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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

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

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018 , and ending 12-31-2018

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

C Name of organization
St Elizabeth Medical Center Inc

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
One Medical Village Drive

City or town, state or province, country, and ZIP or foreign postal code
Edgewood, KY 41017

D Employer identification number
61-0445850

E Telephone number
(859) 655-1642

G Gross receipts $ 1,570,768,874

F Name and address of principal officer
Garren Colvin
One Medical Village Drive
Edgewood, KY 41017

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 ▶

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

J Website: ▶ www stelizabeth com

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

L Year of formation 1861

M State of legal domicile KY

Part I Summary

1 Briefly describe the organization's mission or most significant activities
AS A CATHOLIC HEALTHCARE MINISTRY, WE PROVIDE COMPREHENSIVE AND COMPASSIONATE CARE THAT IMPROVES THE HEALTH OF THE PEOPLE WE SERVE

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**	18
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 2018 (Part V, line 2a)	**5**	8,059
6	Total number of volunteers (estimate if necessary)	**6**	1,571
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	3,534,465
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	3,590,400	8,067,640
9	Program service revenue (Part VIII, line 2g)	1,142,301,509	1,182,872,415
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	36,796,855	28,190,465
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,285,430	5,654,041
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,187,974,194	1,224,784,561
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	8,763,415	4,485,576
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	505,761,860	531,545,385
16a	Professional fundraising fees (Part IX, column (A), line 11e)	34,600	60,000
b	Total fundraising expenses (Part IX, column (D), line 25) ▶1,861,361		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	563,200,526	599,920,005
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	1,077,760,401	1,136,010,966
19	Revenue less expenses Subtract line 18 from line 12	110,213,793	88,773,595

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,768,297,483	1,837,486,904
21	Total liabilities (Part X, line 26)	465,018,278	503,171,056
22	Net assets or fund balances Subtract line 21 from line 20	1,303,279,205	1,334,315,848

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

****** 2019-11-12
Signature of officer Date

LORI RITCHEY-BALDWIN CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P01316095

Firm's name ▶ CROWE LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 9600 Brownsboro Road Suite 400
Louisville, KY 402411122 — Phone no (502) 326-3996

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

AS A CATHOLIC HEALTHCARE MINISTRY, WE PROVIDE COMPREHENSIVE AND COMPASSIONATE CARE THAT IMPROVES THE HEALTH OF THE PEOPLE WE SERVE

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 691,044,211 including grants of $ 4,485,576) (Revenue $ 1,177,386,147)

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 ▶ 691,044,211

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		
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		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *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		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
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	Yes	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17	Yes	
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	Yes	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
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		No

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *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**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**	Yes	
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**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
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**	Yes	
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**	Yes	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		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**	Yes	
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**	Yes	
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**	601		
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**	8,059		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	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**	Yes
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**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N			**15**	Yes
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	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**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		**5**		No
6	Did the organization have members or stockholders?		**6**		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		**7a**	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		**7b**	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?		**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*		**9**		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A 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 ▶LORI RITCHEY-BALDWIN ONE MEDICAL VILLAGE DRIVE EDGEWOOD, KY 41017 (859) 655-1642

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										

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										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, **Section A** ▶										
d Total (add lines 1b and 1c) ▶								17,774,717	1,482,735	1,515,759

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 ▶ 523

			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
Danis Building Construction Company 50 E Business Way Cincinnati, OH 45241	Construction	13,759,754
Intuitive Surgical Inc PO Box 39000 Dept 33629 San Francisco, CA 94139	Technical Services	10,932,692
Turner Construction Company 250 West Court St Suite 300 Cincinnati, OH 45202	Construction	9,999,735
Epic Systems Corporation PO Box 88314 Milwaukee, WI 523880314	Technical Services	8,127,155
Hammel Green and Abrahamson Inc SDS 12-1861 PO Box 86 Minneapolis, MN 554861861	Architectural Services	5,098,229

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 ▶ 202

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	61,423			
d Related organizations	1d				
e Government grants (contributions)	1e	2,086,567			
f All other contributions, gifts, grants, and similar amounts not included above	1f	5,919,650			
g Noncash contributions included in lines 1a - 1f $ 156,803					
h **Total.** Add lines 1a-1f		8,067,640			
Program Service Revenue	Business Code				
2a NET PATIENT REVENUE	621400	1,046,290,511	1,046,290,511		
b OTHER RELATED REVENUE	900099	63,122,956	63,122,956		
c PATIENT/EMPLOYEE DRUGS	446110	4,843,835		2,859,038	1,984,797
d LABORATORY	621500	68,615,113	67,972,680	642,433	
e					
f All other program service revenue		0	0	0	0
g **Total.** Add lines 2a–2f		1,182,872,415			
3 Investment income (including dividends, interest, and other similar amounts)		22,195,958		32,994	22,162,964
4 Income from investment of tax-exempt bond proceeds		189,392			189,392
5 Royalties					
6a Gross rents (i) Real 2,249,149 (ii) Personal					
b Less rental expenses (i) Real 2,480,586 (ii) Personal					
c Rental income or (loss) (i) Real -231,437 (ii) Personal 0					
d Net rental income or (loss)		-231,437			-231,437
7a Gross amount from sales of assets other than inventory (i) Securities 347,495,747 (ii) Other 1,539,788					
b Less cost or other basis and sales expenses (i) Securities 341,570,026 (ii) Other 1,660,394					
c Gain or (loss) (i) Securities 5,925,721 (ii) Other -120,606					
d Net gain or (loss)		5,805,115			5,805,115
Other Revenue 8a Gross income from fundraising events (not including $ 61,423 of contributions reported on line 1c) See Part IV, line 18 a	384,346				
b Less direct expenses b	272,821				
c Net income or (loss) from fundraising events		111,525			111,525
9a Gross income from gaming activities See Part IV, line 19 a	7,204				
b Less direct expenses b	486				
c Net income or (loss) from gaming activities		6,718			6,718
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 CAFETERIA	722210	3,979,007			3,979,007
b GIFT SHOP	900099	1,666,961			1,666,961
c VENDING	453220	121,267			121,267
d All other revenue		0	0	0	0
e **Total.** Add lines 11a–11d		5,767,235			
12 **Total revenue.** See Instructions		1,224,784,561	1,177,386,147	3,534,465	35,796,309

