | |
| | 6 Volunteer labor | ☐ Yes % ☐ No | ☐ Yes % ☐ No | ☑ Yes 5 000 % ☐ No | |
| | 7 Direct expense summary Add lines 2 through 5 in column (d) ▶ | | | | 10,120 |
| | 8 Net gaming income summary Subtract line 7 from line 1, column (d) ▶ | | | | 20,973 |

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

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

b If "No," explain

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

b If "Yes," explain

**11** Does the organization conduct gaming activities with nonmembers? ☑ Yes ☐ No

**12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☑ No

**13** Indicate the percentage of gaming activity conducted in

| | | |
|---|---|---|
| **a** The organization's facility | **13a** | 25 000 % |
| **b** An outside facility | **13b** | 75 000 % |

**14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ▶ AMBER MURRAY

Address ▶ 1055 N CURTIS RD
BOISE, ID 83706

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

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

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

Name ▶

Address ▶

**16** Gaming manager information

Name ▶ JILL ALDAPE

Gaming manager compensation ▶ $

Description of services provided ▶ EXECUTIVE DIRECTOR OF FOUNDATION AND OVERSEES ALL FOUNDATION EVENTS

☐ Director/officer ☑ Employee ☐ Independent contractor

**17** Mandatory distributions

**a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☑ No

**b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

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

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

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

# Hospitals

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | | |
| | ☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care | 3a | Yes | |
| | ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ % | | | |
| b | Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care | 3b | Yes | |
| | ☐ 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"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | Yes | |
| 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 eligibile for free or discounted care? | 5c | | No |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| | Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H | | | |

**7** Financial Assistance and Certain Other Community Benefits at Cost

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | | | 15,197,181 | | 15,197,181 | 2 390 % |
| b Medicaid (from Worksheet 3, column a) | | | 88,536,104 | 71,456,923 | 17,079,181 | 2 690 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 103,733,285 | 71,456,923 | 32,276,362 | 5 080 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 3,128,063 | 201,261 | 2,926,802 | 0 460 % |
| f Health professions education (from Worksheet 5) | | | 809,399 | | 809,399 | 0 130 % |
| g Subsidized health services (from Worksheet 6) | | | 1,058,140 | | 1,058,140 | 0 170 % |
| h Research (from Worksheet 7) | | | 1,907 | | 1,907 | 0 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 2,624,675 | 23,389 | 2,601,286 | 0 410 % |
| j **Total.** Other Benefits | | | 7,622,184 | 224,650 | 7,397,534 | 1 170 % |
| k **Total.** Add lines 7d and 7j | | | 111,355,469 | 71,681,573 | 39,673,896 | 6 250 % |

## Part II Community Building Activities

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | | | 43,143 | | 43,143 | 0 010 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | 52,246 | | 52,246 | 0 010 % |
| 7 Community health improvement advocacy | | | 118,984 | | 118,984 | 0 020 % |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | | | 214,373 | | 214,373 | 0 040 % |

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

### Section A. Bad Debt Expense

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15? | | 1 | | No |
| 2 | Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount | 2 34,423,038 | | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 0 | | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements | | | | |

### Section B. Medicare

| | | | |
|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 101,901,055 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 105,950,381 |
| 7 | Subtract line 6 from line 5 This is the surplus (or shortfall) | 7 | -4,049,326 |
| 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? | | 9a | Yes | |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | | 9b | Yes | |

## Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

| | (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |

## Part V Facility Information

### Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? **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) | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
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**Part V Facility Information** *(continued)*

**Section B. Facility Policies and Practices**

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

**Name of hospital facility or letter of facility reporting group** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** 1

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** | | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | 3 | Yes | |
| | If "Yes," indicate what the CHNA report describes (check all that apply) | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The significant health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 20 16 | | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes | |
| 6 a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C | 6b | Yes | |
| 7 | Did the hospital facility make its CHNA report widely available to the public? | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| a | ☑ Hospital facility's website (list url) SEE PART V, SECTION C | | | |
| b | ☐ Other website (list url) | | | |
| c | ☑ Made a paper copy available for public inspection without charge at the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 16 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes | |
| a | If "Yes" (list url) SEE PART V, SECTION C | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | | |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

**Part V Facility Information** *(continued)*

**Financial Assistance Policy (FAP)**

SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☑ Asset level | | | |
| d | ☑ Medical indigency | | | |
| e | ☑ Insurance status | | | |
| f | ☑ Underinsurance discount | | | |
| g | ☑ Residency | | | |
| h | ☑ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d | ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | | |
| a | ☑ The FAP was widely available on a website (list url) SEE PART V, PAGE 8 | | | |
| b | ☑ The FAP application form was widely available on a website (list url) SEE PART V, PAGE 8 | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, PAGE 8 | | | |
| d | ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☑ 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 | ☑ 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 | ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j | ☐ Other (describe in Section C) | | | |

## Part V Facility Information *(continued)*

### Billing and Collections

SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

| | | Yes | No |
|---|---|---|---|
| **17** Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? | 17 | Yes | |
| **18** Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | | |
| **a** ☐ Reporting to credit agency(ies) | | | |
| **b** ☐ Selling an individual's debt to another party | | | |
| **c** ☐ 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** ☐ Actions that require a legal or judicial process | | | |
| **e** ☐ Other similar actions (describe in Section C) | | | |
| **f** ☑ None of these actions or other similar actions were permitted | | | |
| **19** Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? | 19 | | No |
| If "Yes," check all actions in which the hospital facility or a third party engaged | | | |
| **a** ☐ Reporting to credit agency(ies) | | | |
| **b** ☐ Selling an individual's debt to another party | | | |
| **c** ☐ 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** ☐ Actions that require a legal or judicial process | | | |
| **e** ☐ 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** ☑ 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** ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process | | | |
| **c** ☑ Processed incomplete and complete FAP applications | | | |
| **d** ☑ Made presumptive eligibility determinations | | | |
| **e** ☐ Other (describe in Section C) | | | |
| **f** ☐ None of these efforts were made | | | |

### Policy Relating to Emergency Medical Care

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

**Part V Facility Information** *(continued)*

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

| | | Yes | No |
|---|---|---|---|
| **22** | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | |
| **a** | ☑ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period | | |
| **b** | ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | |
| **c** | ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | |
| **d** | ☐ The hospital facility used a prospective Medicare or Medicaid method | | |
| **23** | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . **23** | | No |
| | 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? . . . . . **24** | | No |
| | If "Yes," explain in Section C | | |

**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.

| Form and Line Reference | Explanation |
|---|---|
| See Add'l Data | |
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**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? **40**

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

## Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc )

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

### 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINE 3C | IN ADDITION TO LOOKING AT A MULTIPLE OF THE FEDERAL POVERTY GUIDELINES, OTHER FACTORS ARE CONSIDERED SUCH AS THE PATIENT'S FINANCIAL STATUS AND/OR ABILITY TO PAY AS DETERMINED THROUGH THE ASSESSMENT PROCESS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINE 6A | SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) PREPARES AN ANNUAL COMMUNITY BENEFIT REPORT, WHICH IT SUBMITS TO THE STATE OF IDAHO IN ADDITION, SARMC REPORTS ITS COMMUNITY BENEFIT INFORMATION AS PART OF THE CONSOLIDATED COMMUNITY BENEFIT INFORMATION REPORTED BY TRINITY HEALTH (EIN 35-1443425) IN ITS AUDITED FINANCIAL STATEMENTS, AVAILABLE AT WWW TRINITY-HEALTH ORG SARMC ALSO INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON BOTH ITS OWN WEBSITE AND TRINITY HEALTH'S WEBSITE |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINE 7 | THE BEST AVAILABLE DATA WAS USED TO CALCULATE THE COST AMOUNTS REPORTED IN ITEM 7 FOR CERTAIN CATEGORIES, PRIMARILY TOTAL CHARITY CARE AND MEANS-TESTED GOVERNMENT PROGRAMS, SPECIFIC COST-TO-CHARGE RATIOS WERE CALCULATED AND APPLIED TO THOSE CATEGORIES THE COST-TO-CHARGE RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES IN OTHER CATEGORIES, THE BEST AVAILABLE DATA WAS DERIVED FROM THE HOSPITAL'S COST ACCOUNTING SYSTEM |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LN 7 COL(F) | THE FOLLOWING NUMBER, $34,423,038, REPRESENTS THE AMOUNT OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990, PART IX, LINE 25 PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H, PART I, LINE 7, COLUMN (F) |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART II, COMMUNITY BUILDING ACTIVITIES | SARMC STRIVES TO BE A TRANSFORMING HEALING PRESENCE WITHIN OUR COMMUNITIES THROUGH OUR COMMUNITY NEEDS ASSESSMENT AND OTHER COMMUNITY DATA, WE LEARNED THAT SEVERAL AREAS CAN BENEFIT FROM OUR HEALTH CARE EXPERTISE AND MONETARY SUPPORT SPECIFIC EXAMPLES OF OUR COMMUNITY BUILDING ACTIVITIES ARE DESCRIBED BELOW PARTICIPATION IN LOCAL BOARDS & TASK FORCE SARMC LEADERS AND ASSOCIATES PARTICIPATED IN A VARIETY OF LOCAL NONPROFIT BOARDS AND TASK FORCES AIMED AT IMPROVING THE HEALTH OF OUR COMMUNITY MEMBERS AND MAKING OUR COMMUNITY A MORE LIVABLE PLACE EXAMPLES OF BOARD PARTICIPATION INCLUDED - FAMILY MEDICINE RESIDENCY OF IDAHO THROUGH ACTIVE PARTICIPATION ON THE BOARD OF FAMILY MEDICINE RESIDENCY OF IDAHO, SARMC HAS HELPED GUIDE THE CONTINUING DEVELOPMENT AND EXPANSION OF FAMILY MEDICINE RESIDENCY CAPACITY IN IDAHO, A CRITICAL NEED SINCE IDAHO RANKS 49TH NATIONWIDE IN PRIMARY CARE PHYSICIANS PER CAPITA THROUGH THIS PARTNERSHIP, WE ARE ABLE TO SUPPORT A PSYCHIATRIC RESIDENCY PROGRAM BASED IN BOISE - BOYS & GIRLS CLUBS OF ADA COUNTY ENHANCEMENT OF BEFORE & AFTER-SCHOOL PROGRAMMING FOR LOCAL AT-RISK YOUTH LOCAL CLUBS HAVE ALSO TAKEN ON A SIGNIFICANT ROLE IN PROVIDING MEALS AND ACTIVITY FOR LOW INCOME CHILDREN IN ADA AND CANYON COUNTIES AND HAVE RECEIVED NATIONAL AWARDS FOR THEIR NUTRITION PROGRAMMING - YMCA YMCA PROVIDES ACCESS TO LOW-INCOME AND VULNERABLE POPULATIONS FOR FITNESS, YOUTH EMPOWERMENT, AND MORE THE YMCA ALSO HAS A HEALTHY LIVING CENTER FOR PEOPLE LIVING WITH CHRONIC ILLNESS - UNITED WAY OF TREASURE VALLEY UNITED WAY IS THE LEAD ORGANIZER FOR THE TRIENNIAL COMMUNITY HEALTH NEEDS ASSESSMENT IT IS ALSO FOCUSED ON BUILDING AND MOVING RESOURCES TO SIGNIFICANTLY IMPROVE COMMUNITIES AND NEIGHBORHOODS, HELPING PEOPLE AND FAMILIES BUILD RESILIENCY IN EDUCATION, FINANCIAL INDEPENDENCE AND HEALTH SARMC PARTICIPATED IN SEVERAL OTHER NON-PROFIT BOARDS, SUCH AS - AMERICAN HEART ASSOCIATION- FACES (FAMILY JUSTICE CENTER)- WOMEN AND CHILDREN'S ALLIANCE (PREVENT DOMESTIC ABUSE)- MEDICAL AND HOSPITAL ASSOCIATIONS AND NURSING ASSOCIATIONS- CHILDREN'S HOME SOCIETY (MENTAL HEALTH ASSISTANCE)- MARCH OF DIMES- IDAHO QUALITY OF LIFE BOARD- CATHOLIC CHARITIES OF IDAHO (SOCIAL SERVICE ARM OF CHURCH)WE HAVE ALSO TAKEN HEALTH OUTREACH INTO THE COMMUNITY SETTING INCLUDING USING FAITH COMMUNITY NURSES TO DO HOMELESS FOOT CARE CLINICS, SPIRITUAL WELLNESS WORK WITH FAITH COMMUNITY NURSES AND ALSO THE SAINT JOHN'S BIBLE PROGRAM AND DISASTER READINESS EDUCATION SAINT ALPHONSUS HEALTH SYSTEM ALSO CONTINUED DEVELOPMENT OF A FORMAL OBESITY STRATEGY THAT ENGAGES THE COMMUNITY PARTNERS, AS PART OF OUR CHNA IMPLEMENTATION STRATEGY OBESITY FOCUS, WITH MUCH EMPHASIS ON CHILDHOOD OBESITY PREVENTION ADVOCACY FOR COMMUNITY HEALTH IMPROVEMENT SARMC HAS BEEN AN ACTIVE PARTICIPANT IN ADVOCACY FOR HEALTH IMPROVEMENT INITIATIVES SUCH AS - HEALTH CARE ACCESS FOR THOSE WHO ARE POOR IN ADDITION TO ADVOCACY FOR THE HEALTH INSURANCE EXCHANGE, SARMC JOINED A COALITION OF BUSINESS AND HEALTH ORGANIZATIONS TO SUPPORT MEDICAID EXPANSION AND REDESIGN AS PROPOSED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, THIS WOULD EXTEND HEALTH COVERAGE TO OVER 70,000 ADULT IDAHOANS LEGISLATION WAS PROPOSED AND HAS FAILED ANNUALLY SINCE 2015, BUT SARMC CONTINUES TO HELP FACILITATE LEGISLATIVE WORKGROUP DISCUSSIONS REGARDING REDESIGN/EXPANSION - MENTAL HEALTH ADVOCACY PARTICIPATED IN NEW AND ONGOING COMMUNITY ROUNDTABLES ON MENTAL HEALTH ALSO WITH A NEW OPPORTUNITY FOR AN ADA COUNTY CRISIS CENTER, SAINT ALPHONSUS HEALTH SYSTEM PARTICIPATED IN A COALITION THAT HAS ORGANIZED AND ESTABLISHED THE THIRD CRISIS CENTER FOR IDAHO IN THE TREASURE VALLEY COMMUNITY - HOUSING AND HOMELESSNESS ROUNDTABLE PARTICIPATED IN NEW AND ONGOING COMMUNITY ROUNDTABLES ADVOCATING AFFORDABLE HOUSING AND HOUSING FIRST PROPOSAL AND IMPLEMENTATION FOR CHRONICALLY HOMELESS WE ALSO SUPPORTED SMALLER HOMELESSNESS PREVENTION PROJECTS INCLUDING JESSE TREE WHICH PROVIDES RENTAL ASSISTANCE FOR VULNERABLE FAMILIES -HUMAN TRAFFICKING NEW ATTENTION WAS GIVEN TO EXPLORING HUMAN TRAFFICKING RESOURCES AND COLLABORATIONS IN THE TREASURE VALLEY COMMUNITY AND BUILDING RELATIONSHIPS WITH COMMUNITY PARTNERS ON THIS TOPIC THIS IS PART OF PREVENTING VIOLENCE SOCIAL DETERMINANT OF HEALTH WORK COALITION SUPPORT - TOBACCO 21 SAINT ALPHONSUS HEALTH SYSTEM LED THE ORIGINATION OF A TOBACCO 21 COALITION THAT ADVOCATES FOR RAISING THE LEGAL TOBACCO SALES AGE TO 21 - REFUGEE RESOURCE STEERING COMMITTEE SARMC PARTICIPATED IN THE ONGOING COLLABORATION AND STRATEGIC PLANNING AMONG COMMUNITY LEADERS WITH THE PRIMARY GOAL OF STRENGTHENING SUPPORTS FOR REFUGEE RESETTLEMENT IN THE GREATER BOISE AREA THE STEERING COMMITTEE IS MADE UP OF COMMUNITY LEADERS ADDRESSING NEEDS AND RESOURCES RELATED TO TRANSPORTATION, EDUCATION, HOUSING, EMPLOYMENT, HEALTH, AND SOCIAL INTEGRATION |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 2 | METHODOLOGY USED FOR LINE 2 - ANY DISCOUNTS PROVIDED OR PAYMENTS MADE TO A PARTICULAR PATIENT ACCOUNT ARE APPLIED TO THAT PATIENT ACCOUNT PRIOR TO ANY BAD DEBT WRITE-OFF AND ARE THUS NOT INCLUDED IN BAD DEBT EXPENSE AS A RESULT OF THE PAYMENT AND ADJUSTMENT ACTIVITY BEING POSTED TO BAD DEBT ACCOUNTS, WE ARE ABLE TO REPORT BAD DEBT EXPENSE NET OF THESE TRANSACTIONS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 3 | SARMC USES A PREDICTIVE MODEL THAT INCORPORATES THREE DISTINCT VARIABLES IN COMBINATION TO PREDICT WHETHER A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE (1) SOCIO-ECONOMIC SCORE, (2) ESTIMATED FEDERAL POVERTY LEVEL (FPL), AND (3) HOMEOWNERSHIP BASED ON THE MODEL, CHARITY CARE CAN STILL BE EXTENDED TO PATIENTS EVEN IF THEY HAVE NOT RESPONDED TO FINANCIAL COUNSELING EFFORTS AND ALL OTHER FUNDING SOURCES HAVE BEEN EXHAUSTED FOR FINANCIAL STATEMENT PURPOSES, SARMC IS RECORDING AMOUNTS AS CHARITY CARE (INSTEAD OF BAD DEBT EXPENSE) BASED ON THE RESULTS OF THE PREDICTIVE MODEL THEREFORE, SARMC IS REPORTING ZERO ON LINE 3, SINCE THEORETICALLY ANY POTENTIAL CHARITY CARE SHOULD HAVE BEEN IDENTIFIED THROUGH THE PREDICTIVE MODEL |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 4 | SARMC IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH THE FOLLOWING IS THE TEXT OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOOTNOTE FROM PAGE 14 OF THOSE STATEMENTS "THE CORPORATION RECOGNIZES A SIGNIFICANT AMOUNT OF PATIENT SERVICE REVENUE AT THE TIME THE SERVICES ARE RENDERED EVEN THOUGH THE CORPORATION DOES NOT ASSESS THE PATIENT'S ABILITY TO PAY AT THAT TIME AS A RESULT, THE PROVISION FOR BAD DEBTS IS PRESENTED AS A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL PROVISIONS AND DISCOUNTS) FOR UNINSURED AND UNDERINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, THE CORPORATION ESTABLISHES AN ALLOWANCE TO REDUCE THE CARRYING VALUE OF SUCH RECEIVABLES TO THEIR ESTIMATED NET REALIZABLE VALUE THIS ALLOWANCE IS ESTABLISHED BASED ON THE AGING OF ACCOUNTS RECEIVABLE AND THE HISTORICAL COLLECTION EXPERIENCE BY THE HEALTH MINISTRIES FOR EACH TYPE OF PAYOR A SIGNIFICANT PORTION OF THE CORPORATION'S PROVISION FOR DOUBTFUL ACCOUNTS RELATES TO SELF-PAY PATIENTS, AS WELL AS CO-PAYMENTS AND DEDUCTIBLES OWED TO THE CORPORATION BY PATIENTS WITH INSURANCE "PART III, LINE 5 TOTAL MEDICARE REVENUE REPORTED IN PART III, LINE 5 HAS BEEN REDUCED BY THE TWO PERCENT SEQUESTRATION REDUCTION |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 8 | SARMC DOES NOT BELIEVE ANY MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT THIS IS SIMILAR TO CATHOLIC HEALTH ASSOCIATION RECOMMENDATIONS, WHICH STATE THAT SERVING MEDICARE PATIENTS IS NOT A DIFFERENTIATING FEATURE OF TAX-EXEMPT HEALTH CARE ORGANIZATIONS AND THAT THE EXISTING COMMUNITY BENEFIT FRAMEWORK ALLOWS COMMUNITY BENEFIT PROGRAMS THAT SERVE THE MEDICARE POPULATION TO BE COUNTED IN OTHER COMMUNITY BENEFIT CATEGORIES PART III, LINE 8 COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE OBTAINED FROM THE FILED MEDICARE COST REPORT THE COSTS ARE BASED ON MEDICARE ALLOWABLE COSTS AS REPORTED ON WORKSHEET B, COLUMN 27, WHICH EXCLUDE DIRECT MEDICAL EDUCATION COSTS INPATIENT MEDICARE COSTS ARE CALCULATED BASED ON A COMBINATION OF ALLOWABLE COST PER DAY TIMES MEDICARE DAYS FOR ROUTINE SERVICES AND COST TO CHARGE RATIO TIMES MEDICARE CHARGES FOR ANCILLARY SERVICES OUTPATIENT MEDICARE COSTS ARE CALCULATED BASED ON COST TO CHARGE RATIO TIMES MEDICARE CHARGES BY ANCILLARY DEPARTMENT |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 9B | THE HOSPITAL'S COLLECTION POLICY CONTAINS PROVISIONS ON THE COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE CHARITY DISCOUNTS ARE APPLIED TO THE AMOUNTS THAT QUALIFY FOR FINANCIAL ASSISTANCE COLLECTION PRACTICES FOR THE REMAINING BALANCES ARE CLEARLY OUTLINED IN THE ORGANIZATION'S COLLECTION POLICY THE HOSPITAL HAS IMPLEMENTED BILLING AND COLLECTION PRACTICES FOR PATIENT PAYMENT OBLIGATIONS THAT ARE FAIR, CONSISTENT AND COMPLIANT WITH STATE AND FEDERAL REGULATIONS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 2 | NEEDS ASSESSMENT - SARMC ASSESSED THE HEALTH STATUS OF ITS COMMUNITY, IN PARTNERSHIP WITH COMMUNITY COALITIONS, AS PART OF THE NORMAL COURSE OF OPERATIONS AND IN THE CONTINUOUS EFFORTS TO IMPROVE PATIENT CARE AND THE HEALTH OF THE OVERALL COMMUNITY TO ASSESS THE HEALTH OF THE COMMUNITY, THE HOSPITAL USED PATIENT DATA, PUBLIC HEALTH DATA, ANNUAL COUNTY HEALTH RANKINGS, MARKET STUDIES AND GEOGRAPHICAL MAPS SHOWING AREAS OF HIGH UTILIZATION FOR EMERGENCY SERVICES AND INPATIENT CARE, WHICH MAY INDICATE POPULATIONS OF INDIVIDUALS WHO DO NOT HAVE ACCESS TO PREVENTATIVE SERVICES OR ARE UNINSURED SARMC ALSO EVALUATED INPATIENT, OUTPATIENT, EMERGENCY DEPARTMENT, CLINICAL AND FINANCIAL DATA, TO DETERMINE, (1) WHAT TYPE OF AMBULATORY-SENSITIVE CONDITIONS, THAT ARE OTHERWISE PREVENTABLE OR SHOULD BE WELL-MANAGED IN THE COMMUNITY SETTING, ARE TREATED IN THE EMERGENCY ROOM AND (2) TO WHAT QUANTIFIABLE EXTENT ARE THESE CASES INVOLVING PATIENTS WHO ARE UNINSURED OR UNDER-INSURED WE BUILT SYSTEMS TO HELP CONNECT THESE MOST "AT-RISK" PATIENTS WITH OUR FINANCIAL ASSISTANCE PROGRAMS AND WITH CARE PROVIDERS WHO CAN ASSIST THEM MORE REGULARLY AT A MORE APPROPRIATE LEVEL OF CARE EVALUATION OF HOSPITAL DATA ON HOMELESS INDIVIDUALS LED TO GREATER SUPPORT FOR COMMUNITY EFFORTS TO PREVENT HOMELESSNESS WE HAVE ALSO INCREASED CARE OUTREACH EFFORTS FOR THOSE WHO ARE HOMELESS, AS WELL AS CONNECTING THEM WITH FINANCIAL ASSISTANCE, TO ACCESS CARE WITH OUR HOSPITAL AND WITH OTHER LOCAL HEALTH PROVIDERS SARMC ALSO UTILIZED THE EXPERTISE OF PUBLIC HEALTH PARTNERS AND THEIR ANALYSIS OF COMMUNITY NEEDS WWW CHNA ORG CONTINUED TO BE A GREAT RESOURCE TO THE HEALTH SYSTEM FOR EXAMINING PUBLICLY AVAILABLE DATA SAINT ALPHONSUS HEALTH SYSTEM RECEIVED REGULAR INPUT FROM PEER HEALTH ADVISORS WITHIN THE REFUGEE COMMUNITIES AND IMPLEMENTED PATIENT-FAMILY ADVISORY COUNCILS FOR COMMUNITY INPUT SARMC ALSO HAD PERIODIC CONVERSATIONS WITH ALIGNED HEALTH CARE AND SOCIAL SUPPORT AGENCIES, LIKE CATHOLIC CHARITIES OF IDAHO, WHO SERVE THOSE WHO ARE POOR AND UNDERSERVED, REGARDING HEALTH TRENDS AND PRESSING NEEDS IN THEIR PATIENT/CUSTOMER POPULATIONS AND STRATEGIZED WAYS IN WHICH THE HEALTH SYSTEM COULD PARTNER IN SERVING THESE INDIVIDUALS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 3 | PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE - SARMC COMMUNICATES EFFECTIVELY WITH PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS FINANCIAL COUNSELING IS PROVIDED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HOSPITAL BILLS INFORMATION ON HOSPITAL-BASED FINANCIAL SUPPORT POLICIES, FEDERAL, STATE, AND LOCAL GOVERNMENT PROGRAMS, AND OTHER COMMUNITY-BASED CHARITABLE PROGRAMS THAT PROVIDE COVERAGE FOR SERVICES ARE MADE AVAILABLE TO PATIENTS DURING THE PRE-REGISTRATION AND REGISTRATION PROCESSES AND/OR THROUGH COMMUNICATIONS WITH PATIENTS SEEKING FINANCIAL ASSISTANCE FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY ASSIST THEM IN OBTAINING AND PAYING FOR HEALTH CARE SERVICES EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY PRIOR TO OR AT THE TIME OF ADMISSION OR SERVICE SARMC OFFERS FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS THIS SUPPORT IS AVAILABLE TO UNINSURED AND UNDERINSURED PATIENTS WHO DO NOT QUALIFY FOR PUBLIC PROGRAMS OR OTHER ASSISTANCE NOTIFICATION ABOUT FINANCIAL ASSISTANCE, INCLUDING CONTACT INFORMATION, IS AVAILABLE THROUGH PATIENT BROCHURES, MESSAGES ON PATIENT BILLS, POSTED NOTICES IN PUBLIC REGISTRATION AREAS INCLUDING EMERGENCY ROOMS, ADMITTING AND REGISTRATION DEPARTMENTS, AND OTHER PATIENT FINANCIAL SERVICES OFFICES SUMMARIES OF HOSPITAL PROGRAMS ARE MADE AVAILABLE TO APPROPRIATE COMMUNITY HEALTH AND HUMAN SERVICES AGENCIES AND OTHER ORGANIZATIONS THAT ASSIST PEOPLE IN NEED INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAMS IS ALSO AVAILABLE ON HOSPITAL WEBSITES IN ADDITION TO ENGLISH, THIS INFORMATION IS ALSO AVAILABLE IN OTHER LANGUAGES AS REQUIRED BY INTERNAL REVENUE CODE SECTION 501(R), REFLECTING OTHER PRIMARY LANGUAGES SPOKEN BY THE POPULATION SERVICED BY OUR HOSPITAL SARMC HAS ESTABLISHED A WRITTEN POLICY FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS SARMC MAKES EVERY EFFORT TO ADHERE TO THE POLICY AND IS COMMITTED TO IMPLEMENTING AND APPLYING THE POLICY FOR ASSISTING PATIENTS WITH LIMITED MEANS IN A PROFESSIONAL, CONSISTENT MANNER |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 4 | COMMUNITY INFORMATION - SARMC SERVES PATIENTS FROM THE PRIMARY, SECONDARY AND TERTIARY SER VICE AREAS LISTED BELOW - PRIMARY SERVICE AREA (75% OF DISCHARGES) ADA AND CANYON COUNTIE S- SECONDARY SERVICE AREA (75-90% OF DISCHARGES) BOISE, GEM, MALHEUR, ELMORE, PAYETTE, OW YHEE, BAKER AND UNION COUNTIES - TERTIARY SERVICE AREA (90-95% OF DISCHARGES) TWIN FALLS, VALLEY, WASHINGTON, ADAMS, BLAINE, CASSIA, GOODING AND JEROME COUNTIES- SARMC ALSO PARTIC IPATES IN RURAL TELEHEALTH WORK, FOR EXAMPLE, SERVING PSYCHIATRY NEEDS IN NORTHERN IDAHO A REA HOSPITAL FACILITIES WITHIN SARMC'S PRIMARY SERVICE AREA INCLUDE ST LUKE'S BOISE AND M ERIDIAN, ST LUKE'S (ELKS) REHABILITATION CENTER, TREASURE VALLEY HOSPITAL, SAINT ALPHONSU S MEDICAL CENTER-NAMPA, WEST VALLEY MEDICAL CENTER, SAINT ALPHONSUS MEDICAL CENTER-ONTARIO , SAINT ALPHONSUS MEDICAL CENTER-BAKER CITY, GRANDE RONDE AND VALOR HEALTH (FORMERLY WALTE R KNOX MEMORIAL HOSPITAL) SARMC'S PRIMARY SERVICE AREA IS A MIX OF URBAN AND RURAL COMMUN ITIES WITHIN THE TREASURE VALLEY, BORDERED BY RUGGED MOUNTAINOUS TERRAIN AND DESERT THE R EGION HAS EXPERIENCED RAPID POPULATION GROWTH OVER THE PAST DECADE, WITH DRAMATIC GROWTH R ATES IN ADA & CANYON COUNTIES, THE TWO LARGEST COUNTIES IN THE SERVICE AREA - MIGRATION N ET MIGRATION, OR THE DIFFERENCE BETWEEN HOW MANY PEOPLE MOVED IN AND HOW MANY MOVED OUT, I S ONE PART OF POPULATION CHANGE (INDICATORSIDAHO ORG)FROM 2010 TO 2015 - ADA COUNTY GAINE D 35,186 RESIDENTS THROUGH NET IN-MIGRATION, AND HAD A NET MIGRATION RATE OF 8 9% COMPARED TO 3% FOR IDAHO - CANYON COUNTY GAINED 11,016 RESIDENTS THROUGH NET IN-MIGRATION, AND HA D A NET MIGRATION RATE OF 5 8% COMPARED TO 3% FOR IDAHO - GEM COUNTY, GAINED 433 RESIDENTS THROUGH NET IN-MIGRATION, AND HAD A NET MIGRATION RATE OF 2 6% COMPARED TO 3% FOR IDAHO O THER RELEVANT STATISTICS CHARACTERIZING SARMC'S PRIMARY SERVICE AREA ARE INCLUDED BELOW (C ENSUS GOV) TOTAL POPULATION (2017 ESTIMATE) AND GROWTH (2017, GROWTH 2010-2017) ADA COUNTY - 456,849 (16 4%)CANYON COUNTY - 216,699 (14 7%)ELMORE COUNTY - 26,823 (-0 8%)GEM COUNTY - 17,379 (3 9%)MALHEUR COUNTY - 30,480 (-2 7%)PERCENT WHITE PERSONS NOT HISPANIC (2017) AD A COUNTY - 84 7%CANYON COUNTY - 70 4%ELMORE COUNTY - 72 6%GEM COUNTY - 87 6%MALHEUR COUNTY - 60 8%PERCENT HISPANIC/LATINO ORIGIN (2017) ADA COUNTY - 8 2%CANYON COUNTY - 25 3%ELMORE COUNTY - 17 0%GEM COUNTY - 8 5%MALHEUR COUNTY - 34 0%MEDIAN HOUSEHOLD INCOME (2012-2016) ADA COUNTY - $58,099CANYON COUNTY - $44,860ELMORE COUNTY - $44,444GEM COUNTY - $40,767MALH EUR COUNTY - $34,720PERSONS IN POVERTY (2012-2016) ADA COUNTY - 10 8%CANYON COUNTY - 15 1% ELMORE COUNTY - 13 9%GEM COUNTY - 17 9%MALHEUR COUNTY - 22 9%FOREIGN-BORN PERSONS, PERCENT (2012-2016) ADA COUNTY - 6 1%CANYON COUNTY - 7 7%ELMORE COUNTY - 9 7% GEM COUNTY - 3 2%MAL HEUR COUNTY - 10 7%LANGUAGE OTHER THAN ENGLISH, SPOKEN AT HOME AGE 5+ (2012-2016) ADA COUN TY - 8 6%CANYON COUNTY - 17 7%ELMORE COUNTY - 14 6%GEM COUNTY - 7 8%MALHEUR COUNTY - 24 7% PERSONS WITHOUT HEALTH INSURANCE, UNDER 65, PERCENT (2012-2016) ADA COUNTY - 8 9%CANYON CO UNTY - 15 3%ELMORE COUNTY - 13 4%GEM COUNTY - 13 4%MALHEUR COUNTY - 10 1%GALLUP POSTED AN INCREASE IN IDAHO'S UNINSURED RATE AT 16 5% (UP FROM 14%, GALLUP, 2017), HIGHER THAN THE N ATIONAL AVERAGE UNINSURED RATE OF 12 2% IN THE 4TH QUARTER OF 2017 IT IS ESTIMATED THAT U P TO 78,000 LOW-INCOME IDAHOANS DO NOT HAVE HEALTH INSURANCE COVERAGE, IN A RECENT EVALUAT ION OF MEDICAID EXPANSION EFFORTS (CLOSETHEGAPIDAHO ORG) IN IDAHO IN 2015 (INDICATORSIDAH O ORG), 13% OF THE POPULATION UNDER AGE 65, OR 177,426 PEOPLE, HAD NO HEALTH INSURANCE COV ERAGE COMPARED TO 11% IN ALL OF THE U S , THE PERCENT UNDER AGE 65 WITHOUT HEALTH INSURANC E RANKED 14TH, FROM HIGHEST TO LOWEST, OUT OF THE U S 'S 50 STATES, 5 9% OF CHILDREN UNDER THE AGE OF 19, OR 26,438 CHILDREN, HAD NO HEALTH INSURANCE COVERAGE COMPARED TO 5% OF ALL CHILDREN IN THE U S , THE PERCENT OF CHILDREN WITHOUT HEALTH COVERAGE RANKED 15TH, FROM H IGHEST TO LOWEST, OUT OF THE U S 'S 50 STATES IN 1975, GOVERNOR JOHN EVANS ESTABLISHED TH E INDOCHINESE REFUGEE ASSISTANCE PROGRAM IN RESPONSE TO THE NEED FOR ALL STATES TO PARTICI PATE IN THE RESETTLEMENT OF REFUGEES FLEEING THE OVERTHROW OF U S SUPPORTED GOVERNMENTS I N SOUTHEAST ASIA IN IDAHO THERE ARE FOUR DIFFERENT REFUGEE RESETTLEMENT AGENCIES, THREE I N BOISE THE LOCAL REFUGEE POPULATION HAS MORE THAN DOUBLED SINCE 2005 IDAHO RECEIVED AN AVERAGE OF 1,000 REFUGEES ANNUALLY SINCE 2008 (UNTIL CURRENT ADMINISTRATION REFUGEE LIMITI NG POLICIES), WITH ROUGHLY 70% RESETTLING IN BOISE (REFUGEES IN IDAHO, IDAHO AT A GLANCE, UNIV OF IDAHO, NOV 2016) IN 2015, 70% OF REFUGEE ARRIVALS IN IDAHO WERE WOMEN AND CHILDRE N SOME REFUGEES ARE HIGHLY EDUCATED WHILE OTHERS HAVE NEVER HAD THE OPPORTUNITY TO ATTEND SCHOOL SEVERAL RESETTLEMENT AND ASSISTANCE AGENCIES ASSIST LOCALLY AND THROUGHOUT THE ST ATE THERE WERE 703 ANNUAL REFUGEE ARRIVALS IN BOISE (1,015 IN IDAHO) IN 2015 (IDAHO OFFIC E FOR REFUGEES) THE TOP COUNTRIES OF ORIGIN FOR R |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 4 | EFUGEES RESETTLED IN IDAHO IN 2016 WERE CONGO, SYRIA, IRAQ, AFGHANISTAN, BHUTAN, BURMA, SU DAN, UKRAINE AND SOMALIA UPON REVIEW OF DEMOGRAPHIC AND SOCIO-ECONOMIC DATA AND TRENDS, S EVERAL FACTORS CLEARLY HAVE AN IMPACT ON THE HEALTH STATUS OF THE COMMUNITIES SERVED BY SA RMC, WITH IMPLICATIONS FOR FUTURE PLANNING POPULATION GROWTH, ESPECIALLY IN ADA AND CANYO N COUNTIES, IS EXPECTED TO CONTINUE, WITH A GROWING HISPANIC POPULATION THE SIGNIFICANT R EFUGEE POPULATION CREATES GREATER LANGUAGE INTERPRETATION AND HEALTH EDUCATION NEEDS AS WE LL GROWTH IN IDAHO'S SENIOR POPULATION IS ALSO PROJECTED TO ACCELERATE, WHICH WILL LIKELY RESULT IN INCREASED HEALTH CARE SPENDING MAMMOGRAPHY RATES, RATE OF LOW BIRTH WEIGHT BABI ES, OVERWEIGHT AND OBESITY, TOBACCO USE, MENTAL HEALTH AND DRINKING/DRUG USE ARE ALSO OF G REAT CONCERN THE REGION SEES A HIGH PREVALENCE OF MENTAL HEALTH & SUBSTANCE ABUSE ISSUES, WITH INADEQUATE PUBLIC BEHAVIORAL HEALTH SYSTEMS IN PLACE TO MEET THE EXISTING NEEDS FOR COMMUNITY-BASED AND INPATIENT SERVICES |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 | OTHER INFORMATION - CONSISTENT WITH ITS NONPROFIT STATUS, SARMC USED SURPLUS REVENUES TO R EINVEST IN FACILITIES, TECHNOLOGY AND MEDICAL SERVICES FOR THE COMMUNITY, AND COLLABORATED WITH COMMUNITY PARTNERS BY INVESTING IN NEEDED COMMUNITY PROGRAMS SUCH AS ALLUMBAUGH HOUS E (SOBERING, DETOXIFICATION & CRISIS MENTAL HEALTH SERVICES), HOUSING FIRST (HOMELESSNESS PREVENTION AND SUPPORT SERVICES), AND HEALTHTEACHER AND GONOODLE HEALTH LITERACY CURRICULU M FOR SEVERAL AREA SCHOOL DISTRICTS SAINT ALPHONSUS ALSO ASSESSED AND ENGAGED IN COMMUNIT Y HEALTH WORK THAT ADDRESSED THE SOCIAL DETERMINANTS OF HEALTH THE ORGANIZATION IS FOCUSE D ON PREVENTING VIOLENCE IN VULNERABLE POPULATIONS, INCLUDING WOMEN, CHILDREN, AND THE HOM ELESS THERE WAS ADDITIONAL FOCUS AND ENGAGEMENT WITH SENIOR POPULATIONS AND REFUGEE POPUL ATIONS SPECIFICALLY, FOUNDATIONAL WORK BEGAN WITH COMMUNITY PARTNERS TO COLLABORATIVELY E DUCATE PATIENTS AND COMMUNITY MEMBERS ON ADVANCED CARE PLANNING PROVIDING EDUCATION AND WO RKFORCE DEVELOPMENT FOR RURAL IDAHO AND OREGON SARMC STRONGLY SUPPORTED HEALTH CARE WORKFO RCE DEVELOPMENT EFFORTS, INCLUDING SUPPORT TO THE PSYCHIATRIC RESIDENCY, DENTAL RESIDENCY, AND THE BOISE STATE UNIVERSITY NURSING BUILDING FUND IN ADDITION, SARMC SERVED AS A KEY CLINICAL TRAINING SITE FOR NEW PHYSICIANS, NURSES AND OTHER ALLIED HEALTH PROFESSIONALS, I NCLUDING FAMILY MEDICAL RESIDENCY OF IDAHO SARMC IS A LEVEL II TRAUMA CENTER AND CONTINUED TO TAKE A LEADERSHIP ROLE IN IMPROVING SYSTEMS OF CARE FOR TRAUMA PATIENTS SARMC ALSO HO STED AN ANNUAL SKI & MOUNTAIN TRAUMA CONFERENCE TO TRAIN FIRST RESPONDERS (EMS, FIRE, SKI PATROL, ETC ) THROUGHOUT THE NORTHWEST ON BEST PRACTICES FOR TRAUMA CARE IN THE PRE-HOSPIT AL SETTING TRAUMA PREVENTION AND DISASTER PREPAREDNESS EFFORTS IN THE REGION ARE OFTEN LE D BY STAFF AT SARMC, WHO IN THE PAST HAVE CHAMPIONED TOUGHER SEAT BELT AND HELMET LAWS SA RMC COORDINATED A REGIONAL TELEMEDICINE NETWORK THROUGHOUT WESTERN & NORTHERN IDAHO AND EA STERN OREGON SERVICES PROVIDED THROUGH THE NETWORK INCLUDE MUCH-NEEDED SERVICES SUCH AS T ELEPSYCHIATRY, STROKE CARE, CLINICAL EDUCATION AND EMERGENCY MEDICINE CONSULTATIONS TO RUR AL HOSPITALS IN REMOTE LOCATIONS, OFTEN PREVENTING UNNECESSARY TRANSPORTS AND ALLOWING PAT IENTS TO BE CARED FOR CLOSER TO HOME COLLABORATING ON CHNA STRATEGY AND SOCIAL DETERMINAN TS OF HEALTH SARMC ALSO COLLABORATED WITH UNITED WAY OF TREASURE VALLEY TO ADDRESS COMMUNI TY NEEDS INCLUDING HEALTH, EDUCATION, AND INCOME SARMC WAS REPRESENTED ON THE UNITED WAY BOARD OF DIRECTORS AND THE HEALTH VISION COUNCIL IN ADDITION, SARMC HAS AN ANNUAL UNITED WAY WORKPLACE GIVING CAMPAIGN TO SUPPORT UNITED WAY INITIATIVES AND GRANTS TO LOCAL NONPRO FITS PRODUCING MEASURABLE OUTCOMES IN ADDRESSING TOP COMMUNITY NEEDS SAINT ALPHONSUS HEALT H SYSTEM WAS EXTREMELY ACTIVE IN BOTH GRASSROOTS AND LEGISLATIVE EFFORTS AROUND MEDICAID E XPANSION IN IDAHO AS WELL AS IN COALITION BUILDING AND STRATEGIZING AROUND TOBACCO 21 SAI NT ALPHONSUS HEALTH SYSTEM WAS A LEADING PARTICIPANT IN A LOCAL HOUSING AND HOMELESSNESS R OUNDTABLE AND MAIN ADVOCATE AND FUNDER OF A HOUSING FIRST EFFORT TO PREVENT HOMELESSNESS, IN ALIGNMENT WITH CHNA-FOCUSED SOCIAL DETERMINANTS OF HEALTH WORK ADDITIONALLY, SAINT ALP HONSUS HEALTH SYSTEM COLLABORATED WITH COMMUNITY PARTNERS, SERVICE PROVIDERS, LEADERS, AND COMPETITORS TO PREVENT CHILDHOOD SEXUAL ABUSE FINALLY, SAINT ALPHONSUS HEALTH SYSTEM COL LABORATED IN A COMMUNITY ROUNDTABLE ON MENTAL HEALTH, INCLUDING ADVOCACY WORK IN SUPPORTIN G AND PLANNING A LOCAL CRISIS CENTER TRANSFORMING COMMUNITIES SAINT ALPHONSUS HEALTH SYSTE M PARTNERS WITH THE UNITED WAY OF TREASURE VALLEY AND OTHER COMMUNITY PARTNERS IN THE TRAN SFORMING COMMUNITIES INITIATIVE (TCI) COMMUNITY PARTNERS IN THE TRANSFORMING COMMUNITIES INITIATIVE INCLUDE SARMC, UNITED WAY OF TREASURE VALLEY, BOISE STATE UNIVERSITY, SOUTHWES T DISTRICT HEALTH, IDAHO MOMS FOR NURSING IN PUBLIC, VITRUVIAN PLANNING, BOISE SCHOOL DIST RICT, CALDWELL SCHOOL DISTRICT, CITY OF BOISE, CITY OF CALDWELL, TOBACCO 21, ALBERTSONS, Z IONS BANK, GARDNER COMPANY, AND ST LUKE'S HEALTH SYSTEM AS PART OF TCI EFFORTS, AND AS ST ATED ABOVE, SAINT ALPHONSUS HEALTH SYSTEM LED A STATEWIDE COALITION OF STAKEHOLDERS TO PRE SENT LEGISLATION TO RAISE THE SALE AGE OF TOBACCO FROM 18 TO 21 IN IDAHO WHILE LEGISLATIO N WAS NOT PASSED OUT OF COMMITTEE FOR THE SECOND YEAR, GAINS WERE MADE IN RALLYING YOUTH A ND OTHER COMMUNITY PARTNERS TO RAISE AWARENESS, TESTIFY, AND ADVOCATE FOR TOBACCO POLICY EFFORTS WILL CONTINUE IN YEAR 3 WITH AN EMPHASIS ON ELECTRONIC CIGARETTE USAGE BY IDAHO YO UTH TCI EFFORTS COALESCED A SECOND STATEWIDE COALITION OF BREASTFEEDING ADVOCATES, LACTAT ION CONSULTANTS, MOTHERS, SAINT ALPHONSUS HEALTH SYSTEM AND HEALTH SYSTEM PARTNERS, ETC , WHO WERE SUCCESSFUL IN THE PASSAGE OF LEGISLATION EXEMPTING BREASTFEEDING MOTHERS FROM PRO SECUTION FOR BREASTFEEDING IN PUBLIC, OR ANYWHERE THEY LEGALLY HAVE THE RIGHT TO BE RELATE DLY, SAINT ALPHONSUS HEALTH SYSTEM CONDUCTED A CUR |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 | RENT STATE AND GAP ASSESSMENT OF EACH HOSPITAL RELATED TO BABY FRIENDLY DESIGNATION AND WE HAVE SIGNED A COMMITMENT LETTER TO BECOME A BABY FRIENDLY HOSPITAL SYSTEM AND HAVE COMPLE TED SUBSTANTIAL WORK (80%) COMPLETION IN THAT DIRECTION BABY FRIENDLY HOSPITALS ARE HOSPI TALS RECOGNIZED FOR ENCOURAGING BREASTFEEDING AND MOTHER/BABY BONDING, WHICH IS KNOWN TO P ROVIDE HEALTH BENEFITS FOR INFANTS, CHILDREN, AND MOTHERS SAINT ALPHONSUS HEALTH SYSTEM H AS ALSO ACHIEVED 70% HEALTHY VENDING CONTRACTS AND HAS A SMOKE FREE CAMPUS POLICY THAT INC LUDES E-CIGARETTES AS AN EXTENSION OF THE TCI WORK, THE UNITED WAY OF TREASURE VALLEY, SAI NT ALPHONSUS HEALTH SYSTEM, AND VARIOUS COMMUNITY ORGANIZATIONS, REFERRED TO AS THE PROMIS E PARTNERSHIP, PILOTED THE CALDWELL SCHOOL DISTRICT'S FIRST COMMUNITY SCHOOL AT SACAJAWEA ELEMENTARY AS A MEANS FOR ADDRESSING HEALTH, EDUCATION, AND THE SOCIAL DETERMINANTS OF HEA LTH THIS STRATEGY BRINGS SERVICES OF GREATEST NEED, AS IDENTIFIED BY THE NEIGHBORHOOD, TO THE SCHOOL LOCATION, OFTEN OFFERED AT LOW OR NO COST TO STUDENTS, FAMILIES, AND NEIGHBORS THE PROMISE PARTNERSHIP FORMED A MONTHLY LEARNING COLLABORATIVE TO SUPPORT THE COMMUNITY SCHOOL COORDINATORS BY PROVIDING PROFESSIONAL DEVELOPMENT AND SHARING RESOURCES AND BEST PRACTICES THE PROMISE PARTNERSHIP ALSO CONDUCTED SEVERAL COMMUNITY SCHOOL 101 LEARNING SE SSIONS FOR SCHOOL DISTRICTS AND COMMUNITY ORGANIZATIONS INTERESTED IN LEARNING MORE ABOUT HOW TO DEVELOP A COMMUNITY SCHOOL INFRASTRUCTURE IN THEIR RESPECTIVE COMMUNITIES OTHER CO LLABORATIONS BEYOND THOSE PREVIOUSLY MENTIONED, ADDITIONAL KEY COLLABORATIONS INCLUDE CLOS E THE GAP COALITION FOR EXPANDING/REDESIGNING MEDICAID AND ALSO MENTAL HEALTH ROUNDTABLES CONVENED BY COMMUNITY PARTNERS (1) THE UNITED WAY OF TREASURE VALLEY AND (2) BOISE STATE U NIVERSITY'S "BLUE SKY INSTITUTE" THAT TACKLES COMPLEX SOCIAL PROBLEMS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 6 | SARMC IS A MEMBER OF TRINITY HEALTH, ONE OF THE LARGEST CATHOLIC HEALTH CARE DELIVERY SYSTEMS IN THE COUNTRY TRINITY HEALTH ANNUALLY REQUIRES THAT ALL MEMBER MINISTRIES DEFINE - AND ACHIEVE - SPECIFIC COMMUNITY HEALTH AND WELL-BEING GOALS IN FISCAL YEAR 2018, EVERY MINISTRY FOCUSED ON FOUR GOALS 1 REDUCE TOBACCO USE 2 REDUCE OBESITY PREVALENCE3 ADDRESS AT LEAST ONE SIGNIFICANT HEALTH NEED IDENTIFIED IN THE MINISTRY COMMUNITY HEALTH NEEDS ASSESSMENT4 ADDRESS AT LEAST ONE SOCIAL DETERMINANT OF HEALTH TRINITY HEALTH ACKNOWLEDGES THE IMPACT SOCIAL DETERMINANTS SUCH AS ADEQUATE HOUSING, SAFETY, ACCESS TO FOOD, EDUCATION, INCOME, AND HEALTH COVERAGE HAVE ON THE HEALTH OF THE COMMUNITY IN FISCAL YEAR 2016, TRINITY HEALTH LAUNCHED THE TRANSFORMING COMMUNITIES INITIATIVE (TCI) TO ADVANCE COMMUNITY PARTNERSHIPS THAT FOCUS ON IMPROVING THE HEALTH AND WELL-BEING IN COMMUNITIES SERVED BY THE MINISTRIES OF TRINITY HEALTH TCI IS AN INNOVATIVE FUNDING MODEL AND TECHNICAL ASSISTANCE INITIATIVE SUPPORTING EIGHT COMMUNITIES USING POLICY, SYSTEM, AND ENVIRONMENTAL (PSE) CHANGE STRATEGIES TO PREVENT TOBACCO USE AND CHILDHOOD OBESITY, AS WELL AS ADDRESS SOCIAL DETERMINANTS OF HEALTH TRINITY HEALTH INVESTED $3 6 MILLION IN FISCAL YEAR 2018 IN TCI IN FISCAL YEAR 2018, TRINITY HEALTH LAUNCHED THE GOOD SAMARITAN INITIATIVE (GSI) TO SUPPORT THE MOST VULNERABLE PATIENTS' SOCIAL AND ECONOMIC NEEDS IN OUR SYSTEM THROUGH INTEGRATING COMMUNITY HEALTH WORKERS AS PART OF CARE TEAMS ACROSS NINE MINISTRIES TRINITY HEALTH INVESTED OVER $260,000 IN FISCAL YEAR 2018 IN GSI ADDITIONALLY, TRINITY HEALTH INVESTED $500,000 IN ELEVEN GRANTS TO IMPROVE THE BUILT ENVIRONMENT ACROSS EIGHT MINISTRIES AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO OUR COMMUNITIES THROUGH PROMOTING WELLNESS AND DEVELOPING PROGRAMS SPECIFICALLY SUPPORTING THOSE WHO ARE POOR AND VULNERABLE, HELPING MANAGE CHRONIC CONDITIONS LIKE DIABETES, PROVIDING HEALTH EDUCATION, AND MOVING FORWARD POLICY, SYSTEM AND ENVIRONMENTAL CHANGE THE ORGANIZATION WORKS TO ENSURE THAT ITS MEMBER HOSPITALS AND OTHER ENTITIES/AFFILIATES ENHANCE THE OVERALL HEALTH OF THE COMMUNITIES THEY SERVE BY ADDRESSING THE SPECIFIC NEEDS OF EACH COMMUNITY IN FISCAL YEAR 2018, TRINITY HEALTH INVESTED OVER $1 1 BILLION IN SUCH COMMUNITY BENEFITS FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT WWW TRINITY-HEALTH ORG |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 7, REPORTS FILED WITH STATES | ID |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 82-0200895