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	4,485,576	4,485,576		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
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	13,361,840	9,412,953	3,923,930	24,957
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	406,690,957	301,462,625	104,434,217	794,115
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	22,558,594	15,891,748	6,624,713	42,133
9 Other employee benefits	60,810,224	44,832,934	15,874,056	103,234
10 Payroll taxes	28,123,770	21,256,637	6,805,770	61,363
11 Fees for services (non-employees)				
a Management				
b Legal	3,413,591	16,160	3,397,431	
c Accounting	687,663	9,997	677,666	
d Lobbying				
e Professional fundraising services See Part IV, line 17	60,000			60,000
f Investment management fees	1,867,872		1,867,372	500
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	198,166,888	53,412,998	144,735,990	17,900
12 Advertising and promotion	11,608,806	567,177	10,822,142	219,487
13 Office expenses	4,378,327	2,165,184	2,024,303	188,840
14 Information technology	16,988,882	874,645	16,057,494	56,743
15 Royalties				
16 Occupancy	12,359,741	904,042	11,455,699	
17 Travel	914,437	427,523	482,231	4,683
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	2,730,384	492,873	2,073,743	163,768
20 Interest	5,963,458		5,963,458	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	67,973,397	12,806	67,960,591	
23 Insurance	2,407,527		2,407,527	
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	184,401,011	180,422,031	3,978,330	650
b BAD DEBT	39,007,910	39,007,910		
c GENERAL SUPPLIES	24,998,198	13,941,585	10,984,411	72,202
d PROVIDER TAX	12,549,589		12,549,589	
e All other expenses	9,502,324	1,446,807	8,004,731	50,786
25 **Total functional expenses.** Add lines 1 through 24e	1,136,010,966	691,044,211	443,105,394	1,861,361
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		3,558,922	1	3,558,922
	2	Savings and temporary cash investments		87,130,693	2	76,027,737
	3	Pledges and grants receivable, net		3,601,682	3	6,102,637
	4	Accounts receivable, net		121,240,249	4	121,911,389
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		3,448,615	5	9,368,104
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		0	6	0
	7	Notes and loans receivable, net		5,573,148	7	8,388,469
	8	Inventories for sale or use		27,521,732	8	30,391,581
	9	Prepaid expenses and deferred charges		9,929,897	9	8,683,313
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 1,038,455,258			
	b	Less accumulated depreciation	10b 595,657,670	441,650,693	10c	442,797,588
	11	Investments—publicly traded securities		726,973,696	11	689,095,772
	12	Investments—other securities See Part IV, line 11		308,973,520	12	376,682,604
	13	Investments—program-related See Part IV, line 11		6,014,340	13	14,751,767
	14	Intangible assets		13,396,082	14	13,454,499
	15	Other assets See Part IV, line 11		9,284,214	15	36,272,522
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,768,297,483	16	1,837,486,904
Liabilities	17	Accounts payable and accrued expenses		135,246,798	17	167,566,556
	18	Grants payable			18	
	19	Deferred revenue		5,191,317	19	4,177,903
	20	Tax-exempt bond liabilities		190,721,239	20	210,006,462
	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		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties			23	
	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		133,858,924	25	121,420,135
	26	**Total liabilities.** Add lines 17 through 25		465,018,278	26	503,171,056
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		1,105,217,011	27	1,311,553,091
	28	Temporarily restricted net assets		7,450,380	28	13,002,103
	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		190,611,814	32	9,760,654
	33	Total net assets or fund balances		1,303,279,205	33	1,334,315,848
	34	Total liabilities and net assets/fund balances		1,768,297,483	34	1,837,486,904

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	1,224,784,561
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,136,010,966
3	Revenue less expenses Subtract line 2 from line 1	3	88,773,595
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,303,279,205
5	Net unrealized gains (losses) on investments	5	-71,592,006
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	13,855,054
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,334,315,848

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		No
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		

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

Form 990 (2018)

Form 990, Part III, Line 4a:

St Elizabeth Healthcare is one of the oldest, largest and most respected medical providers in the Northern Kentucky, Southern Ohio and Southern Indiana Areas For more than 150 years, St Elizabeth has been the heart and soul of healthcare in Northern Kentucky Founded with one small hospital in 1861, St Elizabeth Healthcare now operates five facilities throughout Northern Kentucky - St Elizabeth Covington, St Elizabeth Edgewood, St Elizabeth Florence, St Elizabeth Ft Thomas and St Elizabeth Grant St Elizabeth Healthcare is sponsored by the Diocese of Covington and provided more than $117 million in uncompensated care and benefit to the community in 2017 Within our thriving, multi-faceted organization, some of the nation's top medical professionals are working together to deliver the best care available to these areas Our mission is to provide comprehensive and compassionate care that improves the health of the people we serve We accomplish this through state-of the-art technology and our dedicated associates, led by a well-respected board and executive leadership team who love this organization and our community St Elizabeth Healthcare's state-of-the-art technology includes a secure, internal electronic medical records system that not only gives providers access to their patients' medical records at any St Elizabeth Healthcare or St Elizabeth Physicians facility, but also gives you, the patient, faster, more convenient access to your personal medical records, test results and healthcare providers through a web portal called "MyChart " St Elizabeth Healthcare also became the first and only healthcare system in Kentucky, Ohio or Indiana to pass Mayo Clinic's rigorous review process and become a member of the Mayo Clinic Care Network, a collaboration that allows physicians from St Elizabeth Healthcare to consult with Mayo Clinic physicians, providing even better care to our patients St Elizabeth Healthcare has invested in our community for generations St Elizabeth Healthcare believes that reaching out to help the underprivileged and improving the overall health of the community is the foundation of its mission to provide comprehensive and compassionate care to our neighborhood and our families It is because of this belief that the St Elizabeth Healthcare community benefit program helps others have access to St Elizabeth Healthcare resources and services It is St Elizabeth Healthcare's intention to always balance financial viability with compassionate care, and to stay true to its non-profit roots During 2018 St Elizabeth Healthcare had total admissions of 90,010, total patient visits of 200,163 and total emergency room visits of 191,794