**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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

| **Section A. Hospital Facilities**<br><br>(list in order of size from largest to smallest—see instructions)<br>How many hospital facilities did the organization operate during the tax year?<br>**1**<br><br>Name, address, primary website address, and state license number | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | **Other (Describe)** | **Facility reporting group** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | SAINT ALPHONSUS REGIONAL MEDICAL CENTER<br>1055 N CURTIS ROAD<br>BOISE, ID 83706<br>WWW SAINTALPHONSUS ORG<br>LICENSE 02 | X | X | | X | | | X | | | |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 3J N/APART V, SECTION B, LINE 3E SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) INCLUDED IN ITS CHNA WRITTEN REPORT A PRIORITIZED LIST AND DESCRIPTION OF THE COMMUNITY'S SIGNIFICANT HEALTH NEEDS, WHICH WERE IDENTIFIED THROUGH THE MOST RECENTLY CONDUCTED COMMUNITY HEALTH NEEDS ASSESSMENT THE COMMUNITY HEALTH NEEDS WERE DEEMED SIGNIFICANT AND WERE PRIORITIZED THROUGH A COMMUNITY-INVOLVED SELECTION PROCESS THE SARMC EXTERNAL REVIEW COMMITTEE IDENTIFIED SIGNIFICANT HEALTH NEEDS, WHICH WERE THEN PRIORITIZED BASED ON PERSONS AFFECTED, IMPACT ON QUALITY OF LIFE, AND FEASIBILITY OF REASONABLE IMPACT THE SIGNIFICANT HEALTH NEEDS AND HOW THEY ARE BEING ADDRESSED WERE DETAILED IN THE PUBLIC SARMC IMPLEMENTATION STRATEGY SARMC FOCUSED ON DEVELOPING AND/OR SUPPORTING INITIATIVES, AND MEASURING THEIR EFFECTIVENESS, TO IMPROVE THE FOLLOWING HEALTH NEEDS 1 HEALTHCARE ACCESS (INCLUDING MENTAL HEALTH)2 NUTRITION, PHYSICAL ACTIVITY AND WEIGHT STATUS3 HARMFUL SUBSTANCE USE4 ORAL HEALTHSARMC FORMED AN OVERARCHING GOAL TO CO-CREATE AND SUPPORT HEALTHY ENVIRONMENTS WITH COMMUNITY PARTNERS TO ENSURE A HEALTHY INFRASTRUCTURE FOR AN ACTIVE COMMUNITY, SAFETY AND ASSISTANCE FOR THOSE AT RISK THEREFORE, SARMC PRIORITIZED ADDITIONAL NEEDS AROUND HOUSING AND HOMELESSNESS, UNSAFE RELATIONSHIPS, AND TRANSPORTATION |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 5 THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS CONDUCTED BETWEEN AUGUST 2016 AND JUNE 2017, AND APPROVED BY THE BOARD ON JUNE 8, 2017 THE UNITED WAY ORGANIZED A COMMUNITY ASSESSMENT SPONSOR GROUP COMPRISED OF SARMC, SAINT ALPHONSUS MEDICAL CENTER-NAMPA, ST LUKE'S HEALTH SYSTEM, DELTA DENTAL OF IDAHO, AND IDAHO ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN ADDITIONAL ADVISORY GROUP MEMBERS INCLUDED IDAHO DEPARTMENT OF HEALTH AND WELFARE, CENTRAL DISTRICT HEALTH DEPARTMENT, VALLEY REGIONAL TRANSIT, NAMPA CHAMBER OF COMMERCE, GENESIS COMMUNITY HEALTH, CATCH, INC , BOISE STATE UNIVERSITY, IDAHO HOUSING AND FINANCE ASSOCIATION, TREASURE VALLEY EDUCATION PARTNERSHIP, BLUE CROSS OF IDAHO FOUNDATION FOR HEALTH, AND THE UNITED WAY OF TREASURE VALLEY RESEARCH PARTNER UTAH FOUNDATION COLLECTED DATA INDICATORS FROM A VARIETY OF SOURCES, INCLUDING COUNTY HEALTH RANKINGS, IDAHO VITAL STATISTICS, BRFSS, AND MANY OTHER SECONDARY DATA SOURCES LITERATURE REVIEW AND SECONDARY DATA SOURCES WERE USED TO SELECT COLLECTIVE MEASURES/INDICATORS IN THE AREAS OF EDUCATION, FINANCIAL INDEPENDENCE, AND HEALTH AT THE REGIONAL, COUNTY AND CITY LEVEL ADDITIONAL COMMUNITY INPUT WAS COLLECTED BETWEEN AUGUST 2016 & JUNE 2017 THROUGH FOCUS GROUPS AND SURVEYS CONDUCTED WITH AFFECTED POPULATIONS, AND INTERVIEWS WITH COMMUNITY LEADERS AND LEADERS OF NONPROFIT ORGANIZATIONS AFFECTED POPULATIONS INCLUDED FAMILIES SURVIVING VIOLENCE, PEOPLE EXPERIENCING HOMELESSNESS AND FOOD INSECURITY, REFUGEES AND IMMIGRANTS, AND LOW-INCOME/WORKING-POOR ADULTS AND CHILDREN FOCUS GROUP HOSTS INCLUDED THE FOLLOWING ORGANIZATIONS SERVING IMPACTED POPULATIONS BOYS & GIRLS CLUB OF NAMPA, CORPUS CHRISTI HOUSE, FAMILY ADVOCATES, GENESIS COMMUNITY HEALTH, IDAHO DEPARTMENT OF HEALTH AND WELFARE, IDAHO DEPARTMENT OF LABOR, IDAHO FOODBANK, LEARNING LAB, SALVATION ARMY-BOISE, SALVATION ARMY-NAMPA, ST VINCENT DE PAUL, WESTERN IDAHO COMMUNITY ACTION PARTNERSHIP, INC , WOMEN'S & CHILDREN'S ALLIANCE, AND YMCA OF TREASURE VALLEYCOMMUNITY LEADER INTERVIEWS INCLUDED THE FOLLOWING ORGANIZATION PARTICIPANTS VALLEY REGIONAL TRANSIT, PACIFICSOURCE HEALTH PLANS, BOYS & GIRLS CLUB OF ADA COUNTY, GENESIS COMMUNITY HEALTH, GIRAFFE LAUGH, TERRY REILLY HEALTH SERVICES, LEARNING LAB, MAYOR'S OFFICE-CITY OF BOISE, EMMETT VALLEY FRIENDSHIP COALITION, MAYOR'S OFFICE-CITY OF CALDWELL, ST LUKE'S REGIONAL FAMILY PRACTICE, IDAHO ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN, REPRESENTATIVE'S OFFICE-IDAHO STATE LEGISLATURE, SUPERINTENDENT'S OFFICE-NAMPA SCHOOL DISTRICT, SUPERINTENDENT'S OFFICE-EMMETT SCHOOL DISTRICT, COMPASS, SARMC, IDAHO FOODBANK, IDAHO HOUSING AND FINANCE ASSOCIATION, AND HOME PARTNERSHIP FOUNDATION BPA HEALTH |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 6A THE CHNA WAS CONDUCTED IN PARTNERSHIP WITH THE FOLLOWING HOSPITALS SAINT ALPHONSUS MEDICAL CENTER - NAMPA AND ST LUKE'S HEALTH SYSTEM |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 6B THE CHNA WAS CONDUCTED IN PARTNERSHIP WITH THE FOLLOWING ORGANIZATIONS DELTA DENTAL OF IDAHO, IDAHO ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN, AND THE UNITED WAY OF TREASURE VALLEY |

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 11 A TRIENNIAL CHNA WAS PERFORMED AND POSTED BY THE END OF THE 20 17 FISCAL YEAR, AN UPDATED IMPLEMENTATION STRATEGY WAS ADOPTED IN OCTOBER 2017 FOR IMPLEME NTATION IN FISCAL YEARS 2018-2020 THESE DOCUMENTS GUIDE THE COMMUNITY BENEFIT WORK FOR TA X YEARS 2017-2019 THE SARMC EXTERNAL REVIEW COMMITTEE IDENTIFIED FOUR SIGNIFICANT HEALTH N EEDS, WHICH WERE THEN PRIORITIZED BASED ON PERSONS AFFECTED, IMPACT ON QUALITY OF LIFE, AN D FEASIBILITY OF REASONABLE IMPACT THREE OF THE SIGNIFICANT HEALTH NEEDS AND HOW THEY ARE BEING ADDRESSED WERE DETAILED IN THE PUBLIC SARMC IMPLEMENTATION STRATEGY SARMC FOCUSED ON DEVELOPING AND/OR SUPPORTING INITIATIVES, AND MEASURING THEIR EFFECTIVENESS, TO IMPROVE THE FOLLOWING HEALTH NEEDS HEALTH CARE ACCESS (INCLUDING MENTAL HEALTH), NUTRITION, PHYS ICAL ACTIVITY AND WEIGHT STATUS, AND HARMFUL SUBSTANCE USE SARMC FORMED AN OVERARCHING GO AL TO CO-CREATE AND SUPPORT HEALTHY ENVIRONMENTS WITH COMMUNITY PARTNERS TO ENSURE A HEALT HY INFRASTRUCTURE FOR AN ACTIVE COMMUNITY, SAFETY AND ASSISTANCE FOR THOSE AT RISK (UNSAFE RELATIONSHIPS, HOMELESS, OR HUNGRY), AND HEALTH CARE ACCESS FOR ALL, ESPECIALLY THOSE MOS T VULNERABLE INITIATIVES IN FISCAL YEAR 2018 THAT ADDRESSED NUTRITION, PHYSICAL ACTIVITY AND WEIGHT STATUS INCLUDED MEET ME MONDAY OBESITY PREVENTION COMMUNITY WALKING PROGRAM, G ONOODLE NUTRITION AND ACTIVITY PROGRAMS IN TREASURE VALLEY SCHOOLS, YMCA PARTNERSHIP, NUTR ITION CONSULTATION SERVICES IN THE FAMILY CENTER, AND A DIABETES COMPREHENSIVE OUTPATIENT AND OUTREACH PROGRAM SARMC WAS FOCUSED ON RAISING AWARENESS OF NUTRITION AND EXERCISE OPP ORTUNITIES AND PROGRAMS TO ADDRESS HEALTH LITERACY AROUND WEIGHT MANAGEMENT, ACTIVE LIVING , AND HEALTHY CHOICES THE OBJECTIVE WAS TO DEVELOP HEALTHY HABITS AND GET KIDS MOVING BY INCREASING THE NUMBER OF GONOODLE TEACHER USERS IN THE COMMUNITIES THAT SARMC SERVES SARM C ALSO PARTICIPATED IN A CHILDREN'S HEALTH COLLABORATIVE, HOSTED GONOODLE PRESENTATIONS AT ELEMENTARY SCHOOLS AND PROMOTED MEET ME MONDAY COMMUNITY WALK SARMC ALSO TOOK STEPS TO G AINING A BABY FRIENDLY DESIGNATION FOR PROMOTING BREASTFEEDING, A KNOWN HEALTH BENEFIT TO INFANTS AND MOTHERS INITIATIVES IN FISCAL YEAR 2018 THAT ADDRESSED HARMFUL SUBSTANCE USE AND PREVENTION INCLUDED SUPPORT FOR COMMUNITY INITIATIVES (TOBACCO 21), OFFERED TOBACCO " QUIT" PROGRAMS, AND SARMC FOCUSED ON INCREASING PUBLIC AWARENESS OF TOBACCO, ALCOHOL, AND DRUG USE PREVENTION AND CESSATION, WITH THE OBJECTIVE TO PROMOTE AVAILABLE COMMUNITY RESOU RCES AND DECREASE COMMUNITY RATES OF TOBACCO USE SARMC TOOK A LEADING ROLE IN FORMING A T OBACCO 21 COALITION AND ADVANCING AN ADVOCACY AGENDA TO RAISE THE LEGAL TOBACCO SALES AGE TO 21 SUPPORT ALSO INCLUDED TOBACCO COALITIONS, PROVIDING AN AFFORDABLE LUNG SCREENING PR OGRAM, RAISING AWARENESS OF COMMUNITY RESOURCES SUCH AS IDAHO QUITLINE, AND UTILIZING EXIS TING FORUMS TO PROVIDE COMMUNITY EDUCATION SAINT ALPHONSUS HEALTH SYSTEM ALSO IDENTIFIED A PHYSICIAN CHAMPION FOR OPIOI |

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | D ABUSE ISSUES AND BEGAN EDUCATING PROVIDER AND COMMUNITY GROUPS ON THE TOPIC ADDITIONALLY , THE HOSPITAL WAS INVOLVED IN A PARTNERSHIP THAT WAS AWARDED A TRINITY HEALTH TRANSFORMIN G COMMUNITIES INITIATIVE GRANT, WHICH IS TO BE USED ON EFFORTS THAT REDUCE/PREVENT TOBACCO USE AND CHILDHOOD OBESITY INITIATIVES IN FISCAL YEAR 2018 THAT ADDRESSED HEALTH CARE ACCE SS INCLUDED ADVOCACY FOR THE HEALTH INSURANCE EXCHANGE AND MEDICAID REDESIGN/EXPANSION, S UPPORTED ACCESS TO MENTAL HEALTH THROUGH ALLUMBAUGH HOUSE, SUICIDE HOTLINE AND PREVENTION IN SCHOOLS, TELEPSYCHIATRY, AND STATE SUICIDE PREVENTION COUNCIL, AND PARTNERED WITH AND/O R SUPPORTED OTHER SAFETY NET ORGANIZATIONS (GENESIS COMMUNITY HEALTH) SARMC FOCUSED ON IM PROVING ACCESS TO HEALTH CARE BY REMOVING BARRIERS AND PROVIDING SERVICES FOR THE POOR AND UNDERSERVED, ESPECIALLY VULNERABLE POPULATIONS REFUGEES, SENIORS, WOMEN, CHILDREN, AND T HE HOMELESS THE OBJECTIVE WAS TO IMPROVE PATIENT HEALTH BY BUILDING COMMUNITY PARTNERSHIP S AND INCREASE ACCESS TO HEALTH CARE SERVICES TARGETED FOR THE LOW INCOME AND UNINSURED S ARMC SUPPORTED SPECIAL REFUGEE CARE THROUGH ITS CENTER FOR GLOBAL HEALTH AND HEALING AND A LSO THE CARE (CULTURALLY APPROPRIATE RESOURCES AND EDUCATION) CLINIC FOR REFUGEE MOMS FISC AL YEAR 2018 CONTINUED TO HAVE A MAJOR FOCUS ON THE SOCIAL DETERMINANTS OF HEALTH THAT WER E IDENTIFIED IN THE CHNA, WITH AN EMPHASIS ON PREVENTING FAMILY VIOLENCE, AND PREVENTING H OMELESSNESS, AND ASSISTING WITH TRANSPORTATION ISSUES TO PREVENT VIOLENCE, SARMC (1) CON TINUED TO BE A MAJOR SUPPORTER AND FACILITATOR FOR THE DARKNESS TO LIGHT PROGRAM, WHICH AI MS TO PREVENT CHILDHOOD SEXUAL ABUSE, AND (2) SUPPORTED THE LOCAL WOMEN'S AND CHILDREN'S S HELTER TO PREVENT AND INTERVENE IN HOMELESSNESS, SARMC CONTINUED SUPPORT FOR THE FIRST "H OUSING FIRST" MODEL IN BOISE, "NEW PATH" WHICH WILL OPEN ITS DOORS IN FALL 2018 FOR 40 CHR ONICALLY HOMELESS INDIVIDUALS WHO WILL RECEIVE PERMANENT SHELTER AND SUPPORTIVE SERVICES, SARMC ALSO SUPPORTED JESSE TREE, WHICH PROVIDES EMERGENCY RENTAL ASSISTANCE FOR TRANSPORT ATION ISSUES, IN FISCAL YEAR 2018, SARMC SUPPORTED A CONTINUED PILOT IN COLLABORATION WITH A LOCAL TRANSIT COMPANY THAT PROVIDES HEALTHCARE RIDES FOR LOW-INCOME INDIVIDUALS WHO DO NOT OTHERWISE HAVE TRANSPORTATION SUPPORT SARMC ACKNOWLEDGED THE WIDE RANGE OF PRIORITY HE ALTH ISSUES THAT EMERGED FROM THE CHNA PROCESS, AND DETERMINED THAT IT COULD EFFECTIVELY F OCUS ON THESE THREE PRIMARY HEALTH NEEDS ONE ADDITIONAL HEALTH NEED, ORAL HEALTH, WAS NOT ADDRESSED WITHIN THE IMPLEMENTATION STRATEGY SARMC CONTINUED TO PROVIDE EMERGENCY SUPPORT FOR ORAL HEALTH ISSUES, BUT LIMITED EXPERTISE AND RESOURCES EXCLUDE THIS AS AN AREA CHOSE N FOR ADDITIONAL ACTION SEVERAL COMMUNITY PARTNERS PROVIDE ORAL HEALTH SUPPORT FOR PERSON S IN NEED, AND SARMC REFERRED PATIENTS TO THESE ORGANIZATIONS |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT ALPHONSUS REGIONAL MEDICAL CENTER | PART V, SECTION B, LINE 13H THE HOSPITAL RECOGNIZES THAT NOT ALL PATIENTS ARE ABLE TO PROVIDE COMPLETE FINANCIAL AND/OR SOCIAL INFORMATION THEREFORE, APPROVAL FOR FINANCIAL SUPPORT MAY BE DETERMINED BASED ON AVAILABLE INFORMATION EXAMPLES OF PRESUMPTIVE CASES INCLUDE DECEASED PATIENTS WITH NO KNOWN ESTATE, THE HOMELESS, UNEMPLOYED PATIENTS, NON-COVERED MEDICALLY NECESSARY SERVICES PROVIDED TO PATIENTS QUALIFYING FOR PUBLIC ASSISTANCE PROGRAMS, PATIENT BANKRUPTCIES, AND MEMBERS OF RELIGIOUS ORGANIZATIONS WHO HAVE TAKEN A VOW OF POVERTY AND HAVE NO RESOURCES INDIVIDUALLY OR THROUGH THE RELIGIOUS ORDER FOR THE PURPOSE OF HELPING FINANCIALLY NEEDY PATIENTS, A THIRD PARTY IS UTILIZED TO CONDUCT A REVIEW OF PATIENT INFORMATION TO ASSESS FINANCIAL NEED THIS REVIEW UTILIZES A HEALTH CARE INDUSTRY-RECOGNIZED, PREDICTIVE MODEL THAT IS BASED ON PUBLIC RECORD DATABASES THESE PUBLIC RECORDS ENABLE THE HOSPITAL TO ASSESS WHETHER THE PATIENT IS CHARACTERISTIC OF OTHER PATIENTS WHO HAVE HISTORICALLY QUALIFIED FOR FINANCIAL ASSISTANCE UNDER THE TRADITIONAL APPLICATION PROCESS IN CASES WHERE THERE IS AN ABSENCE OF INFORMATION PROVIDED DIRECTLY BY THE PATIENT, AND AFTER EFFORTS TO CONFIRM COVERAGE AVAILABILITY, THE PREDICTIVE MODEL PROVIDES A SYSTEMATIC METHOD TO GRANT PRESUMPTIVE ELIGIBILITY TO FINANCIALLY NEEDY PATIENTS |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, SECTION B, LINE 7A | WWW SAINTALPHONSUS ORG/ABOUT-US/COMMUNITY-BENEFITS/COMMUNITY-NEEDS-ASSESSMENT |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, SECTION B, LINE 10A | WWW SAINTALPHONSUS ORG/ABOUT-US/COMMUNITY-BENEFIT/COMMUNITY-NEEDS-ASSESSMENT/IMPLEMENTATION-STRATEGY |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, LINE 16A, FAP WEBSITE | WWW SAINTALPHONSUS ORG/FOR-PATIENTS/AFTER-YOUR-VISIT/FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, LINE 16B, FAP APPLICATION WEBSITE | WWW SAINTALPHONSUS ORG/FOR-PATIENTS/AFTER-YOUR-VISIT/FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, LINE 16C, FAP WEBSITE | WWW SAINTALPHONSUS ORG/FOR-PATIENTS/AFTER-YOUR-VISIT/FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE |

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

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

| Form and Line Reference | Explanation |
|---|---|
| PART V, SECTION B, LINE 9 | AS PERMITTED IN THE FINAL SECTION 501(R) REGULATIONS, THE HOSPITAL IMPLEMENTATION STRATEGY WAS ADOPTED WITHIN THE FIRST 4 1/2 MONTHS AFTER THE FISCAL YEAR END THAT THE CHNA WAS COMPLETED AND MADE WIDELY AVAILABLE TO THE PUBLIC |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| 1 | 1 - EAGLE HEALTH PLAZA<br>323 E RIVERSIDE DR STE 224<br>EAGLE, ID 83616 | ER, INTERNAL, PEDIATRIC, OB/GYN, HEART CARE, REHAB, RADIOLOGY, LAB, VISION |
| 1 | 2 - FRUITLAND HEALTH PLAZA<br>910 NW 16TH ST<br>FRUITLAND, ID 83619 | URGENT CARE, FAMILY, CARDIOLOGY, NEURO , PHYS THER , ORTHO , LAB, RADIOLOGY |
| 2 | 3 - MERIDIAN HEALTH PLAZA<br>3025 CHERRY LANE<br>MERIDIAN, ID 83642 | URGENT CARE,PRIMARY CARE,DIABETES, SLEEP DIS , ORTHO, CARDI, LAB, PHYS THER |
| 3 | 4 - NAMPA HEALTH PLAZA<br>4400 E FLAMINGO<br>NAMPA, ID 83687 | URGENT CARE, PRIMARY CARE, RADIOLOGY, DIABETES, VISION, LAB, DERMATOLOGY |
| 4 | 5 - SAINT ALPHONSUS HOME HEALTH & HOSPICE<br>5959 S SHERWOOD FOREST BLVD<br>BATON ROUGE, LA 70816 | HOME HEALTH AND HOSPICE |
| 5 | 6 - SAINT ALPHONSUS REHABILITATION SERVICES<br>901 N CURTIS RD<br>BOISE, ID 83706 | REHABILITION SERVICES |
| 6 | 7 - ALLUMBAUGH HOUSE<br>400 N ALLUMBAUGH STREET<br>BOISE, ID 83704 | SHORT-TERM MENTAL HEALTH CRISIS, DETOXIFICATION, SOBERING STATION |
| 7 | 8 - LIFE FLIGHT NETWORK<br>3815 WEST RICKENBACKER STREET<br>BOISE, ID 83705 | AIR MEDICAL TRANSPORT |
| 8 | 9 - BOISE-OVERLAND FAMILY MEDICINE<br>10255 W OVERLAND RD<br>BOISE, ID 83709 | FAMILY PRACTICE |
| 9 | 10 - ST ALPHONSUS MEDICAL GROUP-MCMILLAN<br>12273 W MCMILLAN RD<br>BOISE, ID 83713 | FAMILY PRACTICE, INTERNAL MEDICINE |
| 10 | 11 - FINDLEY URGENT CARE<br>3587 S FEDERAL WAY<br>BOISE, ID 83715 | URGENT CARE |
| 11 | 12 - ST ALPHONSUS MEDICAL GROUP-EMERALD<br>6533 W EMERALD ST<br>BOISE, ID 83704 | FAMILY MEDICINE, SPORTS MEDICINE, URGENT CARE |
| 12 | 13 - ST ALPHONSUS MEDICAL GROUP-FEDERAL WAY<br>1880 W JUDITH LANE<br>BOISE, ID 83705 | FAMILY PRACTICE |
| 13 | 14 - ST ALPHONSUS MEDICAL GROUP-CALDWELL<br>1906 FAIRVIEW AVE STE 430<br>CALDWELL, ID 83605 | HEART CARE, NEUROLOGY |
| 14 | 15 - CANCER CARE CENTER<br>3123 MEDICAL DRIVE<br>CALDWELL, ID 83605 | ONCOLOGY |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| **16** | 16 - ST ALPHONSUS MEDICAL GROUP-CALDWELL ELM<br>315 E ELM ST<br>CALDWELL, ID 83605 | URGENT CARE, FAMILY PRACTICE, PEDIATRICS, WOUND HEALING |
| **1** | 17 - CASCADE FAMILY PRACTICE<br>402 LAKE CASCADE PKWY<br>CASCADE, ID 83611 | CARDIOLOGY |
| **2** | 18 - OASIS MEDICAL CENTER<br>3217 W BAVAIRA ST<br>EAGLE, ID 83616 | FAMILY MEDICINE, INTERNAL MEDICINE, OB/GYN AND URGENT CARE |
| **3** | 19 - CLINIC AT EAGLE<br>600 E STATE ST STE 200<br>EAGLE, ID 83616 | FAMILY PRACTICE |
| **4** | 20 - EMMETT MEDICAL CENTER<br>1024 E LOCUST ST<br>EMMETT, ID 83617 | WOUND HEALING & HYPERBARIC MEDICINE, CARDIOLOGY |
| **5** | 21 - ST ALPHONSUS CANCER CARE CENTER<br>1202 E LOCUST ST<br>EMMETT, ID 83617 | CANCER CARE |
| **6** | 22 - ST ALPHONSUS MEDICAL GROUP HEART CARE<br>21 E MAPLE ST STE A<br>HAILEY, ID 83333 | CARDIOLOGY |
| **7** | 23 - WOOD RIVER MEDICAL CENTER<br>100 HOSPITAL DR STE 107<br>KETCHUM, ID 83340 | ORTHOPEDICS, CARDIOLOGY |
| **8** | 24 - KUNA CLINIC<br>757 E WYTHE CREEK CT<br>KUNA, ID 83634 | FAMILY MEDICINE, PEDIATRICS |
| **9** | 25 - GARRITY CLINIC<br>1200 GARRITY BLVD<br>NAMPA, ID 83687 | FAMILY PRACTICE |
| **10** | 26 - SAINT ALPHONSUS IOWA CLINIC<br>211 W IOWA<br>NAMPA, ID 83686 | FAMILY PRACTICE, PODIATRY, ORTHOPEDICS, OBGYN |
| **11** | 27 - ST ALPHONSUS MEDICAL GROUP - ONTARIO<br>1050 SW 3RD AVE<br>ONTARIO, OR 97914 | OBGYN, WOMEN'S HEALTH, PULMONARY, ONCOLOGY, CARDIOLOGY |
| **12** | 28 - ST ALPHONSUS GARRITY MOB<br>4424 E FLAMINGO AVE STE 200<br>NAMPA, ID 83687 | OBGYN, CARDIOLOGY, ORTHOPEDICS |
| **13** | 29 - ST ALPHONSUS HEART CARE<br>1524 12TH AVE<br>NAMPA, ID 83686 | CARDIOLOGY |
| **14** | 30 - BROWN CROSSING HEALTH PLAZA<br>2141 E PARKCENTER BLVD<br>BOISE, ID 83706 | URGENT CARE, FAMILY MEDICINE, PHYSICAL THERAPY |

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

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

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

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

| | Name and address | Type of Facility (describe) |
|---|---|---|
| **31** | 31 - LAKE HAZEL CLINIC<br>10583 W LAKE HAZEL RD<br>BOISE, ID 83709 | FAMILY MEDICINE |
| **1** | 32 - COPPER POINT CLINIC<br>3041 E COPPER POINT DR<br>MERIDIAN, ID 83642 | FAMILY MEDICINE |
| **2** | 33 - 12TH AVENUE CLINIC<br>1510 12TH AVENUE RD SUITE 200<br>NAMPA, ID 83686 | FAMILY MEDICINE, PODIATRY, DIABETES CARE |
| **3** | 34 - KARCHER CLINIC<br>11035 W KARCHER RD<br>NAMPA, ID 83651 | FAMILY MEDICINE, PEDIATRICS |
| **4** | 35 - CITY OF STAR CLINIC<br>10717 W STATE ST<br>STAR, ID 83669 | FAMILY MEDICINE, URGENT CARE |
| **5** | 36 - STARS PHYSICAL THERAPY BOISE LIBERTY C<br>717 N LIBERTY ST<br>BOISE, ID 83704 | PHYSICAL THERAPY |
| **6** | 37 - STARS PHYSICAL THERAPY YMCA WEST BOISE<br>5959 N DISCOVERY PLACE<br>BOISE, ID 83713 | PHYSICAL THERAPY |
| **7** | 38 - STARS PHYSICAL THERAPY DOWNTOWN YMCA<br>1050 W STATE ST<br>BOISE, ID 83702 | PHYSICAL THERAPY |
| **8** | 39 - STARS PHYSICAL THERAPY MERIDIAN PEDIATRI<br>179 SW 5TH AVENUE<br>MERIDIAN, ID 83642 | PEDIATRIC THERAPY |
| **9** | 40 - STARS PHYSICAL THERAPY MERIDIAN TALUS<br>3875 E OVERLAND RD<br>MERIDIAN, ID 83642 | PHYSICAL THERAPY |