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			
GARREN COLVIN PRESIDENT/CEO	50 0 5 0	X		X				1,215,287	0	51,735
ROBERT BAKER MD PHYSICIAN / DIRECTOR	4 0 50 0	X						0	174,600	48,950
MICHAEL A CONNER TRUSTEE	4 0 0	X						4,310	0	0
MARSHA CROXTON TRUSTEE	4 0 0	X						3,034	0	0
THOMAS R DIETZ TRUSTEE	4 0 0	X						17,694	0	0
CHRISTOPER FISTER TRUSTEE	4 0 0	X						4,009	0	0
DOUG FLORA MD TRUSTEE	4 0 50 0	X						0	784,185	56,563
GEORGE S HALL MD Former VP Medical Affairs/TRUSTEE	4 0 0	X						0	0	0
MICHAEL E JONES TRUSTEE	4 0 0	X						1,776	0	0
TILLIE HIDALGO LIMA Trustee	4 0 0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GARY W MOORE TRUSTEE	4 0 0	X						4,025	0	0
HEIDI MURLEY MD TRUSTEE	4 0 ..... 50 0	X						0	523,950	37,181
ROGER PETERMAN TRUSTEE	4 0 0	X						16,396	0	0
JAMES ROEBKER TRUSTEE	4 0 0	X						9,533	0	0
DEBBIE SIMPSON Trustee	4 0 0	X						0	0	0
ROBERT HOFFER TRUSTEE/FOUNDATION CHAIRMAN	4 0 0	X						1,694	0	0
JAMES VOTRUBA Chairman	4 0 0	X						2,261	0	0
FRED A MACKE JR VICE CHAIRMAN	4 0 0	X						20,741	0	0
GARY BLANK EXECUTIVE VP & COO, CNE	50 0 ..... 1 0			X				653,639	0	24,563
LISA FREY VP LEGAL SERVICES/GENERAL COUNSEL/CORPORATE SECRETARY	50 0 ..... 1 0			X				363,267	0	31,384

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			
LAROY KENDALL VP Medical Services, CMO	50 0 4 0			X				472,000	0	49,283
BARBARA KROHMAN CORPORATE SECRETARY THRU 1/5/2018	50 0 0			X				29,486	0	2,251
ROBERT PRICHARD MD Chief Clinical Integration Officer, SEP President & CEO	25 0 25 0			X				865,244	0	45,337
LORI RITCHEY-BALDWIN Senior Vice President/CFO/Treasurer	50 0 5 0			X				704,036	0	57,685
BENITA ANDERSON VP Nursing - Florence/Ft Thomas	50 0 0				X			306,047	0	35,592
WILLIAM BANKS VP MANAGED CARE	50 0 0				X			411,702	0	48,699
JACOB BAST SEP COO / SECRETARY	35 0 15 0				X			450,758	0	33,216
JOSEPH BOZZELLI VP MISSION SVCS & PASTORAL CARE	50 0 0				X			208,104	0	26,110
CHRISTOPER CARLE PRESIDENT & CEO SEPN	50 0 0				X			458,524	0	33,140
CARRI CHANDLER VP - FOUNDATION	50 0 0				X			263,385	0	28,447

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			
PAMELA DEETER VP FINANCE	50 0 0				X			329,985	0	37,021
BRUNO GIACOMUZZI COO Flo FT Cov & SVP Prof Svcs	50 0 0				X			422,239	0	47,943
SARAH GIOLANDO SVP/CHIEF STRATEGY OFFICER	50 0 0				X			484,667	0	34,509
VERA HALL SVP System CNE	50 0 0				X			332,770	0	48,184
ANTHONY HELTON VP Revenue Cycle	50 0 0				X			270,748	0	38,423
BRUCE HENLEY SEP CFO / TREASURER	35 0 15 0				X			317,030	0	50,358
MATTHEW HOLLENKAMP VP MARKETING AND CONSUMER RELATIONS	50 0 0				X			232,234	0	32,864
JAMES HORN VP/CHIEF QUALITY OFFICER/ PHYSICIAN	50 0 0				X			376,165	0	36,940
KATHY LYNN JENNINGS VP PATIENT CARE/ONCOLOGY	50 0 0				X			243,849	0	35,205
JAMES McCARVILLE VP - QUALITY	50 0 0				X			242,052	0	33,462

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SUSAN MCDONALD VP Nursing - Edgewood	50 0 0				X			319,799	0	36,980
JOHN MITCHELL SVP - COO FT THOMAS	50 0 0				X			266,326	0	30,766
ROSANNA NIELDS VP PLANNING & GOVT RELATIONS	50 0 0				X			231,978	0	24,916
JAMES PARSONS SVP HUMAN RESOURCES	50 0 0				X			196,652	0	7,275
ALEXANDER RODRIGUEZ VP CIO	50 0 0				X			463,414	0	31,769
HARRY WATSON Sr VP Facilities	50 0 0				X			339,210	0	13,897
JASON WESSEL VP OF PROFESSIONAL SERVICES	50 0 0				X			218,902	0	34,154
DARRYL DIAS MD PHYSICIAN	50 0 0					X		1,168,359	0	57,219
JEROME SCHUTZMAN MD PHYSICIAN	50 0 0					X		1,384,147	0	58,192
MOHAMAD SINNO MD PHYSICIAN	50 0 0					X		987,025	0	57,005

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			
JON HAYS MD PHYSICIAN	50 0 0					X		1,053,570	0	56,267
JEFFREY REICHARD MD PHYSICIAN	50 0 0					X		1,015,673	0	59,443
MARTIN OSCADAL FORMER SVP HUMAN RESOURCES	50 0 0						X	390,970	0	42,832

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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.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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)2014	(b)2015	(c)2016	(d)2017	(e)2018	(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 2018 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2017 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2018.** 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—2017.** 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—2018.** 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—2017.** 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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 2018 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2018** (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from **2017** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2018.** 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—2017.** 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 2018 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-2018**	**(iii) Distributable Amount for 2018**
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, 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 2018 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 2019.** Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