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**Schedule I (Form 990)**

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

## Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

## Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

| (a) Name and address of organization or government | (b) EIN | (c) IRC section (if applicable) | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of noncash assistance | (h) Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| (1) See Additional Data | | | | | | | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |
| (8) | | | | | | | |
| (9) | | | | | | | |
| (10) | | | | | | | |
| (11) | | | | | | | |
| (12) | | | | | | | |

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

3 Enter total number of other organizations listed in the line 1 table . . . . ▶ 0

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

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of noncash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|---|---|---|---|---|---|
| (1) RENT AND UTILITIES ASSISTANCE | 45 | 25,289 | | | |
| (2) SCHOLARSHIPS | 9 | 21,250 | | | |
| (3) HEALTH CARE ASSISTANCE | 662 | | 60,562 | FMV | RADIOLOGY SERVICES |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

| Return Reference | Explanation |
|---|---|
| PART I, LINE 2 | DONATIONS MADE BY SAINT ALPHONSUS REGIONAL MEDICAL CENTER TO CHARITABLE ORGANIZATIONS ARE MADE IN FURTHERANCE OF THE RECIPIENT ORGANIZATION'S EXEMPT PURPOSE DONATIONS ARE INCLUDED IN COMMUNITY BENEFITS IN SCHEDULE H IF THE CONTRIBUTION HAS BEEN FORMALLY RESTRICTED TO A COMMUNITY BENEFIT ACTIVITY THAT MEETS THE CRITERIA TO BE REPORTED ON SCHEDULE H |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 82-0200895
**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| BOISE RESCUE MISSION<br>575 S 13TH ST<br>BOISE, ID 83702 | 82-0259387 | 501(C)(3) | 15,000 | | | | MENTAL HEALTH PROGRAM FOR THE HOMELESS |
| ST PAULS BENEVOLENT EDUCATION<br>111 SOUTH RIDGE ST<br>RYE BROOK, NY 10573 | 22-6034713 | 501(C)(3) | 10,000 | | | | PROGRAM SUPPORT |

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| ST LUKE FOUNDATION FOR HAITI<br>3999 GREAT HARVEST CT<br>DUMFRIES, VA 22025 | 27-4377746 | 501(C)(3) | 203,000 | | | | PROJECT HAITI |
| AMERICAN LUNG ASSOCIATION<br>5601 6TH AVE S<br>SEATTLE, WA 98108 | 13-1632524 | 501(C)(3) | 11,121 | | | | SCHOOL NURSE ASTHMA PROGRAM |

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

| **(a)** Name and address of organization or government | **(b)** EIN | **(c)** IRC section if applicable | **(d)** Amount of cash grant | **(e)** Amount of non-cash assistance | **(f)** Method of valuation (book, FMV, appraisal, other) | **(g)** Description of non-cash assistance | **(h)** Purpose of grant or assistance |
|---|---|---|---|---|---|---|---|
| VALLEY REGIONAL TRANSIT<br>700 N EAST 2ND ST<br>MERIDIAN, ID 83642 | 82-0515697 | GOVERNMENT ORG | 20,000 | | | | RIDES TO WELLNESS PILOT PROGRAM |

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# Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

## Compensation Information

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

## Part I Questions Regarding Compensation

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items | | | |
| | ☐ First-class or charter travel | ☐ Housing allowance or residence for personal use | | |
| | ☐ Travel for companions | ☐ Payments for business use of personal residence | | |
| | ☐ Tax idemnification and gross-up payments | ☐ Health or social club dues or initiation fees | | |
| | ☐ Discretionary spending account | ☐ Personal services (e g , maid, chauffeur, chef) | | |
| **b** | If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | **1b** | | |
| **2** | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | **2** | | |
| **3** | Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III | | | |
| | ☐ Compensation committee | ☐ Written employment contract | | |
| | ☐ Independent compensation consultant | ☐ Compensation survey or study | | |
| | ☐ Form 990 of other organizations | ☐ Approval by the board or compensation committee | | |
| **4** | During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization | | | |
| **a** | Receive a severance payment or change-of-control payment? | **4a** | | No |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | **4b** | Yes | |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement? | **4c** | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III | | | |
| | **Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.** | | | |
| **5** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of | | | |
| **a** | The organization? | **5a** | | No |
| **b** | Any related organization? | **5b** | | No |
| | If "Yes," on line 5a or 5b, describe in Part III | | | |
| **6** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of | | | |
| **a** | The organization? | **6a** | | No |
| **b** | Any related organization? | **6b** | | No |
| | If "Yes," on line 6a or 6b, describe in Part III | | | |
| **7** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III | **7** | | No |
| **8** | Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III | **8** | | No |
| **9** | If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)? | **9** | | |

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

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

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

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

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

| Return Reference | Explanation |
|---|---|
| PART I, LINE 3 | SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) IS A SUBSIDIARY IN THE TRINITY HEALTH SYSTEM SARMC'S CEO IS PAID DIRECTLY BY THE SYSTEM'S PARENT ENTITY, TRINITY HEALTH CORPORATION TRINITY HEALTH CORPORATION USED THE FOLLOWING METHODS TO ESTABLISH THE COMPENSATION OF SARMC'S CEO - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - WRITTEN EMPLOYMENT CONTRACT - COMPENSATION SURVEY OR STUDY, AND - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE |
| PART I, LINE 4B | THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) IN 2017 THE PLAN PROVIDES RETIREMENT BENEFITS TO CERTAIN TRINITY HEALTH EXECUTIVES SUBJECT TO MEETING SPECIFIED VESTING AND EMPLOYMENT DATE REQUIREMENTS BENEFITS FOR PARTICIPANTS VESTED IN A PLAN WERE PAID OUT IN 2017, AND BENEFITS FOR PARTICIPANTS NOT YET VESTED IN A PLAN WERE ACCRUED IN 2017 THE FOLLOWING PAYOUTS FOR 2017 FOR THE PLAN ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II MICHAEL HOLPER - $89,621 SALLY JEFFCOAT - $199,865 BLAINE PETERSEN - $66,698 RODNEY REIDER - $122,523 THE FOLLOWING ACCRUAL FOR 2017 IS INCLUDED IN COLUMN C OF SCHEDULE J, PART II ODETTE BOLANO - $80,131 THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH RESTORATION OR RETENTION PLAN THE RESTORATION PLAN PROVIDES RETIREMENT BENEFITS FOR CERTAIN TRINITY HEALTH SYSTEM OFFICE EXECUTIVES WITH EARNINGS ABOVE THE IRS PAY CAP FOR QUALIFIED PLANS ($270,000 FOR 2017) THE FOLLOWING PAYOUTS FOR 2017 FOR THESE PLANS ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II MICHAEL HOLPER $68,760 RODNEY REIDER - $35,371 STEPHANIE WESTERMEIER - $2,744 COLUMN (F) OF SCHEDULE J, PART II INCLUDES THE PORTION OF THESE AMOUNTS THAT WERE REPORTED AS DEFERRED COMPENSATION IN PRIOR YEARS THE FOLLOWING ARE PARTICIPANTS IN A NON-QUALIFIED DEFERRED COMPENSATION PLAN UNDER SECTION 457(F) THERE WERE NO PAYOUTS IN 2017 STEPHEN JONES, MD CHRISTIAN ZIMMERMAN, MD |

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 82-0200895
**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 ODETTE BOLANO<br>DIRECTOR, PRESIDENT | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 496,661 | 134,784 | 10,381 | 92,281 | 13,723 | 747,830 | 0 |
| 1 MICHAEL HOLPER<br>DIRECTOR, TRINITY SVP INTEG/AUDIT SV | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 410,338 | 154,362 | 174,040 | 20,250 | 27,312 | 786,302 | 61,811 |
| 2 RODNEY REIDER<br>DIRECTOR, SAHS PRESIDENT AND CEO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 511,154 | 194,984 | 174,609 | 12,150 | 32,819 | 925,716 | 33,161 |
| 3<br>STEPHANIE WESTERMEIER<br>SECRETARY, SAHS VP & GENERAL COUNSEL | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 301,699 | 82,455 | 4,568 | 16,200 | 25,088 | 430,010 | 0 |
| 4 B LANNIE CHECKETTS<br>TREASURER, SAHS CFO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 335,626 | 49,243 | 130,418 | 16,200 | 27,703 | 559,190 | 0 |
| 5 BRENT CHERNE<br>VP OF FINANCE THRU 5/18 | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 201,810 | 22,560 | 814 | 6,881 | 18,637 | 250,702 | 0 |
| 6 JEAN BASOM<br>REGIONAL DIRECTOR SUPPLY CHAIN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 157,674 | 17,354 | 1,728 | 13,495 | 17,901 | 208,152 | 0 |
| 7 JAMES LEDERER MD<br>SAHS CMO/CHIEF QUALITY OFFICER | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 410,967 | 89,899 | 1,889 | 12,150 | 20,062 | 534,967 | 0 |
| 8<br>CHRISTIAN ZIMMERMAN MD<br>PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 1,200,379 | 40,000 | 8,720 | 11,043 | 23,961 | 1,284,103 | 0 |
| 9 JOSEPH BROOKS MD<br>PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 1,027,648 | 33,778 | 596 | 12,150 | 29,204 | 1,103,376 | 0 |
| 10 MARGOT VLOKA MD<br>PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 784,242 | 33,807 | 1,956 | 12,150 | 22,642 | 854,797 | 0 |
| 11 LINDSAY SALES MD<br>PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 801,150 | 0 | 6,826 | 12,150 | 20,477 | 840,603 | 0 |
| 12 STEPHEN JONES MD<br>PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 745,863 | 33,807 | 5,267 | 8,100 | 24,935 | 817,972 | 0 |
| 13 BLAINE PETERSEN<br>FORMER OFFICER, LOYOLA UNIV CFO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 557,910 | 159,838 | 80,400 | 12,150 | 26,125 | 836,423 | 0 |
| 14 SALLY JEFFCOAT<br>FORMER OFFICER, TRINITY HEALTH EVP | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 898,754 | 388,608 | 230,295 | 12,150 | 31,295 | 1,561,102 | 0 |

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**Schedule L** (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Transactions with Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

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

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

| 1 | (a) Name of disqualified person | (b) Relationship between disqualified person and organization | (c) Description of transaction | (d) Corrected? Yes | No |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

## Part II Loans to and/or From Interested Persons.

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

| (a) Name of interested person | (b) Relationship with organization | (c) Purpose of loan | (d) Loan to or from the organization? To | From | (e) Original principal amount | (f) Balance due | (g) In default? Yes | No | (h) Approved by board or committee? Yes | No | (i) Written agreement? Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |
| Total | | | | ▶ $ | | | | | | | | |

## Part III Grants or Assistance Benefiting Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|---|---|---|---|---|
| | | | | |
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## Part IV Business Transactions Involving Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| See Additional Data Table | | | | | |
| | | | | | |
| | | | | | |
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## Part V Supplemental Information

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

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

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 82-0200895
**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| (1) | | | | | No |
| (1) MICHELLE WILKIN | FAMILY MEMBER OF DON ROUMAGOUX, TRUSTEE | 39,114 | EMPLOYMENT ARRANGEMENT | | No |

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| (3) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 5,919,825 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |
| (1) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 3,372,046 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| (5) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 414,295 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |
| (1) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 290,160 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| (7) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 267,282 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |
| (1) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 221,270 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

| **(a)** Name of interested person | **(b)** Relationship between interested person and the organization | **(c)** Amount of transaction | **(d)** Description of transaction | **(e)** Sharing of organization's revenues? | |
|---|---|---|---|---|---|
| | | | | **Yes** | **No** |
| (9) SUBSTANTIAL CONTRIBUTOR | SUBSTANTIAL CONTRIBUTOR | 186,187 | SUBSTANTIAL CONTRIBUTOR PROVIDED GOODS/SERVICES TO SAINT ALPHONSUS REGIONAL MEDICAL CENTER | | No |

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

# Noncash Contributions

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

Employer identification number
82-0200895

## Part I Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|---|---|---|---|---|
| 1 Art—Works of art | X | 1 | 500 | FMV |
| 2 Art—Historical treasures | | | | |
| 3 Art—Fractional interests | | | | |
| 4 Books and publications | X | | 1,026 | FMV |
| 5 Clothing and household goods | X | | 41,952 | FMV |
| 6 Cars and other vehicles | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded | | | | |
| 10 Securities—Closely held stock | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential | | | | |
| 16 Real estate—Commercial | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | X | | 10,279 | FMV |
| 20 Drugs and medical supplies | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ▶ ( TREE/GREENERY ) | X | 349 | 179,308 | FMV |
| 26 Other ▶ ( AUCTION ITEMS ) | X | 8 | 10,422 | FMV |
| 27 Other ▶ ( MISC DONATIONS ) | X | 9 | 6,869 | FMV |
| 28 Other ▶ ( _____ ) | | | | |

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

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

**Part II** **Supplemental Information.**

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

| Return Reference | Explanation |
|---|---|
| PART I, LINE 32B | THE REPORTING ENTITY HAS USED THIRD PARTIES TO PROCESS OR SELL NON-CASH CONTRIBUTIONS WHEN SPECIFIC EXPERTISE IS WARRANTED WHERE AN EXPERT APPRAISAL IS NECESSARY, A THIRD PARTY APPRAISER WILL BE ENGAGED OCCASIONALLY THE SERVICES OF AN AGENT ARE ENGAGED TO SELL NON-CASH CONTRIBUTIONS THAT WILL NOT BE USED BY THE REPORTING ENTITY |

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

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

**Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.**
**▶ Attach to Form 990 or 990-EZ.**
**▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PAGE 1, DOING BUSINESS AS | SAINT ALPHONSUS PHYSICIAN SERVICES SAINT ALPHONSUS MEDICAL GROUP SAINT ALPHONSUS FOUNDATIO N SAINT ALPHONSUS SAINT ALPHONSUS HEART INSTITUTE SAINT ALPHONSUS REGIONAL MEDICAL CENTER - BOISE |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 4 | THE BYLAWS OF SAINT ALPHONSUS REGIONAL MEDICAL CENTER (SARMC) WERE AMENDED DURING THE YEAR AND THE FOLLOWING CHANGES WERE MADE THE RESERVED POWERS, DESCRIBED IN PART VI, SECTION B , LINE 7B, OF TRINITY HEALTH CORPORATION WERE ADDED, THE MINIMUM NUMBER OF BOARD MEMBERS I NCREASED TO NINE, AND THE BOARD COMPOSITION MUST NOW INCLUDE AT LEAST ONE PHYSICIAN AND AT LEAST ONE PHYSICIAN AND AT LEAST TWO MEMBERS OR ASSOCIATES OF A ROMAN CATHOLIC RELIGIOUS CONGREGATION |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION A, LINE 6 | THE SOLE MEMBER OF SARMC IS SAINT ALPHONSUS HEALTH SYSTEM SEE LINE 7 FOR ADDITIONAL INFORMATION |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION A, LINE 7A | SAINT ALPHONSUS HEALTH SYSTEM IS THE SOLE MEMBER OF SARMC SAINT ALPHONSUS HEALTH SYSTEM H AS THE RIGHT TO APPOINT ALL PERSONS TO THE BOARD OF DIRECTORS OF SARMC |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 7B | AS SOLE MEMBER, SAINT ALPHONSUS HEALTH SYSTEM MUST APPROVE CERTAIN DECISIONS OF THE GOVERN ING BODY, INCLUDING THE STRATEGIC PLAN, ANNUAL CAPITAL PLAN, AND ANNUAL OPERATING BUDGET SAINT ALPHONSUS HEALTH SYSTEM MUST ALSO APPROVE SIGNIFICANT CHANGES SUCH AS A MERGER, DISS OLUTION, SALE OF ASSETS IN EXCESS OF CERTAIN LIMITS, AND MODIFICATIONS TO GOVERNING DOCUME NTS AS THE PARENT OF THE NATIONAL TRINITY HEALTH SYSTEM, CERTAIN POWERS ARE RESERVED TO T RINITY HEALTH CORPORATION THESE INCLUDE THE AUTHORITY TO ADOPT OR MODIFY THE ORGANIZATION 'S GOVERNING DOCUMENTS, TO APPROVE MAJOR CHANGES SUCH AS A MERGER OR DISSOLUTION, AND TO A PPROVE SIGNIFICANT FINANCE MATTERS IN EXCESS OF CERTAIN LIMITS ESTABLISHED BY TRINITY HEAL TH CORPORATION |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, SECTION B, LINE 11B | PRIOR TO FILING, THE FORM 990 FOR SARMC IS REVIEWED BY SENIOR MANAGEMENT IN ADDITION, CER TAIN KEY SECTIONS OF THE FORM ARE REVIEWED BY SAINT ALPHONSUS HEALTH SYSTEM PLANNING AND F INANCE COMMITTEE EACH MEMBER OF THE BOARD RECEIVES A COPY OF THE RETURN IN ITS FINAL FORM BEFORE IT IS FILED WITH THE INTERNAL REVENUE SERVICE |

**990 Schedule O, Supplemental Information**

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 12C | SARMC HAS ADOPTED TRINITY HEALTH'S GOVERNANCE POLICY NO 1, WHICH SETS FORTH THE ORGANIZAT ION'S CONFLICT OF INTEREST POLICY AND PROCESSES IT APPLIES TO ALL "INTERESTED PERSONS" OF SARMC, WHICH INCLUDES DIRECTORS, PRINCIPAL OFFICERS, KEY EMPLOYEES, AND MEMBERS OF COMMIT TEES WITH BOARD-DELEGATED POWERS INTERESTED PERSONS ARE EXPECTED TO DISCHARGE THEIR DUTIE S IN A MANNER THE PERSON REASONABLY BELIEVES TO BE IN THE BEST INTERESTS OF SARMC AND TO A VOID SITUATIONS INVOLVING A CONFLICT OF INTEREST ON AN ANNUAL BASIS, INTERESTED PERSONS A RE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE STATEMENT AND TO AFFIRM THEIR RE CEIPT OF THE CONFLICT OF INTEREST POLICY, COMPLIANCE WITH ITS REQUIREMENTS, AND AGREE TO N OTIFY THE ORGANIZATION OF CHANGES IMPACTING THEIR ANNUAL DISCLOSURE IN ACCORDANCE WITH THE POLICY THE ANNUAL DISCLOSURES ARE PROVIDED TO INTERNAL LEGAL COUNSEL AND THE INTEGRITY A ND COMPLIANCE OFFICER, FROM WHICH LEGAL COUNSEL PREPARES A REPORT FOR THE BOARD CHAIR AND CEO A SUMMARY OF POTENTIAL CONFLICTS IS REVIEWED WITH THE BOARD OF DIRECTORS OF SARMC (OR A DELEGATED COMMITTEE OF THE BOARD) ON A YEARLY BASIS INTERESTED PERSONS ARE REQUIRED TO MAKE FULL DISCLOSURE TO SARMC OF ANY FINANCIAL OR BUSINESS INTERESTS THAT MIGHT RESULT IN OR HAVE THE APPEARANCE OF A CONFLICT OF INTEREST THE BOARD OF DIRECTORS OF SARMC (OR A D ELEGATED COMMITTEE OF THE BOARD) IS RESPONSIBLE FOR THE REVIEW OF TRANSACTIONS TO DETERMIN E WHETHER AN ACTUAL CONFLICT OF INTEREST EXISTS IN THE EVENT OF AN ACTUAL CONFLICT, THE B OARD (OR A DELEGATED COMMITTEE OF THE BOARD) WILL EITHER AVOID THE CONFLICT OR APPROPRIATE LY SCRUTINIZE THE TRANSACTION TO ENSURE IT IS IN THE BEST INTERESTS OF SARMC INTERESTED P ERSONS ARE REQUIRED TO RECUSE THEMSELVES FROM DISCUSSION AND VOTING ON MATTERS INVOLVING A CONFLICT OF INTEREST THE POLICY FURTHER ADDRESSES THE PROPER DOCUMENTATION OF THE PROCEE DINGS AND POTENTIAL DISCIPLINARY AND CORRECTIVE ACTION FOR VIOLATIONS OF THE POLICY THE P OLICY IS AVAILABLE TO THE PUBLIC UPON REQUEST |