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

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493316056279

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

OMB No 1545-0047

2018

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**
St Elizabeth Medical Center Inc	61-0445850

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)** 2015	**(b)** 2016	**(c)** 2017	**(d)** 2018	**(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)?	Yes		
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?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		46,732
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		53,963
j	Total Add lines 1c through 1i			100,695
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
Schedule C, Part II-B, Line 1j OTHER ACTIVIITIES	THE PORTION OF THE KENTUCKY HOSPITAL ASSOCIATION DUES AND SPONSORSHIP THAT ARE ATTRIBUTABLE TO LOBBYING ACTIVITIES IS $53,653
Schedule C, Part II-B, Line 1g Direct contact with legislators	A PORTION OF TWO ST ELIZABETH HEALTHCARE EMPLOYEES' SALARIES IS RELATED TO DIRECT CONTACT WITH LEGISLATORS AS IT RELATES TO LEGISLATION FOR THE TAX YEAR 2018 THE AMOUNT IS $10,750 ST ELIZABETH HEALTHCARE ALSO ENLISTED THE ASSISTANCE OF LOBBYING CONSULTANTS IN 2018 THE AMOUNT PAID TO THESE CONSULTANTS IS $35,050 ST ELIZABETH HEALTHCARE ALSO PAID $932 IN SPONSORSHIP DOLLARS
Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY	ST ELIZABETH HEALTHCARE hired lobbying consultants to provide lobbying support at the state and local levels on legislative issues being considered by the Kentucky General Assembly or by cities and counties in our community Primarily, the consulting work includes monitoring bills, notifying St Elizabeth if there are issues of concern or bills introduced that are of concern, assistance in talking with legislators or other government officials about these concerns, sharing positions on bills or issues with our legislators, and summarizing actions that have taken place on a weekly basis during the session We have hired the consulting firm because they are based in Frankfort, Kentucky and can be at the meetings and hearings every day during the session so that we can be more timely in responding if issues arise
Schedule C, Part II-B, Line 1 DETAILED DESCRIPTION OF THE LOBBYING ACTIVITY	ST ELIZABETH HEALTHCARE hired lobbying consultants to provide lobbying support at the state and local levels on legislative issues being considered by the Kentucky General Assembly or by cities and counties in our community Primarily, the consulting work includes monitoring bills, notifying St Elizabeth if there are issues of concern or bills introduced that are of concern, assistance in talking with legislators or other government officials about these concerns, sharing positions on bills or issues with our legislators, and summarizing actions that have taken place on a weekly basis during the session We have hired the consulting firm because they are based in Frankfort, Kentucky and can be at the meetings and hearings every day during the session so that we can be more timely in responding if issues arise

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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					
b Contributions . . .					
c Net investment earnings, gains, and losses					
d Grants or scholarships . . .					
e Other expenditures for facilities and programs . . .					
f Administrative expenses					
g End of year balance					

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

- a Board designated or quasi-endowment ▶
- b Permanent endowment ▶
- c Temporarily restricted endowment ▶

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

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

	Yes	No
(i) unrelated organizations	3a(i)	
(ii) related organizations	3a(ii)	
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		21,248,291		21,248,291
b Buildings		518,367,322	268,942,522	249,424,800
c Leasehold improvements		18,611,899	7,405,940	11,205,959
d Equipment		445,772,848	319,176,833	126,596,015
e Other		34,454,898	132,375	34,322,523
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* . . ▶				442,797,588

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) UNRESTRICTED	376,682,604	F
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶	376,682,604	

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

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

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
See Additional Data Table	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	121,420,135

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	1,118,794,482
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains (losses) on investments	2a	-71,592,006		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d	9,392,422		
e	Add lines **2a** through **2d**			2e	-62,199,584
3	Subtract line **2e** from line **1**			3	1,180,994,066
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	1,867,872		
b	Other (Describe in Part XIII)	4b	41,922,623		
c	Add lines **4a** and **4b**			4c	43,790,495
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	1,224,784,561

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	1,103,937,209
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	10,252,893		
e	Add lines **2a** through **2d**			2e	10,252,893
3	Subtract line **2e** from line **1**			3	1,093,684,316
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	1,867,872		
b	Other (Describe in Part XIII)	4b	40,458,778		
c	Add lines **4a** and **4b**			4c	42,326,650
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	1,136,010,966

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

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

1 (a) Description of Liability	(b) Book Value
ANNUITY PAYMENT LIABILITY	96,336
ACCRUED PENSION LIABILITY	20,635,209
OTHER LONG TERM LIABILITIES	29,423,474
SELF-INSURANCE	52,687,891
OTHER CURRENT LIABILITIES HOSPITAL	6,531,040
INTEREST RATE SWAP	5,264,817
ASSET RETIREMENT OBLIGATION	408,055
LT DEBT TO ST REMRKTG ARRANGEMENT	
MEDICARE PAYABLE	5,249,943
MEDICAID PAYABLE	1,123,370

Supplemental Information

Return Reference	Explanation
Schedule D, Part X, Line 2 FIN 48 (ASC 740) footnote	NO PROVISION HAS BEEN MADE FOR INCOME TAXES SINCE ST ELIZABETH HEALTHCARE IS EXEMPT FROM FEDERAL INCOME TAXES UNDER INTERNAL REVENUE CODE SECTION 501(C)(3) AND IS CLASSIFIED AS OT HER THAN A PRIVATE FOUNDATION BY THE INTERNAL REVENUE SERVICE MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN BY ST ELIZABETH AND HAS CONCLUDED THAT AS OF DECEMBER 31, 2018, THER E ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY OR DISCLOSURE IN THE FINANCIAL STATEMENTS ST ELIZABETH HEALTHCARE IS NOT CURRENTLY UNDER EXAMINATION BY THE INTERNAL REVENUE SERVICE OR ANY STATE OR LOCAL TAX AUTH ORITIES ST ELIZABETH HEALTHCARE'S FEDERAL TAX RETURNS FOR THE YEARS ENDED PRIOR TO DECEM BER 31, 2015 AND PRIOR YEARS ARE NO LONGER SUBJECT TO EXAMINATION AS THE STATUTE OF LIMITA TIONS HAS EXPIRED FOR THOSE YEARS