**990 Schedule O, Supplemental Information**

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 15 | QUESTIONS 15A AND 15B ARE ANSWERED "NO" BECAUSE THE COMPENSATION FOR CERTAIN OFFICERS AND KEY MANAGEMENT OFFICIALS OF SARMC IS ESTABLISHED BY TRINITY HEALTH, A RELATED ORGANIZATION IN ESTABLISHING CEO AND SYSTEM CFO COMPENSATION, TRINITY HEALTH FOLLOWS A PROCESS AND PO LICY THAT IS INTENDED TO MIRROR THE IRC SECTION 4958 GUIDELINES FOR OBTAINING A "REBUTTABL E PRESUMPTION OF REASONABLENESS" WITH REGARD TO COMPENSATION AND BENEFITS AS PART OF THAT PROCESS, THE COMPENSATION AND BENEFITS OF THE CEO AND SYSTEM CFO OF SARMC ARE REVIEWED AT LEAST ANNUALLY BY THE TRINITY HEALTH BOARD OR THE TRINITY HEALTH HUMAN RESOURCES AND COMP ENSATION COMMITTEE (HRCC) OF THE BOARD, AUTHORIZED TO ACT ON BEHALF OF THE BOARD WITH RESP ECT TO CERTAIN COMPENSATION MATTERS AS PART OF ITS REVIEW PROCESS, THE HRCC RETAINS AN IN DEPENDENT FIRM EXPERIENCED IN COMPENSATION AND BENEFIT MATTERS FOR NOT-FOR-PROFIT HEALTH C ARE ORGANIZATIONS TO ADVISE IT IN THE DETERMINATIONS IT MAKES ON THE REASONABLENESS OF PRO POSED COMPENSATION AND BENEFITS ARRANGEMENTS |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION C, LINE 19 | SARMC IS A SUBSIDIARY ORGANIZATION IN THE TRINITY HEALTH SYSTEM TRINITY HEALTH MAKES CERT AIN OF ITS KEY DOCUMENTS AVAILABLE TO THE PUBLIC ON ITS WEBSITE, WWW TRINITY-HEALTH ORG, I N THE "ABOUT US" SECTION IN THIS SECTION, THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS A RE PUBLICLY AVAILABLE IN ADDITION, SARMC INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHED ULE H ON BOTH ITS OWN WEBSITE AND TRINITY HEALTH'S WEBSITE SARMC'S GOVERNING DOCUMENTS AN D CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART XI, LINE 9 | EQUITY TRANSFERS (TO)/FROM AFFILIATES -15,725,449 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART XII, LINE 2 | SARMC'S FINANCIAL STATEMENTS WERE INCLUDED IN THE FY18 CONSOLIDATED FINANCIAL STATEMENTS O F TRINITY HEALTH, WHICH WERE AUDITED BY AN INDEPENDENT PUBLIC ACCOUNTING FIRM |

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# SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**Employer identification number**
82-0200895

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|---|---|---|---|---|
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**Part II** **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

See Additional Data Table

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | (g) Section 512(b)(13) controlled entity? No |
|---|---|---|---|---|---|---|---|
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**Part III** **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

See Additional Data Table

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | | Yes | No | |
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**Part IV** **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| See Additional Data Table | | | | | | | | | |
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**Part V Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule

| | | Yes | No |
|---|---|---|---|
| **1** During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV? | | | |
| **a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity | 1a | | No |
| **b** Gift, grant, or capital contribution to related organization(s) | 1b | Yes | |
| **c** Gift, grant, or capital contribution from related organization(s) | 1c | Yes | |
| **d** Loans or loan guarantees to or for related organization(s) | 1d | | No |
| **e** Loans or loan guarantees by related organization(s) | 1e | | No |
| **f** Dividends from related organization(s) | 1f | | No |
| **g** Sale of assets to related organization(s) | 1g | | No |
| **h** Purchase of assets from related organization(s) | 1h | | No |
| **i** Exchange of assets with related organization(s) | 1i | | No |
| **j** Lease of facilities, equipment, or other assets to related organization(s) | 1j | | No |
| **k** Lease of facilities, equipment, or other assets from related organization(s) | 1k | | No |
| **l** Performance of services or membership or fundraising solicitations for related organization(s) | 1l | Yes | |
| **m** Performance of services or membership or fundraising solicitations by related organization(s) | 1m | Yes | |
| **n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | 1n | | No |
| **o** Sharing of paid employees with related organization(s) | 1o | | No |
| **p** Reimbursement paid to related organization(s) for expenses | 1p | Yes | |
| **q** Reimbursement paid by related organization(s) for expenses | 1q | Yes | |
| **r** Other transfer of cash or property to related organization(s) | 1r | Yes | |
| **s** Other transfer of cash or property from related organization(s) | 1s | | No |

**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

See Additional Data Table

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|---|---|---|
| | | | |
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**Part VI** **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

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

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
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**Part VII** **Supplemental Information**

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

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 82-0200895
**Name:** SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 245 STATE ST SE<br>GRAND RAPIDS, MI 49503<br>27-2491974 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 33920 US HIGHWAY 19 NORTH SUITE 269<br>PALM HARBOR, FL 34684<br>58-1492325 | GRANT MAKING | FL | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1450170 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 255 NORTH WELCH AVENUE<br>PRIMGHAR, IA 51245<br>42-1500277 | HEALTH CARE AND HOSPITAL SERVICES | IA | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 255 NORTH WELCH AVENUE<br>PRIMGHAR, IA 51245<br>26-2973307 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | BAUM HARMON MERCY HOSPITAL | Yes | |
| 2212 BURDETT AVE<br>TROY, NY 12180<br>14-1651563 | TITLE HOLDING COMPANY | NY | 501(C)(2) | N/A | LTC (EDDY) INC | Yes | |
| 905 WATSON STREET<br>PITTSBURGH, PA 15219<br>25-1436685 | HOMELESS SHELTER | PA | 501(C)(3) | LINE 7 | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |
| 40 AUTUMN DRIVE<br>SLINGERLANDS, NY 12159<br>14-1717028 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>04-2182395 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 10 | THE MERCY HOSPITAL INC | Yes | |
| 421 WEST COLUMBIA STREET<br>COHOES, NY 12047<br>14-1701597 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 1200 EARHART RD<br>ANN ARBOR, MI 48105<br>20-1681131 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | GLACIER HILLS INC | Yes | |
| PO BOX 995<br>ANN ARBOR, MI 48106<br>38-2507173 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH-MICHIGAN | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152 | GOVERNANCE AND MANAGEMENT OF TRINITY HEALTH SYSTEM | VT | 501(C)(3) | LINE 1 | N/A | | No |
| 111 CENTRAL AVENUE<br>NEWARK, NJ 07102<br>26-2616342 | INACTIVE ENTITY | NJ | 501(C)(3) | LINE 10 | SAINT MICHAEL'S MEDICAL CENTER | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>34-2032340 | HEALTH CARE AND HOSPITAL SERVICES | OH | 501(C)(3) | LINE 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 250 MERCY DRIVE<br>DUBUQUE, IA 52001<br>26-2227941 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 1111 3RD STREET SW<br>DYERSVILLE, IA 52040<br>20-5383271 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2515999 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 433 RIVER ST SUITE 3000<br>TROY, NY 12180<br>14-1818568 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 3 | LTC (EDDY) INC | Yes | |
| 333 BUTTERNUT DRIVE<br>DEWITT, NY 13214<br>46-1051881 | PACE PROGRAM | NY | 501(C)(3) | LINE 10 | ST JOSEPH'S HEALTH INC | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 10 BLACKSMITH DRIVE<br>MALTA, NY 12020<br>14-1795732 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 10 | HOME AIDE SERVICE OF EASTERN NEW YORK INC | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>04-2501711 | LONG TERM CARE | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| PO BOX 2500<br>WILMINGTON, DE 19805<br>22-3008680 | LONG TERM CARE (INACTIVE) | DE | 501(C)(3) | LINE 10 | ST FRANCIS HOSPITAL | Yes | |
| 1200 EARHART RD<br>ANN ARBOR, MI 48105<br>20-8072723 | FOUNDATION | MI | 501(C)(3) | LINE 12A, I | GLACIER HILLS INC | Yes | |
| 1200 EARHART RD<br>ANN ARBOR, MI 48105<br>38-1891500 | SENIOR LIVING COMMUNITY | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1 GLEN EDDY DRIVE<br>NISKAYUNA, NY 12309<br>14-1794150 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>42-1253527 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 5401 LAKE OCONEE PARKWAY<br>GREENSBORO, GA 30642<br>26-1720984 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 701 W NORTH AVE<br>MELROSE PARK, IL 60160<br>36-3332852 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | GOTTLIEB MEMORIAL HOSPITAL | Yes | |
| 701 WEST NORTH AVENUE<br>MELROSE PARK, IL 60160<br>74-3260011 | FOUNDATION | IL | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
| 701 W NORTH AVE<br>MELROSE PARK, IL 60160<br>36-2379649 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | Yes | |
| 945 OTTAWA AVE NW<br>GRAND RAPIDS, MI 49503<br>23-7270669 | MEDICAL EDUCATION TRAINING PROGRAMS | MI | 501(C)(3) | LINE 12A, I | TRINITY HEALTH-MICHIGAN | Yes | |
| 125 E SOUTHERN AVENUE<br>MUSKEGON, MI 49442<br>38-1386362 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | MERCY HEALTH PARTNERS | Yes | |
| 30 COMMUNITY WAY<br>EAST GREENBUSH, NY 12061<br>80-0102840 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| PO BOX 2153<br>WATERBURY, CT 06722<br>83-0416893 | MANAGEMENT | CT | 501(C)(3) | LINE 12A, I | N/A | | No |
| 2920 TIBBITS AVE<br>TROY, NY 12180<br>14-1725101 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48152<br>52-1945054 | LONG TERM CARE | MD | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 10720 COLUMBIA PIKE<br>SILVER SPRING, MD 20901<br>20-8428450 | FOUNDATION | MD | 501(C)(3) | LINE 7 | HOLY CROSS HEALTH INC | Yes | |
| 1500 FOREST GLEN ROAD<br>SILVER SPRING, MD 20910<br>52-0738041 | HEALTH CARE AND HOSPITAL SERVICES | MD | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 4725 NORTH FEDERAL HIGHWAY<br>FT LAUDERDALE, FL 33308<br>59-0791028 | HEALTH CARE AND HOSPITAL SERVICES | FL | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 4725 NORTH FEDERAL HIGHWAY<br>FT LAUDERDALE, FL 33308<br>46-5421068 | HEALTH CARE SERVICES | FL | 501(C)(3) | LINE 10 | HOLY CROSS HOSPITAL INC | Yes | |
| 4725 NORTH FEDERAL HIGHWAY<br>FT LAUDERDALE, FL 33308<br>81-2531495 | HEALTH CARE SERVICES | FL | 501(C)(3) | LINE 10 | HOLY CROSS HOSPITAL INC | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>81-0723591 | HOME HEALTH SERVICES | CT | 501(C)(3) | LINE 10 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 433 RIVER ST SUITE 3000<br>TROY, NY 12180<br>14-1514867 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 232 SECOND STREET SE<br>MASON CITY, IA 50401<br>42-1173708 | HOSPICE SERVICES | IA | 501(C)(3) | LINE 10 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 4300 HAMILTON BLVD<br>SIOUX CITY, IA 51104<br>38-3320710 | HOSPICE SERVICES | IA | 501(C)(3) | LINE 12A, I | N/A | | No |
| 24 FRANK LLOYD WRIGHT DR LOBBY J<br>ANN ARBOR, MI 48106<br>38-3316559 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>47-5676956 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>23-2519529 | HEALTH CARE SERVICES (INACTIVE) | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>23-2571699 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 2475 MCCLELLAN AVENUE<br>PENNSAUKEN, NJ 08109<br>26-1854750 | PACE PROGRAM | NJ | 501(C)(3) | LINE 3 | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 7TH AND CLAYTON STREETS<br>WILMINGTON, DE 19805<br>45-2569214 | PACE PROGRAM | DE | 501(C)(3) | LINE 10 | ST FRANCIS HOSPITAL | Yes | |
| 7500 K JOHNSON BOULEVARD<br>BORDENTOWN, NJ 08505<br>22-2797282 | PACE PROGRAM | NJ | 501(C)(3) | LINE 10 | ST FRANCIS MEDICAL CENTER TRENTON NJ | Yes | |
| 100 GOSSMAN DRIVE<br>SOUTHERN PINES, NC 28387<br>27-2159847 | PACE PROGRAM | NC | 501(C)(3) | LINE 3 | ST JOSEPH OF THE PINES INC | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>26-2976184 | PACE PROGRAM | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>22-2568525 | VOLUNTEER SERVICE AUXILIARY | NJ | 501(C)(3) | LINE 12B, II | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>27-4357794 | HEALTH CARE SERVICES | NJ | 501(C)(3) | LINE 3 | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 218 SUNSET ROAD<br>WILLINGBORO, NJ 08046<br>22-3612265 | HEALTH CARE AND HOSPITAL SERVICES | NJ | 501(C)(3) | LINE 3 | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 905 W NORTH AVE<br>MELROSE PARK, IL 60160<br>47-4147171 | TRANSPORATION SERVICES | IL | 501(C)(3) | LINE 10 | LOYOLA UNIVERSITY MEDICAL CENTER | Yes | |
| 2160 SOUTH FIRST AVENUE<br>MAYWOOD, IL 60153<br>36-3342448 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |

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

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|---|---|---|---|---|---|---|---|
| 2160 SOUTH FIRST AVENUE<br>MAYWOOD, IL 60153<br>36-4015560 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | Yes | |
| 2212 BURDETT AVE<br>TROY, NY 12180<br>22-2564710 | MANAGEMENT SERVICES FOR LONG TERM CARE | NY | 501(C)(3) | LINE 12B, II | ST PETER'S HEALTH PARTNERS | Yes | |
| 801 5TH STREET<br>SIOUX CITY, IA 51101<br>38-3320705 | HOME HEALTH SERVICES (INACTIVE) | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 3805 WEST CHESTER PIKE STE 100<br>NEWTOWN SQUARE, PA 19073<br>91-1940902 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE) | PA | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 275 STEELE ROAD<br>WEST HARTFORD, CT 06117<br>06-1058086 | SENIOR LIVING COMMUNITY | CT | 501(C)(3) | LINE 10 | MERCY COMMUNITY HEALTH INC | Yes | |
| PO BOX 992<br>ANN ARBOR, MI 48106<br>38-2561013 | HEALTH CARE SERVICES (INACTIVE) | MI | 501(C)(3) | LINE 3 | CATHERINE MCAULEY HEALTH SERVICES CORP | Yes | |
| 3333 FIFTH AVENUE<br>PITTSBURGH, PA 15213<br>94-3436142 | GRANT MAKING | PA | 501(C)(3) | LINE 12B, II | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |
| 600 NORTHERN BLVD<br>ALBANY, NY 12204<br>14-1338457 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 17410 COLLEGE PARKWAY STE 150<br>LIVONIA, MI 48152<br>38-3320698 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>58-1448522 | FOUNDATION | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-1352191 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 2021 ALBANY AVENUE<br>WEST HARTFORD, CT 06117<br>06-1492707 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | CT | 501(C)(3) | LINE 12B, II | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1001 BALTIMORE PIKE SUITE 310<br>SPRINGFIELD, PA 19064<br>23-2325059 | HOME HEALTH SERVICES | PA | 501(C)(3) | LINE 10 | MERCY HOME HEALTH SERVICES | Yes | |
| 2525 SOUTH MICHIGAN AVENUE<br>CHICAGO, IL 60616<br>36-3227350 | FOUNDATION | IL | 501(C)(3) | LINE 7 | MERCY HEALTH SYSTEM OF CHICAGO | Yes | |
| 888 TERRACE STREET<br>MUSKEGON, MI 49440<br>38-3321856 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2829864 | FOUNDATION | PA | 501(C)(3) | LINE 12B, II | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 1111 6TH AVENUE<br>DES MOINES, IA 50314<br>42-1478417 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | DE | 501(C)(3) | LINE 12B, II | N/A | | No |
| 1500 E SHERMAN BLVD<br>MUSKEGON, MI 49444<br>38-2589966 | HEALTH CARE AND HOSPITAL SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH-MICHIGAN | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>22-2483605 | MEDICAID MANAGED CARE PLAN | PA | 501(C)(3) | LINE 12B, II | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 1000 4TH STREET SW<br>MASON CITY, IA 50401<br>31-1373080 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |

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

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|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 2525 SOUTH MICHIGAN AVENUE<br>CHICAGO, IL 60616<br>36-3163327 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2212638 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | PA | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 114 WAWBEEK AVENUE<br>TUPPER LAKE, NY 12986<br>15-0532211 | HEALTH CARE AND HOSPITAL SERVICES (INACTIVE) | NY | 501(C)(3) | LINE 3 | MERCY UIHLEIN HEALTH CORPORATION | Yes | |
| 1410 N 4TH ST<br>CLINTON, IA 52732<br>42-1316126 | FOUNDATION | IA | 501(C)(3) | LINE 7 | N/A | | No |
| 1001 BALTIMORE PIKE SUITE 310<br>SPRINGFIELD, PA 19064<br>23-1352099 | HOME HEALTH SERVICES | PA | 501(C)(3) | LINE 10 | MERCY HOME HEALTH SERVICES | Yes | |
| 1001 BALTIMORE PIKE SUITE 310<br>SPRINGFIELD, PA 19064<br>23-2325058 | MANAGEMENT SERVICES FOR HOME HEALTH | PA | 501(C)(3) | LINE 12B, II | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 2525 SOUTH MICHIGAN AVENUE<br>CHICAGO, IL 60616<br>36-2170152 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF CHICAGO | Yes | |
| 1820 44TH ST SE<br>KENTWOOD, MI 49508<br>20-3357131 | FOUNDATION | MI | 501(C)(3) | LINE 12A, I | TRINITY HEALTH-MICHIGAN | Yes | |
| 1200 REEDSDALE STREET<br>PITTSBURGH, PA 15233<br>25-1604115 | COMMUNITY OUTREACH | PA | 501(C)(3) | LINE 10 | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |
| PO BOX 7957<br>MOBILE, AL 36670<br>27-3163002 | PACE PROGRAM | AL | 501(C)(3) | LINE 3 | TRINITY HEALTH PACE | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>45-3086711 | PACE PROGRAM | MA | 501(C)(3) | LINE 3 | SISTERS OF PROVIDENCE CARE CENTERS INC | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2627944 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 1410 NORTH 4TH ST<br>CLINTON, IA 52732<br>42-1336618 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 801 5TH STREET<br>SIOUX CITY, IA 51102<br>14-1880022 | FOUNDATION | IA | 501(C)(3) | LINE 7 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 1000 4TH STREET SW<br>MASON CITY, IA 50401<br>42-1229151 | FOUNDATION | IA | 501(C)(3) | LINE 7 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| PO BOX 7957<br>MOBILE, AL 36670<br>63-6002215 | PACE PROGRAM | AL | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>45-4884805 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>46-1187365 | MANAGEMENT SERVICES FOR PHYSICIAN SERVICE ORGANIZATIONS | PA | 501(C)(3) | LINE 12B, II | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>58-1366508 | COMMUNITY OUTREACH | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>27-2046353 | TITLE HOLDING COMPANY | GA | 501(C)(3) | LINE 12B, II | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |

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|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>38-2719605 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>26-4033168 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-1396763 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| 3805 WEST CHESTER PIKE SUITE 100<br>NEWTOWN SQUARE, PA 19073<br>16-1535133 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE) | NY | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 37595 SEVEN MILE ROAD<br>LIVONIA, MI 48152<br>38-3181557 | BUILDING MANAGEMENT SERVICES | DE | 501(C)(3) | LINE 12A, I | N/A | | No |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1308555 | COLLEGE OF NURSING | OH | 501(C)(3) | LINE 2 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>25-1912781 | HEALTH INSURANCE | OH | 501(C)(4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1471229 | MEDICARE HMO | OH | 501(C)(4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1439334 | HEALTH CARE AND HOSPITAL SERVICES | OH | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1113966 | FOUNDATION | OH | 501(C)(3) | LINE 12A, I | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>22-2584082 | FOUNDATION | CT | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1422973 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 7 HIGHTOWER STREET<br>WATERVILLE, ME 04901<br>01-0274998 | LONG TERM CARE | ME | 501(C)(3) | LINE 3 | MERCY COMMUNITY HEALTH INC | Yes | |
| 1820 44TH STREET<br>KENTWOOD, MI 49508<br>38-3073745 | HEALTH CARE SERVICES (INACTIVE) | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 565 W WESTERN AVENUE<br>MUSKEGON, MI 49440<br>91-1932918 | COMMUNITY OUTREACH | MI | 501(C)(3) | LINE 7 | MERCY HEALTH PARTNERS | Yes | |
| 2701 HOLME AVENUE<br>PHILADELPHIA, PA 19152<br>23-2300951 | FOUNDATION | PA | 501(C)(3) | LINE 12A, I | NAZARETH HOSPITAL | Yes | |
| 2601 HOLME AVENUE<br>PHILADELPHIA, PA 19152<br>23-2794121 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>20-3261266 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2497355 | HEALTH CARE SERVICES (INACTIVE) | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 601 EAST 2ND STREET<br>OAKLAND, NE 68045<br>20-8072234 | HEALTH CARE AND HOSPITAL SERVICES | NE | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |

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|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 601 E 2ND STREET<br>OAKLAND, NE 68045<br>31-1678345 | FOUNDATION | NE | 501(C)(3) | LINE 12A, I | OAKLAND MERCY HOSPITAL | Yes | |
| 6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1654603 | COOPERATIVE HEALTH CARE DELIVERY SYSTEM | OH | 501(C)(3) | LINE 12A, I | N/A | | No |
| 1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>22-2568528 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NJ | 501(C)(3) | LINE 12B, II | MAXIS HEALTH SYSTEM | Yes | |
| 1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>22-2351960 | FOUNDATION | NJ | 501(C)(3) | LINE 7 | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>21-0635001 | HEALTH CARE AND HOSPITAL SERVICES | NJ | 501(C)(3) | LINE 3 | OUR LADY OF LOURDES HEALTH CARE SERVICES | Yes | |
| 2 MERCYCARE LANE<br>GUILDERLAND, NY 12084<br>14-1743506 | LONG TERM CARE | NY | 501(C)(3) | LINE 3 | ST PETER'S HOSPITAL | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>45-4208896 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 3333 5TH AVENUE<br>PITTSBURGH, PA 15213<br>25-1464211 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 2058 S STATE STREET<br>ANN ARBOR, MI 48104<br>20-2020239 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 965 FORK STREET<br>MUSKEGON, MI 49442<br>38-2638284 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | MERCY HEALTH PARTNERS | Yes | |
| 271 CAREW ST<br>SPRINGFIELD, MA 01104<br>81-1807730 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>27-1763712 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 1303 EAST HERNDON AVE<br>FRESNO, CA 93720<br>94-1437713 | HEALTH CARE AND HOSPITAL SERVICES | CA | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 1303 EAST HERNDON AVE<br>FRESNO, CA 93720<br>94-2839324 | HEALTH CARE SERVICES | CA | 501(C)(3) | LINE 12A, I | SAINT AGNES MEDICAL CENTER | Yes | |
| 1055 NORTH CURTIS RD<br>BOISE, ID 83706<br>82-0401011 | BUILDING MANAGEMENT SERVICES | ID | 501(C)(3) | LINE 10 | SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC | Yes | |
| 1055 NORTH CURTIS RD<br>BOISE, ID 83706<br>94-3028978 | HEALTH CARE SYSTEM SUPPORT | ID | 501(C)(3) | LINE 12A, I | SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC | Yes | |
| 3325 POCAHONTAS ROAD<br>BAKER CITY, OR 97814<br>94-3164869 | FOUNDATION | OR | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER - BAKER CITY | Yes | |
| 351 SW 9TH STREET<br>ONTARIO, OR 97914<br>20-2683560 | FOUNDATION | OR | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER-ONTARIO | Yes | |
| 1055 N CURTIS ROAD<br>BOISE, ID 83706<br>27-1929502 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | ID | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 351 SW 9TH STREET<br>ONTARIO, OR 97914<br>94-3059469 | VOLUNTEER SERVICE AUXILIARY | OR | 501(C)(3) | LINE 10 | SAINT ALPHONSUS MEDICAL CENTER-ONTARIO | Yes | |