Supplemental Information

Return Reference	Explanation
Schedule D, Part XI, Line 2(d) Other revenues in audited financial statements not in form 990	FUNDRAISING EXPENSES - 272821 GAMING EXPENSES - 486 LOSS/GAIN ON FIXED ASSET DISPOSAL - 12 0606 SEPN - 720442 RENTAL EXPENSES - 2480586 PENSION EXPENSE BOOKED TO REVENUE - 5797481

Supplemental Information

Return Reference	Explanation
Schedule D, Part XI, Line 4(b) Other revenues in form 990 not in audited financial statements	UNCOLLECTIBLE PLEDGES - 29667 SEPN - 703408 FIVE LABS - 367874 PROVISION FOR BAD DEBT - 39 007910 CHANGE IN FMV IN INTEREST RATE SWAP - 1813764

Supplemental Information

Return Reference	Explanation
Schedule D, Part XII, Line 2(d) Other expenses in audited financial statements not in form 990	SEPN - 1580913 GAIN/LOSS ON FIXED ASSET DISPOSALS - 120606 RENTAL EXPENSES - 2480586 FUNDR AISING EXPENSES - 272821 GAMING EXPENSES - 486 PENSION EXPENSES BOOKED TO REVENUE - 579748 1

Supplemental Information

Return Reference	Explanation
Schedule D, Part XII, Line 4(b) Other expenses in form 990 not in audited financial statements	SEPS - 25365 PROVISION FOR BAD DEBT - 39007910 FIVE LABS - 367874 SEPN - 703408 Reclass of Grant to HANKY reported on balance sheet - 354221

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

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

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

3 Activites per Region (The following Part I, line 3 table can be duplicated if additional space is needed)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
Central America and the Caribbean	0	0	Investments	N/A	114,463,460
3a Sub-total	0	0			114,463,460
b Total from continuation sheets to Part I					0
c **Totals** (add lines 3a and 3b)	0	0			114,463,460

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes,"the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☑ Yes	☐ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A, don't file with Form 990)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)*	☑ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*	☑ Yes	☐ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☐ Yes	☑ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, don't file with Form 990)*	☐ Yes	☑ No

Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

990 Schedule F, Supplemental Information

Return Reference	Explanation
Schedule F, Part I, Line 2 PROCEDURES FOR MONITORING USE OF GRANT FUNDS	ST ELIZABETH HEALTHCARE MAINTAINS RECORDS TO SUBSTANTIATE AMOUNTS AND ELIGIBILITY TO BE USED FOR THE CRITERIA FOR SELECTING PROGRAM RELATED INVESTMENTS ST ELIZABETH HEALTHCARE'S PROGRAM RELATED INVESTMENTS ARE CONSIDERED TO BE LOW RISK AND HAVE LOW VOLATILITY TO THE MARKETPLACE ST ELIZABETH HEALTHCARE MONITORS THEIR PROGRAM RELATED INVESTMENTS BY HAVING AN INDEPENDENT INVESTMENT CONSULTANT RECEIVE, ON A QUARTERLY BASIS, SEPARATE FINANCIAL REPORTS FOR EACH INVESTMENT AND ON AN ANNUAL BASIS, AUDITED FINANCIAL STATEMENTS PERFORMED BY THIRD PARTY INDEPENDENT AUDITORS FOR EACH INVESTMENT THESE REPORTS AND FINANCIAL STATEMENTS ARE REVIEWED BY THE INDEPENDENT INVESTMENT CONSULTANT AND PERFORMANCE IS CALCULATED BASED ON ACTUAL AND PROJECTED CASH FLOWS FOR EACH INVESTMENT THIS PERFORMANCE IS COMPARED TO BENCHMARKED INDUSTRY STANDARDS IN ADDITION, RATES OF RETURN ARE COMPARED TO WHAT IS ACTUALLY REPORTED AND WHAT THE INDUSTRY STANDARDS PROVIDE ANY SIGNIFICANT DISPARITIES ARE DISCUSSED WITH ST ELIZABETH HEALTHCARE'S INVESTMENT COMMITTEE FURTHERMORE, IF NECESSARY, AN INVESTMENT TEAM WILL REVIEW THE STRATEGY, PERFORMANCE, AND GOALS OF THE PROGRAM RELATED INVESTMENT(S) TO ENSURE THAT THE FUNDS ARE BEING USED FOR THEIR PROPER PURPOSE AND ARE NOT OTHERWISE DIVERTED FROM THEIR INTENDED USE

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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.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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
BOUTS VENTURE LLC PO Box 99 Dimondal, MI 488210099	CONSULTANT FEE		No		60,000	-60,000
Total			▶	0	60,000	-60,000

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

KY, OH

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 Golf Partee (event type)	(b) Event #2 Style Show (event type)	(c) Other events 1 (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts	321,021	80,128	44,620	445,769
	2 Less Contributions	32,121	25,838	3,464	61,423
	3 Gross income (line 1 minus line 2)	288,900	54,290	41,156	384,346
Direct Expenses	4 Cash prizes	0	0	0	0
	5 Noncash prizes	18,348	0	488	18,836
	6 Rent/facility costs	0	0	0	0
	7 Food and beverages	88,450	20,893	11,289	120,632
	8 Entertainment	0	0	0	0
	9 Other direct expenses	40,396	27,949	18,845	87,190
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				226,658
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				157,688

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				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____% ☐ No	☐ Yes ____% ☐ No	☐ Yes ____% ☐ No	
	7 Direct expense summary Add lines 2 through 5 in column (d) ▶				
	8 Net gaming income summary Subtract line 7 from line 1, column (d) ▶				

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

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

b If "No," explain _____

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

b If "Yes," explain _____

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

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

13 Indicate the percentage of gaming activity conducted in

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶

----

16 Gaming manager information

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

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

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

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

Return Reference	Explanation
Schedule G, Part I, Line 2b(i) BOUTS VENTURES LLC	BOUTS VENTURES PROVIDE CONSULTING SERVICES ON FUNDRAISING AND RETREATS RELATED TO DEVELOPMENT TO ST ELIZABETH HEALTHCARE BOUTS VENTURES LLC DOES NOT PARTICIPATE IN THE SOLICITATION OF CONTRIBUTIONS

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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.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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)			36,182,518	24,369,987	11,812,531	1 04 %
b Medicaid (from Worksheet 3, column a)			184,879,707	140,511,854	44,367,853	3 91 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0 %
d **Total** Financial Assistance and Means-Tested Government Programs	0	0	221,062,225	164,881,841	56,180,384	4 95 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,931,798	533,817	1,397,981	0 12 %
f Health professions education (from Worksheet 5)			5,706,673	1,948,005	3,758,668	0 33 %
g Subsidized health services (from Worksheet 6)			7,702,058	3,156,766	4,545,292	0 40 %
h Research (from Worksheet 7)			1,437,536	676,592	760,944	0 07 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			15,172,948	1,125,000	14,047,948	1 24 %
j **Total.** Other Benefits	0	0	31,951,013	7,440,180	24,510,833	2 16 %
k **Total.** Add lines 7d and 7j	0	0	253,013,238	172,322,021	80,691,217	7 11 %

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			71,522		71,522	0 01 %
2 Economic development			46,990		46,990	0 %
3 Community support			403,437		403,437	0 04 %
4 Environmental improvements			0		0	0 %
5 Leadership development and training for community members			5,878		5,878	0 %
6 Coalition building			432,190		432,190	0 04 %
7 Community health improvement advocacy			0		0	0 %
8 Workforce development			587,558		587,558	0 05 %
9 Other			310,074		310,074	0 03 %
10 Total	0	0	1,857,649	0	1,857,649	0 16 %

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	39,007,910		
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	3,900,791		
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	219,760,852		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	233,070,052		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-13,309,200		
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	BLUEGRASS DIALYSIS LLC	RENAL DIALYSIS	32 %	0 %	17 %
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?

4

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

A

Name of hospital facility or letter of facility reporting group _____

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

		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 18			
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**		No
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) https //www stelizabeth com/community-outreach/community-benefits			
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 18			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) https //www stelizabeth com/community-outreach/community-benefits			
a			
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)

A

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 0 % and FPG family income limit for eligibility for discounted care of 400 0 %			
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) https //www stelizabeth com/patients-visitors/financial-assistance-programs			
b	☑ The FAP application form was widely available on a website (list url) https //www stelizabeth com/patients-visitors/financial-assistance-programs			
c	☑ A plain language summary of the FAP was widely available on a website (list url) https //www stelizabeth com/patients-visitors/financial-assistance-programs			
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

A

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)