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|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 3325 POCAHONTAS ROAD<br>BAKER CITY, OR 97814<br>27-1790052 | HEALTH CARE AND HOSPITAL SERVICES | OR | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 4300 E FLAMINGO AVENUE<br>NAMPA, ID 83687<br>26-1737256 | FOUNDATION | ID | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER-NAMPA | Yes | |
| 4300 E FLAMINGO AVENUE<br>NAMPA, ID 83687<br>82-0200896 | HEALTH CARE AND HOSPITAL SERVICES | ID | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 351 SW 9TH STREET<br>ONTARIO, OR 97914<br>27-1789847 | HEALTH CARE AND HOSPITAL SERVICES | OR | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 1055 NORTH CURTIS RD<br>BOISE, ID 83706<br>82-0200895 | HEALTH CARE AND HOSPITAL SERVICES | ID | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | | No |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>45-1994612 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF NEW ENGLAND PNO INC | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-0646813 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1008255 | FOUNDATION | CT | 501(C)(3) | LINE 7 | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | Yes | |
| 111 CENTRAL AVENUE<br>NEWARK, NJ 07102<br>26-2616230 | INACTIVE ENTITY | NJ | 501(C)(3) | LINE 10 | SAINT MICHAEL'S MEDICAL CENTER | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>47-3129127 | PACE PROGRAM | IN | 501(C)(3) | LINE 10 | TRINITY HEALTH PACE | Yes | |
| PO BOX 670<br>PLYMOUTH, IN 46563<br>35-1142669 | HEALTH CARE AND HOSPITAL SERVICES | IN | 501(C)(3) | LINE 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 5215 HOLY CROSS PARKWAY<br>MISHAWAKA, IN 46545<br>35-0868157 | HEALTH CARE AND HOSPITAL SERVICES | IN | 501(C)(3) | LINE 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 1915 LAKE AVENUE<br>PLYMOUTH, IN 46563<br>35-6043563 | VOLUNTEER SERVICE AUXILIARY | IN | 501(C)(3) | LINE 12A, I | SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS INC | Yes | |
| 5215 HOLY CROSS PARKWAY<br>MISHAWAKA, IN 46545<br>35-1568821 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>58-1744848 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | GA | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>58-1752700 | HEALTH CARE SERVICES | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>31-1040468 | SENIOR LIVING COMMUNITY | IN | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES - INDIANA INC | Yes | |
| 1430 MONROE NW STE 120<br>GRAND RAPIDS, MI 49505<br>38-3320700 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| 200 JEFFERSON ST SE<br>GRAND RAPIDS, MI 49503<br>38-1779602 | FOUNDATION | MI | 501(C)(3) | LINE 7 | TRINITY HEALTH-MICHIGAN | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>22-2528400 | FOUNDATION | CT | 501(C)(3) | LINE 7 | SAINT MARY'S HOSPITAL INC | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-0646844 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 111 CENTRAL AVENUE<br>NEWARK, NJ 07102<br>26-2616046 | HEALTH CARE AND HOSPITAL SERVICES | NJ | 501(C)(3) | LINE 3 | MAXIS HEALTH SYSTEM | Yes | |
| 2215 BURDETT AVE<br>TROY, NY 12180<br>14-1710225 | CHILD CARE SERVICES | NY | 501(C)(3) | LINE 10 | ST PETER'S HEALTH PARTNERS | Yes | |
| 2215 BURDETT AVE<br>TROY, NY 12180<br>14-1338544 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 504 STATE STREET<br>SCHENECTADY, NY 12305<br>14-1708754 | PACE PROGRAM | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 1300 MASSACHUSETTS AVENUE<br>TROY, NY 12180<br>14-1505031 | VOLUNTEER SERVICE AUXILIARY | NY | 501(C)(3) | LINE 10 | SETON HEALTH SYSTEM INC | Yes | |
| ONE ABELE BLVD<br>CLIFTON PARK, NY 12065<br>14-1756230 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | SETON HEALTH SYSTEM INC | Yes | |
| 310 S MANNING BLVD<br>ALBANY, NY 12208<br>22-2345416 | FOUNDATION | NY | 501(C)(3) | LINE 12A, I | SETON HEALTH SYSTEM INC | Yes | |
| 1300 MASSACHUSETTS AVENUE<br>TROY, NY 12180<br>14-1776186 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>22-2541103 | LONG TERM CARE | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 424 DECATUR STREET<br>ATLANTA, GA 30312<br>47-2299757 | HEALTH CARE SYSTEM SUPPORT | GA | 501(C)(3) | LINE 12B, II | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2840137 | PACE PROGRAM | PA | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF SOUTHEASTERN PENNSYLVANIA | Yes | |
| ONE WEST ELM STREET SUITE 100<br>CONSHOHOCKEN, PA 19428<br>23-2415137 | FOUNDATION | PA | 501(C)(3) | LINE 12A, I | ST AGNES CONTINUING CARE CENTER | Yes | |
| PO BOX 2500<br>WILMINGTON, DE 19805<br>51-0374158 | FOUNDATION | DE | 501(C)(3) | LINE 12A, I | ST FRANCIS HOSPITAL | Yes | |
| PO BOX 2500<br>WILMINGTON, DE 19805<br>51-0064326 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 601 HAMILTON AVENUE<br>TRENTON, NJ 08629<br>52-1025476 | FOUNDATION | NJ | 501(C)(3) | LINE 7 | ST FRANCIS MEDICAL CENTER TRENTON NJ | Yes | |
| 601 HAMILTON AVENUE<br>TRENTON, NJ 08629<br>22-3431049 | HEALTH CARE AND HOSPITAL SERVICES | NJ | 501(C)(3) | LINE 3 | MAXIS HEALTH SYSTEM | Yes | |
| 411 CANISTEO STREET<br>HORNELL, NY 14843<br>22-3127184 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE) | NY | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 100 GOSSMAN DRIVE<br>SOUTHERN PINES, NC 28387<br>56-0694200 | LONG TERM CARE | NC | 501(C)(3) | LINE 3 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 206 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>20-2497520 | COLLEGE OF NURSING | NY | 501(C)(3) | LINE 2 | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>23-7219294 | BUILDING MANAGEMENT SERVICES | NY | 501(C)(3) | LINE 12B, II | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>47-4754987 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>15-0532254 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>22-2149775 | FOUNDATION | NY | 501(C)(3) | LINE 12B, II | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>27-3899821 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 301 PROSPECT AVENUE<br>SYRACUSE, NY 13203<br>16-1516863 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>46-1827502 | TITLE HOLDING COMPANY | PA | 501(C)(2) | N/A | ST MARY MEDICAL CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>46-5354512 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 2021 ALBANY AVENUE<br>WEST HARTFORD, CT 06117<br>06-0646843 | LONG TERM CARE | CT | 501(C)(3) | LINE 3 | MERCY COMMUNITY HEALTH INC | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>23-1913910 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>23-2567468 | FOUNDATION | PA | 501(C)(3) | LINE 7 | ST MARY MEDICAL CENTER | Yes | |
| 1230 BAXTER STREET<br>ATHENS, GA 30606<br>58-2544232 | FOUNDATION | GA | 501(C)(3) | LINE 12A, I | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET<br>ATHENS, GA 30606<br>81-1660088 | FOUNDATION | GA | 501(C)(3) | LINE 12A, I | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET<br>ATHENS, GA 30606<br>58-0566223 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 1230 BAXTER STREET<br>ATHENS, GA 30606<br>02-0576648 | SENIOR LIVING COMMUNITY | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET<br>ATHENS, GA 30606<br>26-1858563 | HEALTH CARE SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 367 CLEAR CREEK PARKWAY<br>LAVONIA, GA 30553<br>47-3752176 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 315 SOUTH MANNING BLVD<br>ALBANY, NY 12208<br>45-3570715 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 315 SOUTH MANNING BLVD<br>ALBANY, NY 12208<br>46-1177336 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 315 SOUTH MANNING BLVD<br>ALBANY, NY 12208<br>14-1348692 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? Yes | (g) Section 512 (b)(13) controlled entity? No |
|---|---|---|---|---|---|---|---|
| 310 SOUTH MANNING BLVD<br>ALBANY, NY 12208<br>22-2262982 | FOUNDATION | NY | 501(C)(3) | LINE 7 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1270 BELMONT AVENUE<br>SCHENECTADY, NY 12308<br>14-1338386 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1270 BELMONT AVE<br>SCHENECTADY, NY 12308<br>22-2505127 | FOUNDATION | NY | 501(C)(3) | LINE 12A, I | SUNNYVIEW HOSPITAL AND REHABILITATION CENTER | Yes | |
| 445 NEW KARNER RD<br>ALBANY, NY 12205<br>22-2692940 | FOUNDATION | NY | 501(C)(3) | LINE 7 | THE COMMUNITY HOSPICE INC | Yes | |
| 445 NEW KARNER RD<br>ALBANY, NY 12205<br>14-1608921 | HOSPICE SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 707 EAST CEDAR STREET STE 175<br>SOUTH BEND, IN 46617<br>35-1654543 | FOUNDATION | IN | 501(C)(3) | LINE 7 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 2256 BURDETT AVE<br>TROY, NY 12180<br>22-2570478 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 421 WEST COLUMBIA ST<br>COHOES, NY 12047<br>14-1793885 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 1221 MAIN STREET SUITE 213<br>HOLYOKE, MA 01040<br>04-3398280 | HEALTH CARE AND HOSPITAL SERVICES | MA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 310 SOUTH MANNING BLVD<br>ALBANY, NY 12208<br>22-2743478 | FOUNDATION | NY | 501(C)(3) | LINE 7 | ST PETER'S HEALTH PARTNERS | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-0660403 | VOLUNTEER SERVICE AUXILIARY | CT | 501(C)(3) | LINE 12B, II | N/A | | No |
| 17410 COLLEGE PARKWAY STE 150<br>LIVONIA, MI 48152<br>38-3320699 | HOSPICE SERVICES (INACTIVE) | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| 309 GRAND RIVER<br>PORT HURON, MI 48060<br>38-2485700 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 12A, I | N/A | | No |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>38-2559656 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>93-0907047 | LONG TERM CARE | IN | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>82-4005577 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>38-2113393 | HEALTH CARE AND HOSPITAL SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>35-1443425 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C)(3) | LINE 12B, II | CATHOLIC HEALTH MINISTRIES | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>47-5244984 | PACE PROGRAM | PA | 501(C)(3) | LINE 10 | TRINITY HEALTH PACE | Yes | |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1491191 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | CT | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No |
| 114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1450168 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>47-3073124 | PACE PROGRAM | MI | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>20-8151733 | RETIREE MEDICAL AND RETIREE LIFE INSURANCE | MI | 501(C)(9) | N/A | TRINITY HEALTH CORPORATION | Yes | |
| 17410 COLLEGE PARKWAY STE 150<br>LIVONIA, MI 48152<br>38-2621935 | MANAGEMENT SERVICES FOR HOME HEALTH SYSTEM | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| 3805 WEST CHESTER PIKE SUITE 100<br>NEWTOWN SQUARE, PA 19073<br>15-0532190 | HEALTH CARE SERVICES (INACTIVE) | NY | 501(C)(3) | LINE 3 | MERCY UIHLEIN HEALTH CORPORATION | Yes | |
| 301 HACKETT BLVD<br>ALBANY, NY 12208<br>14-1438749 | LONG TERM CARE | NY | 501(C)(3) | LINE 3 | ST PETER'S HOSPITAL | Yes | |
| 1820 44TH STREET<br>KENTWOOD, MI 49508<br>38-3280200 | HEALTH NETWORK | MI | 501(C)(4) | N/A | MERCY HEALTH PARTNERS | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | | Yes | No | |
| ADVENT REHABILITATION LLC<br><br>607 DEWEY AVENUE SUITE 300<br>GRAND RAPIDS, MI 49504<br>38-3306673 | REHABILITATION THERAPY SERVICES | MI | N/A | | | | | | | | | |
| BIG RUN MEDICAL OFFICE BUILDING LIMITED PARTNERSHIP<br><br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1608125 | MEDICAL OFFICE BUILDING RENTAL | OH | N/A | | | | | | | | | |
| CATHERINE HORAN BUILDING ASSOCIATES LP<br><br>1221 MAIN STREET SUITE 105<br>HOLYOKE, MA 01040<br>04-2723429 | PROPERTY MANAGEMENT | MA | N/A | | | | | | | | | |
| CENTENNIAL SURGUNIT LLC<br><br>502 CENTENNIAL BLVD SUITE 1<br>VOORHEES, NJ 08043<br>22-3580847 | HEALTH CARE SERVICES | NJ | N/A | | | | | | | | | |
| CENTER FOR DIGESTIVE CARE LLC<br><br>5300 ELLIOTT DRIVE<br>YPSILANTI, MI 48197<br>03-0447062 | PROVIDE GASTROINTESTINAL SERVICES | MI | N/A | | | | | | | | | |
| CENTRAL NEW JERSEY HEART SERVICES LLC<br><br>45 SAPPHIRE DRIVE<br>PRINCETON, NJ 08550<br>20-8525458 | CARDIAC PROGRAM | NJ | N/A | | | | | | | | | |
| CLINTON IMAGING SERVICES LLC<br><br>615 VALLEY VIEW DR STE 202<br>MOLINE, IL 61265<br>41-2044739 | MRI DIAGNOSTIC SERVICES | IA | N/A | | | | | | | | | |
| DIAGNOSTIC IMAGING OF SOUTHBURY LLC<br><br>385 MAIN STREET SOUTH<br>SOUTHBURY, CT 06488<br>06-1487582 | IMAGING CENTER | CT | N/A | | | | | | | | | |
| FOREST PARK IMAGING LLC<br><br>1000 4TH STREET SW<br>MASON CITY, IA 50401<br>13-4365966 | X-RAY AND MAMMOGRAPHY SERVICES | IA | N/A | | | | | | | | | |
| FRANCES WARDE MEDICAL LABORATORY<br><br>300 WEST TEXTILE ROAD<br>ANN ARBOR, MI 48104<br>38-2648446 | LABORATORY | MI | N/A | | | | | | | | | |
| GATEWAY HEALTH PLAN LP<br><br>444 LIBERTY AVE SUITE 2100<br>PITTSBURGH, PA 15222<br>25-1691945 | MEDICAID & MEDICARE/SPECIAL NEEDS MANAGED CARE ORGANIZATION | PA | N/A | | | | | | | | | |
| GREATER HARTFORD LITHOTRIPSY LLC<br><br>114 WOODLAND ST<br>HARTFORD, CT 06105<br>06-1578891 | LITHOTRIPSY SERVICES | CT | N/A | | | | | | | | | |
| HAWARDEN REGIONAL HEALTH CLINICS LLC<br><br>1122 AVENUE L<br>HAWARDEN, IA 51023<br>20-1444339 | MEDICAL CLINIC | IA | N/A | | | | | | | | | |
| HEART INSITUTE OF ST MARY LLC<br><br>1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>45-4903701 | CARDIOVASCULAR SERVICES | PA | N/A | | | | | | | | | |
| IDAHO ASC HOLDINGS LLC<br><br>1055 N CURTIS ROAD<br>BOISE, ID 83706<br>36-4729605 | HOLDING COMPANY FOR AMBULATORY SURGERY | ID | N/A | | | | | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | | Yes | No | |
| INNOVATIVE HEALTH ALLIANCE OF NEW YORK LLC<br><br>14 COLUMBIA CIRCLE DRIVE<br>ALBANY, NY 12203<br>46-5676066 | ACCOUNTABLE CARE ORGANIZATION | NY | N/A | | | | | | | | | |
| LOYOLA AMBULATORY SURGERY CENTER AT OAKBROOK LP<br><br>569 BROOKWOOD VILLAGE<br>SUITE 901<br>BIRMINGHAM, AL 35209<br>36-4119522 | SURGICAL SERVICES | IL | N/A | | | | | | | | | |
| MAGNETIC RESONANCE SERVICES PARTNERSHIP<br><br>1416 SIXTH STREET SW<br>MASON CITY, IA 50401<br>42-1328388 | MRI SERVICES | IA | N/A | | | | | | | | | |
| MASON CITY AMBULATORY SURGERY CENTER LLC<br><br>990 4TH STREET SW<br>MASON CITY, IA 50401<br>20-1960348 | SURGERY-SAME DAY | IA | N/A | | | | | | | | | |
| MCE MOB IV LIMITED PARTNERSHIP<br><br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>42-1544707 | MEDICAL OFFICE BUILDING RENTAL | OH | N/A | | | | | | | | | |
| MDRMRI TECHNICAL SERVICES LLC<br><br>5640 EAST TAFT ROAD 3770<br>SYRACUSE, NY 13220<br>16-1590982 | MRI SERVICES | NY | N/A | | | | | | | | | |
| MEDILUCENT MOB I<br><br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>20-4911370 | MEDICAL OFFICE BUILDING RENTAL | OH | N/A | | | | | | | | | |
| MEDWORKS LLC<br><br>375 EAST CEDAR STREET<br>NEWINGTON, CT 06111<br>06-1490483 | REHABILITATION SERVICES | CT | N/A | | | | | | | | | |
| MERCY ADVANCED MRI LLC<br><br>2525 SOUTH MICHIGAN AVE<br>CHICAGO, IL 60616<br>26-2116721 | SUBLEASE MRI EQUIPMENT | IL | N/A | | | | | | | | | |
| MERCY HEART CTR OP SERVICES LLC<br><br>1000 4TH STREET SW<br>MASON CITY, IA 50401<br>13-4237594 | CARDIOVASCULAR SERVICES | IA | N/A | | | | | | | | | |
| MERCYMANOR PARTNERSHIP<br><br>PO BOX 10086<br>TOLEDO, OH 43699<br>52-1931012 | NURSING HOME | PA | N/A | | | | | | | | | |
| MERCYUSP HEALTH VENTURES LLC<br><br>15305 DALLAS PARKWAY STE<br>1600 LB 28<br>ADDISON, TX 75001<br>47-1290300 | OUTPATIENT SURGERY | IA | N/A | | | | | | | | | |
| MOUNT CARMEL EAST POB III LIMITED PARTNERSHIP<br><br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1369473 | MEDICAL OFFICE BUILDING RENTAL | OH | N/A | | | | | | | | | |
| NAUGATUCK VALLEY MRI LLC<br><br>385 MAIN STREET SOUTH<br>SOUTHBURY, CT 06488<br>06-1239526 | IMAGING CENTER | CT | N/A | | | | | | | | | |
| NAZARETH MEDICAL OFFICE BUILDING ASSOCIATES LP<br><br>C/O NAZARETH HOSP 2601<br>HOLME AVE<br>PHILADELPHIA, PA 19152<br>23-2388040 | MEDICAL OFFICE BUILDING | PA | N/A | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | | Yes | No | |
| OSWEGO HEALTH HOME CARE LLC<br><br>113 SCHUYLER STREET<br>FULTON, NY 13069<br>47-2463736 | HOME HEALTH CARE | NY | N/A | | | | | | | | | |
| PHYSICIANS OUTPATIENT SURGERY CENTER LLC<br><br>1000 NE 56TH STREET<br>OAKLAND PARK, FL 33334<br>35-2325646 | AMBULATORY SURGERY CENTER | FL | N/A | | | | | | | | | |
| PRIMARY CARE PHYSICIAN CENTER LLC<br><br>1445 ROSS AVENUE SUITE 1400<br>DALLAS, TX 75202<br>36-4038505 | OFFICE BUILDING RENTAL | IL | N/A | | | | | | | | | |
| RADISSON SJH PROPERTIES LLC<br><br>5000 CAMPUSWOOD DRIVE SUITE 100<br>EAST SYRACUSE, NY 13057<br>46-1892799 | MEDICAL OFFICE BUILDING | NY | N/A | | | | | | | | | |
| SARMED OUTPATIENT PHARMACY LLC<br><br>999 N CURTIS RD STE 102<br>BOISE, ID 83706<br>51-0483218 | PHARMACY | ID | N/A | | | | | | | | | |
| SIXTY FOURTH STREET LLC<br><br>2373 64TH ST STE 2200<br>BYRON CENTER, MI 49315<br>20-2443646 | PROVIDE OUTPATIENT SURGICAL CARE | MI | N/A | | | | | | | | | |
| SJLS LLC<br><br>7650 SE 27TH ST STE 200<br>MERCER ISLAND, WA 98040<br>20-1796650 | DIALYSIS SERVICES | NY | N/A | | | | | | | | | |
| SJV MANAGEMENT LLC<br><br>200 CENTURY PKWY STE 200E<br>MOUNT LAUREL, NJ 08054<br>20-2273476 | RADIOLOGY | NJ | N/A | | | | | | | | | |
| SMMC MOB II LP<br><br>1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>36-4559869 | INVESTMENT AND OPERATION OF A MEDICAL BUILDING | PA | N/A | | | | | | | | | |
| ST AGNES LONG-TERM INTENSIVE CARE LLP<br><br>C/O MHS ONE WEST ELM ST STE 100<br>CONSHOHOCKEN, PA 19428<br>20-0984882 | LONG TERM INTENSIVE CARE | PA | N/A | | | | | | | | | |
| ST ALPHONSUS CALDWELL CANCER CTR LLC<br><br>3123 MEDICAL DR<br>CALDWELL, ID 83605<br>82-0526861 | HEALTH CARE SERVICES | ID | N/A | | | | | | | | | |
| ST ANN'S MEDICAL OFFICE BLDG II LIMITED PARTNERSHIP<br><br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1603660 | MEDICAL OFFICE BUILDING RENTAL | OH | N/A | | | | | | | | | |
| ST JOSEPH'S IMAGING ASSOCIATES PLLC<br><br>104 UNION AVE SUITE 905<br>SYRACUSE, NY 13203<br>16-1104293 | RADIOLOGY SERVICES | NY | N/A | | | | | | | | | |
| ST MARY REHABILITATION HOSPITAL LLP<br><br>680 SOUTH FOURTH STREET<br>LOUISVILLE, KY 40202<br>27-3938747 | HEALTH CARE SERVICES | DE | N/A | | | | | | | | | |
| ST PETER'S AMBULATORY SURGERY CENTER LLC<br><br>1375 WASHINGTON AVENUE STE 201<br>ALBANY, NY 12206<br>46-0463892 | OUTPATIENT SURGERY | NY | N/A | | | | | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Yes | No | | Yes | No | |
| TAMARACK MEDICAL CLINIC LLC<br><br>402 LAKE CASCADE PARKWAY<br>CASCADE, ID 83611<br>20-1637921 | OUTPATIENT MEDICAL SERVICES | ID | N/A | | | | | | | | | |
| THE AMBULATORY SURGERY CENTER AT ST MARY LLC<br><br>1203 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>27-2871206 | OUTPATIENT SURGERY | PA | N/A | | | | | | | | | |
| WOODLAND IMAGING CENTER LLC<br><br>5301 E HURON RIVER DR<br>ANN ARBOR, MI 48106<br>76-0820959 | RADIOLOGY/ IMAGING | MI | N/A | | | | | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| AFFILIATED MANAGEMENT SERVICES CORPORATION INC<br>1300 MASSACHUSETTS AVENUE<br>TROY, NY 12180<br>14-1668024 | REAL ESTATE | NY | N/A | C | | | | Yes | |
| CATHERINE HORAN BUILDING CORPORATION<br>1233 MAIN STREET<br>HOLYOKE, MA 01040<br>04-2938160 | BUILDING MANAGEMENT | MA | N/A | C | | | | Yes | |
| CHESTNUT RISK SERVICES LTD<br>11 VICTORIA STREET<br>HAMILTON<br>BD | INSURANCE | BD | N/A | C | | | | Yes | |
| DIVERSIFIED COMMUNITY SERVICES INC<br>1233 MAIN STREET<br>HOLYOKE, MA 01040<br>04-3128890 | MEDICAL SERVICES | MA | N/A | C | | | | Yes | |
| FHS SERVICES INC<br>333 BUTTERNUT DRIVE SUITE 100<br>DEWITT, NY 13214<br>27-2995699 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN ASSOCIATES INC<br>333 BUTTERNUT DRIVE SUITE 100<br>DEWITT, NY 13214<br>20-2991688 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN HEALTH SUPPORT INC<br>333 BUTTERNUT DRIVE SUITE 100<br>DEWITT, NY 13214<br>16-1236354 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN MANAGEMENT SERVICES INC<br>333 BUTTERNUT DRIVE SUITE 100<br>DEWITT, NY 13214<br>16-1351193 | MANAGEMENT SERVICES | NY | N/A | C | | | | Yes | |
| FRANKLIN MEDICAL GROUP PC<br>56 FRANKLIN ST<br>WATERBURY, CT 06706<br>06-1470493 | PHYSICIAN OFFICE | CT | N/A | C | | | | Yes | |
| GOTTLIEB MANAGEMENT SERVICES INC<br>701 W NORTH AVE<br>MELROSE PARK, IL 60160<br>36-3330529 | MANAGEMENT SERVICES | IL | N/A | C | | | | Yes | |
| HEF INC<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-3086401 | OFFICE STAFFING | MI | N/A | C | | | | Yes | |
| HACKLEY HEALTH MANAGEMENT CENTER<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-2961814 | WEIGHT MANAGEMENT | MI | N/A | C | | | | Yes | |
| HACKLEY HEALTH VENTURES INC<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-2589959 | OTHER MEDICAL SERVICES | MI | N/A | C | | | | Yes | |
| HACKLEY HEALTHCARE EQUIPMENT<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-2578569 | HOME MEDICAL EQUIPMENT | MI | N/A | C | | | | Yes | |
| HACKLEY PROFESSIONAL PHARMACY<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-2447870 | PHARMACY | MI | N/A | C | | | | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| HEALTH CARE MANAGEMENT<br>333 BUTTERNUT DRIVE SUITE 100<br>DEWITT, NY 13214<br>16-1450960 | HEALTH CARE MANAGEMENT | NY | N/A | C | | | | Yes | |
| HEALTH MANAGEMENT SERVICES ORG INC<br>500 GROVE STREET SUITE 100<br>HADDON HEIGHTS, NJ 08035<br>22-3366580 | MEDICAL ADMINISTRATION | NJ | N/A | C | | | | Yes | |
| HOLY CROSS PRIVATE HOME SERVICES CORP<br>1500 FOREST GLEN RD<br>SILVER SPRING, MD 20910<br>52-1986562 | HOME CARE SERVICES | MD | N/A | C | | | | Yes | |
| HURON ARBOR CORPORATION<br>5301 EAST HURON RIVER DR<br>ANN ARBOR, MI 48106<br>38-2475644 | PROVIDES OFFICE RENTAL SPACE | MI | N/A | C | | | | Yes | |
| IHA AFFILIATION CORPORATION<br>24 FRANK LLOYD WRIGHT DR LOBBY J<br>ANN ARBOR, MI 48106<br>38-3188895 | MEDICAL MANAGEMENT | MI | N/A | C | | | | Yes | |
| LANGHORNE SERVICES II INC<br>1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>26-3795549 | GENERAL PARTNER OF LMOB PARTNERS, II | PA | N/A | C | | | | Yes | |
| LANGHORNE SERVICES INC<br>1201 LANGHORNE-NEWTOWN ROAD<br>LANGHORNE, PA 19047<br>23-2625981 | GENERAL PARTNER OF LMOB PARTNERS | PA | N/A | C | | | | Yes | |
| LOURDES MEDICAL ASSOCIATES PA<br>500 GROVE STREET SUITE 100<br>HADDON HEIGHTS, NJ 08035<br>22-3361862 | MEDICAL SERVICES | NJ | N/A | C | | | | Yes | |
| LOURDES URGENT CARE SERVICES PC<br>1600 HADDON AVENUE<br>CAMDEN, NJ 08103<br>46-4188202 | URGENT CARE CENTER | NJ | N/A | C | | | | Yes | |
| MACNEAL HEALTH PROVIDERS INC<br>750 PASQUINELLI DR SUITE 216<br>WESTMONT, IL 60559<br>36-3361297 | MEDICAL SERVICES | IL | N/A | C | | | | Yes | |
| MARYLAND CARE GROUP INC<br>1500 FOREST GLEN RD<br>SILVER SPRING, MD 20910<br>52-1815313 | HEALTH CARE HOLDING | MD | N/A | C | | | | Yes | |
| MCMC EASTWICK INC<br>C/O MHS ONE WEST ELM STREET STE 100<br>CONSHOHOCKEN, PA 19428<br>23-2184261 | MEDICAL OFFICE BUILDINGS | PA | N/A | C | | | | Yes | |
| MEDNOW INC<br>1512 12TH AVENUE ROAD<br>NAMPA, ID 83686<br>82-0389927 | MEDICAL SERVICES | ID | N/A | C | | | | Yes | |
| MERCY HOME CARE INC<br>1233 MAIN STREET<br>HOLYOKE, MA 01040<br>04-3317426 | HEALTH CARE SERVICES | MA | N/A | C | | | | Yes | |
| MERCY INPATIENT MEDICAL ASSOCIATES INC<br>1233 MAIN STREET<br>HOLYOKE, MA 01040<br>04-3029929 | MEDICAL SERVICES | MA | N/A | C | | | | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| MERCY MEDICAL SERVICES<br>801 5TH STREET<br>SIOUX CITY, IA 51101<br>42-1283849 | PRIMARY CARE PHYSICIANS | IA | N/A | C | | | | Yes | |
| MERCY SERVICES CORPORATION<br>2525 SOUTH MICHIGAN AVENUE<br>CHICAGO, IL 60616<br>36-3227348 | DORMANT | IL | N/A | C | | | | Yes | |
| MOUNT CARMEL HEALTH PROVIDERS INC<br>6150 EAST BROAD STREET<br>COLUMBUS, OH 43213<br>31-1382442 | MEDICAL SERVICES | OH | N/A | C | | | | Yes | |
| NURSING NETWORK INC<br>4725 NORTH FEDERAL HIGHWAY<br>FORT LAUDERDALE, FL 33308<br>59-1145192 | MEDICAL SERVICES | FL | N/A | C | | | | Yes | |
| SAINT ALPHONSUS HEALTH ALLIANCE INC<br>1055 NORTH CURTIS ROAD<br>BOISE, ID 83706<br>82-0524649 | ACCOUNTABLE CARE ORGANIZATION | ID | N/A | C | | | | Yes | |
| SAINT ALPHONSUS PHYSICIANS PA<br>1055 NORTH CURTIS ROAD<br>BOISE, ID 83706<br>33-1078261 | HEALTH CARE SERVICES (INACTIVE) | ID | SAINT ALPHONSUS REGIONAL MEDICAL CENTER | C | | | 100 000 % | Yes | |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP PC<br>114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1384686 | MEDICAL SERVICES | CT | N/A | C | | | | Yes | |
| SAINT FRANCIS CARE MEDICAL GROUP PC<br>114 WOODLAND STREET<br>HARTFORD, CT 06105<br>06-1432373 | MEDICAL SERVICES | CT | N/A | C | | | | Yes | |
| SAMARITAN MEDICAL OFFICE BUILDING INC<br>2212 BURDETT AVENUE<br>TROY, NY 12180<br>14-1607244 | REAL ESTATE | NY | N/A | C | | | | Yes | |
| SJM PROPERTIES INC<br>411 CANISTEO STREET<br>HORNELL, NY 14843<br>16-1294991 | PROPERTY HOLDINGS | NY | N/A | C | | | | Yes | |
| SJPE PRACTICE MANAGEMENT SERVICES INC<br>301 PROSPECT AVE<br>SYRACUSE, NY 13203<br>45-4164964 | MANAGEMENT SERVICES | NY | N/A | C | | | | Yes | |
| SJRMC HOLDINGS INC<br>5215 HOLY CROSS PARKWAY<br>MISHAWAKA, IN 46545<br>47-4763735 | PROPERTY HOLDINGS | IN | N/A | C | | | | Yes | |
| ST ELIZABETH HEALTH SUPPORT SERVICES INC<br>2209 GENESEE STREET<br>UTICA, NY 13501<br>16-1540486 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| ST MARY'S HIGHLAND HILLS VILLAGE INC<br>1230 BAXTER STREET<br>ATHENS, GA 30606<br>58-2276801 | ASSISTED LIVING | GA | N/A | C | | | | Yes | |
| SYSTEM COORDINATED SERVICES INC<br>1233 MAIN STREET<br>HOLYOKE, MA 01040<br>04-2938161 | LAB SERVICES | MA | N/A | C | | | | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| THRE SERVICES LLC<br>20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>45-2603654 | REAL ESTATE BROKERAGE SERVICES | MI | N/A | C | | | | Yes | |
| TRI-HOSPITAL MRI CENTER<br>4190 24TH AVENUE<br>FORT GRATIOT, MI 48054<br>38-2884297 | HEALTH CARE SERVICES | MI | N/A | C | | | | Yes | |
| TRINITY ASSURANCE LTD<br>PO BOX 1159 GRAND CAYMAN<br>GRAND CAYMAN<br>CJ 98-0453602 | SELF-INSURANCE | CJ | N/A | C | | | | Yes | |
| TRINITY HEALTH ACO INC<br>20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>47-3794666 | ACCOUNTABLE CARE ORGANIZATION | DE | N/A | C | | | | Yes | |
| TRINITY HEALTH EMPLOYEE BENEFIT TRUST<br>20555 VICTOR PARKWAY<br>LIVONIA, MI 48152<br>38-3410377 | GRANTOR TRUST | MI | N/A | T | | | | Yes | |
| TRINITY SENIOR SERVICES MANAGEMENT INC<br>PO BOX 9184<br>FARMINGTON HILLS, MI 48333<br>37-1572595 | SENIOR SERVICES | PA | N/A | C | | | | Yes | |
| WORKPLACE HEALTH OF GRAND HAVEN INC<br>1820 44TH STREET SE<br>KENTWOOD, MI 49508<br>38-3112035 | OCCUPATIONAL HEALTH | MI | N/A | C | | | | Yes | |

**Form 990, Schedule R, Part V - Transactions With Related Organizations**

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|---|---|---|---|
| SAINT ALPHONSUS CALDWELL CANCER CENTER LLC | L | 963,994 | PER BOOKS |
| SAINT ALPHONSUS HEALTH ALLIANCE INC | L | 807,249 | PER BOOKS |
| SAINT ALPHONSUS HEALTH ALLIANCE INC | M | 285,432 | PER BOOKS |
| SAINT ALPHONSUS HEALTH SYSTEM INC | B | 118,908 | PER BOOKS |
| SAINT ALPHONSUS HEALTH SYSTEM INC | L | 929,410 | PER BOOKS |
| SAINT ALPHONSUS HEALTH SYSTEM INC | M | 71,784,402 | PER BOOKS |
| SAINT ALPHONSUS HEALTH SYSTEM INC | P | 3,638,700 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA INC | L | 113,512 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA INC | M | 556,582 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA INC | P | 167,132 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-NAMPA INC | Q | 182,837 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-BAKER CITY INC | L | 171,907 | PER BOOKS |
| SAINT ALPHONSUS MEDICAL CENTER-ONTARIO INC | L | 335,605 | PER BOOKS |
| TRINITY HEALTH - MICHIGAN | C | 159,716 | PER BOOKS |
| TRINITY HEALTH - MICHIGAN | M | 794,232 | PER BOOKS |
| TRINITY HEALTH CORPORATION | B | 15,726,548 | PER BOOKS |
| TRINITY HEALTH CORPORATION | C | 609,723 | PER BOOKS |
| TRINITY HEALTH CORPORATION | L | 201,611 | PER BOOKS |
| TRINITY HEALTH CORPORATION | M | 17,671,524 | PER BOOKS |
| TRINITY HEALTH CORPORATION | P | 7,041,449 | PER BOOKS |
| TRINITY HEALTH CORPORATION | Q | 5,643,402 | PER BOOKS |
| TRINITY HEALTH CORPORATION | R | 7,556,547 | PER BOOKS |