A

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	

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? **27**

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part I, Line 7g Subsidized Health Services	ST ELIZABETH HEALTHCARE'S COSTS, REFLECTED AS SUBSIDIZED HEALTH SERVICES, ARE BASED ON ACTUAL COSTS OR DIRECT AND INDIRECT COSTS ST ELIZABETH HEALTHCARE REPORTED THE FOLLOWING AS SUBSIDIZED HEALTH SERVICES (I)FAMILY PRACTICE CENTER, (II)PARISH NURSING-HEALTH MINISTRIES, (III)ATHLETIC TRAINERS AT THE AREA HIGH SCHOOLS AND JUNIOR HIGH SCHOOLS, (IV)WOMEN'S AND CHILDREN'S SERVICES, AND (V)BEHAVIOR HEALTH SERVICES NO PHYSICIAN OFFICES HAVE BEEN REPORTED ON LINE 7G
Schedule H, Part I, Line 7 Costing Methodology used to calculate financial assistance	ST ELIZABETH HEALTHCARE USED COST TO CHARGE RATIOS FOR DETERMINING COSTS RELATED TO FINANCIAL ASSISTANCE ST ELIZABETH HEALTHCARE USED THEIR COST ACCOUNTING SYSTEM TO DETERMINE COSTS RELATED TO UNREIMBURSED MEDICAID ST ELIZABETH USED THE ACTUAL COST, OR DIRECT AND INDIRECT COSTS, TO DETERMINE OTHER COSTS IN SECTION 7(G-I)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 2 Bad debt expense - methodology used to estimate amount	ST ELIZABETH HEALTHCARE RECOGNIZES PATIENT SERVICE REVENUE AT THE TIME SERVICES ARE RENDERED FOR, EVEN THOUGH ST ELIZABETH HEALTHCARE DOES NOT ASSESS THE PATIENT'S ABILITY TO PAY AS A RESULT, THE PROVISION FOR BAD DEBTS AND CHARITY CARE ARE PRESENTED AS A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL PROVISIONS AND DISCOUNTS) ST ELIZABETH HEALTHCARE RECOGNIZES REVENUE WHEN SERVICES ARE RENDERED FOR UNINSURED AND UNDERINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE BASED ON HISTORICAL EXPERIENCE, A SIGNIFICANT PORTION OF ST ELIZABETH HEALTHCARE'S UNINSURED AND UNDERINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES RENDERED AS A RESULT, ST ELIZABETH HEALTHCARE RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS RELATED TO UNINSURED AND UNDERINSURED PATIENTS IN THE PERIOD THE SERVICES ARE RENDERED THE BAD DEBT EXPENSE REPORTED ON PART III, LINE 2, IS THE BAD DEBT EXPENSE REPORTED ON FORM 990, PART IX, LINE 24B
Schedule H, Part III, Line 3 Bad Debt Expense Methodology	THE ESTIMATED AMOUNT OF ST ELIZABETH HEALTHCARE'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER ST ELIZABETH HEALTHCARE'S FINANCIAL ASSISTANCE POLICY IS $3,900,791 THE PERCENTAGE OF BAD DEBTS THAT LIKELY COULD BE CHARITY CARE, IF ENOUGH INFORMATION WAS OBTAINED UP FRONT, WAS DEVELOPED WITH THE HELP OF OUR LARGEST COLLECTION AGENCY WHO HAS DETERMINED, BASED ON ACCOUNTS REVIEWED, WHO MAY NOT HAVE HAD THE FINANCIAL ABILITY TO PAY ST ELIZABETH HEALTHCARE ALSO BELIEVES THAT MANY PATIENTS FALL INTO THE CATEGORY WHERE THEY DO NOT MEET THE FEDERAL POVERTY GUIDELINES BUT YET CANNOT AFFORD THE COST OF THE SERVICES RENDERED, OR HAVE INSURANCE THAT MAY NOT COVER THE COST OF SERVICES THEREFORE, ST ELIZABETH HEALTHCARE BELIEVES THESE NON REIMBURSED COSTS SHOULD BE COUNTED AS A BENEFIT TO THE COMMUNITY WE SERVE THE AMERICAN HOSPITAL ASSOCIATION'S POSITION IS THAT BAD DEBTS SHOULD BE COUNTED AS A COMMUNITY BENEFIT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 4 Bad debt expense - financial statement footnote	Patient accounts are reported at the net consideration in which St Elizabeth Healthcare expects to be entitled to in exchange for providing patient care The portfolio approach is used to determine the reduction to accounts receivables based upon the historical collection experience of St Elizabeth Healthcare adjusted for current environmental risks and trends for each major payor source Amounts recognized are subject to adjustment upon review by third-party payors Significant price concessions are made for self-pay patient accounts in the period of service based on past collection experience and are reported at the net amount St Elizabeth Healthcare expects to collect St Elizabeth Healthcare recognizes patient service revenue at the time in which performance obligations are satisfied These amounts are due from patient, third-party payers, (including managed care and governmental programs), and others are subject to contractual adjustments, discounts and implicit price concessions Patient service revenue is reported at the net consideration in which St Elizabeth Healthcare expects to be entitled to in exchange for providing patient care Settlements are recorded on an estimated basis in the period the related services are rendered and adjusted in future periods based upon additional information, filed cost reports, interim settlements, and final settlements St Elizabeth Healthcare recognizes patient service revenue at the time services are rendered even though they do not assess the patient's ability to pay As a result, implicit price concessions are presented as a deduction from patient service revenue (net of contractual provisions and discounts) Amounts determined to qualify as charity care are not reported as patient service revenue For uninsured and underinsured patients that do not qualify for charity care, St Elizabeth Healthcare recognizes revenue when services are provided Based on historical experience, a significant portion of St Elizabeth Healthcare's uninsured and underinsured patients will be unable or unwilling to pay for the services provided Thus, St Elizabeth Healthcare records significant implicit price concessions related to uninsured and underinsured patients in the period the services are provided
Schedule H, Part III, Line 8 Community benefit & methodology for determining medicare costs	ST ELIZABETH HEALTHCARE USES THE STEP DOWN METHODOLOGY TO DETERMINE COSTS FOR MEDICARE THE REPORTS WERE THEN COMPLETED BY FOLLOWING THE GUIDANCE PROVIDED IN THE INSTRUCTIONS FOR PART III ST ELIZABETH HEALTHCARE BELIEVES MEDICARE LOSSES SHOULD BE AN ALLOWABLE COMMUNITY BENEFIT ST ELIZABETH HEALTHCARE PROVIDES NEEDED SERVICES TO THE ELDERLY AND DISABLED MEDICARE POPULATION AT A FINANCIAL LOSS TO ST ELIZABETH HEALTHCARE TO HELP THOSE INDIVIDUALS GET THE CARE THEY NEED IN THE COMMUNITY WE SERVE THE AMERICAN HOSPITAL ASSOCIATION'S POSITION IS ALSO THAT MEDICARE LOSSES SHOULD BE COUNTED AS COMMUNITY BENEFIT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b Collection practices for patients eligible for financial assistance	ST ELIZABETH HEALTHCARE HAS A WRITTEN DEBT COLLECTION POLICY THAT ALSO INCLUDES A PROVISION ON THE COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE IF A PATIENT QUALIFIES FOR CHARITY OR FINANCIAL ASSISTANCE, CERTAIN COLLECTION PRACTICES DO NOT APPLY
Schedule H, Part V, Section B, Line 16a FAP website	A - ST ELIZABETH FLORENCE Line 16a URL https //www stelizabeth com/patients-visitors/financial-assistance-programs,

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part V, Section B, Line 16b FAP Application website	A - ST ELIZABETH FLORENCE Line 16b URL https //www stelizabeth com/patients-visitors/financial-assistance-programs,
Schedule H, Part V, Section B, Line 16c FAP plain language summary website	A - ST ELIZABETH FLORENCE Line 16c URL https //www stelizabeth com/patients-visitors/financial-assistance-programs,

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2 Needs assessment	IN 2018, ST ELIZABETH HEALTHCARE CONTINUED TO WORK WITH THE NORTHERN KENTUCKY HEROIN IMPACT TASK FORCE TO ADDRESS THE HEROIN EPIDEMIC, ALSO PROVIDING FINANCIAL SUPPORT FOR THE HEROIN HOTLINE THIS INCLUDED PROVIDING DATA AND SUPPORT TO THE STATE OF KENTUCKY LEGISLATURE TO ENACT NEW LEGISLATION DIRECTED TOWARDS EXPANDING TREATMENT IN ADDITION, ST ELIZABETH HEALTHCARE DEVELOPED AN INTERNAL WORKGROUP FOCUSED ON ENHANCING PREVENTION AND PROVIDING TREATMENT FOR THE COMMUNITIES IT SERVES IN 2018, ST ELIZABETH HEALTHCARE COLLABORATED WITH PHYSICIANS AND THE NORTHERN KENTUCKY HEALTH DEPARTMENT TO ENSURE EMERGENCY PREPAREDNESS MEASURES WERE IN PLACE SHOULD ANY MEMBER OF THE COMMUNITY (PATIENT, RESIDENT, AND/OR VISITOR) EXHIBIT SYMPTOMS OF EBOLA PREPAREDNESS MEASURES INCLUDED (I) FOLLOWING PROTOCOLS FOR REVIEWING ST ELIZABETH HEALTHCARE'S INFECTION CONTROL POLICIES AND PROCEDURES, (II) PROVIDING PERSONAL PROTECTIVE EQUIPMENT, AND (III) PROVIDING TRAINING AND EDUCATION TO STAFF MEMBERS, WHICH INCLUDED CONSTRUCTING A SIMULATION ROOM FOR TRAINING EXERCISES AND A SPECIALIZED EBOLA RESPONSE TEAM WAS ORGANIZED IN 2018, ST ELIZABETH HEALTHCARE CONTINUED TO SUPPORT A PERTUSSIS COCOONING PROJECT TO HELP PREVENT THE DEADLY EFFECTS OF INFANT PERTUSSIS BY SURROUNDING INFANTS WITH A PROTECTIVE "COCOON" AND IMMUNIZED MOTHERS, FAMILY MEMBERS, AND CAREGIVERS PERTUSSIS, ALSO KNOWN AS WHOOPING COUGH, IS A HIGHLY CONTAGIOUS RESPIRATORY DISEASE CAUSED BY THE BORDETELLA PERTUSSIS BACTERIUM WHOOPING COUGH IS KNOWN FOR CONTROLLABLE, VIOLENT COUGHING WHICH OFTEN MAKES IT HARD FOR INFANTS TO BREATHE IN 2018, ST ELIZABETH HEALTHCARE CONTINUED TO PROVIDE THE PATIENT AND FAMILY ADVISORY COUNCIL (PAFAC), WHICH MEETS EVERY TWO (2) MONTHS TO IDENTIFY NEEDS OF THE COMMUNITY BASED ON THE FEEDBACK OBTAINED FROM OUR PATIENTS AND FAMILY MEMBERS CONTINUOUSLY, ST ELIZABETH EVALUATES DATA FROM SOURCES SUCH AS OUR PATIENT SATISFACTION AND COMMUNITY HEALTH SURVEYS TO IDENTIFY THE NEEDS OF OUR COMMUNITY FOR THE PEOPLE WE SERVE
Schedule H, Part VI, Line 3 Patient education of eligibility for assistance	THE FINANCIAL ASSISTANCE POLICY IS PUBLISHED ON ST ELIZABETH HEALTHCARE'S WEB SITE A WRITTEN COPY IS ALSO INCLUDED IN THE PATIENT HANDBOOK PROVIDED TO INPATIENT ADMISSIONS A NOTICE THAT FINANCIAL ASSISTANCE IS AVAILABLE FOR QUALIFYING INDIVIDUALS ON THE PATIENT BILLS FINANCIAL COUNSELORS ARE AVAILABLE TO ASSIST PATIENTS TO DETERMINE QUALIFICATION AND A COPY OF THE POLICY IS AVAILABLE TO PATIENTS UPON REQUEST PATIENT FINANCIAL ASSISTANCE PROGRAM INFORMATION IS POSTED AT EACH SITE (THERE IS A FRAMED SIGN POSTED IN SPANISH AND ENGLISH) -IN ADDITION, THERE IS A 1-PAGE DESCRIPTION OF OUR FINANCIAL ASSISTANCE PROGRAM THAT IS ATTACHED TO THE "PATIENT RIGHTS AND RESPONSIBILITIES" DOCUMENT, AND ALL PATIENTS ARE GIVEN THESE DOCUMENTS UPON REGISTRATION -IF A PATIENT DOES NOT HAVE INSURANCE, THEY ARE ALSO OFFERED AN APPLICATION PACKET FOR FINANCIAL ASSISTANCE PATIENTS ARE NOTIFIED OF THEIR FINANCIAL RESPONSIBILITY -THE PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT GIVEN TO ALL PATIENTS STATES THEY HAVE A RESPONSIBILITY TO "PROVIDE NECESSARY FINANCIAL INFORMATION TO ASSURE ACCURATE BILLING AND MEET FINANCIAL COMMITMENTS" -THE FINANCIAL ASSISTANCE PLAN DOCUMENT THEY ARE GIVEN PROVIDES DETAILED INFORMATION ON ELIGIBLE FINANCIAL AID SERVICES, AND ALSO STATES THAT "FINANCIAL ASSISTANCE IS NOT CONSIDERED AN ALTERNATIVE OPTION TO PAYMENT, AND PATIENTS MAY BE ASSISTED IN FINDING OTHER MEANS OF PAYMENT FOR FINANCIAL ASSISTANCE BEFORE APPROVAL FOR ST ELIZABETH FINANCIAL ASSISTANCE PROGRAM "

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4 Community information	ST ELIZABETH HEALTHCARE SERVES THE NORTHERN KENTUCKY COUNTIES, WHICH INCLUDE BOONE, BRACKEN, CAMPBELL, CARROLL, GALLATIN, GRANT, HARRISON, KENTON, MASON, OWEN, PENDLETON, AND ROBERTSON, ALSO HAMILTON COUNTY IN SOUTHERN OHIO, AND DEARBORN COUNTY IN SOUTHERN INDIANA THESE SERVICE AREAS INCLUDE URBAN, SUBURBAN, AND RURAL AREAS THE TOTAL POPULATION OF THE SERVICE AREAS IS OVER 500,000 ST ELIZABETH HEALTHCARE'S PRIMARY SERVICE AREAS DURING 2018 WAS DETERMINED BY IDENTIFYING WHERE 90% OF ITS PATIENT POPULATION ORIGINATES THIS APPROACH ENSURES THAT THE ASSESSMENT WAS NOT LIMITED TO CERTAIN GEOGRAPHIC AREAS BUT INCLUDED THE MAJORITY OF THE POPULATION SERVED THE DATA REVEALED THAT 92 8% OF THE PATIENT POPULATION RESIDES IN THE COUNTIES THAT MAKE UP THE NORTHERN KENTUCKY AREA DEVELOPMENT DISTRICT (NKADD) THE NKADD ENCOMPASSES THE COUNTIES OF BOONE, CAMPBELL, CARROLL, GALLATIN, GRANT, KENTON, OWEN AND PENDLETON, AND REPRESENTS OVER 454,782 RESIDENTS ALL HOSPITALS IN THE ST ELIZABETH HEALTHCARE SYSTEM ARE LOCATED IN THIS REGION THE PRIMARY SERVICE AREAS ARE PREDOMINANTLY WHITE WITH AN INCREASE IN AFRICAN-AMERICAN AND HISPANIC ORIGINS MOVING INTO THE AREA POPULATION BY ORIGIN 89 8% WHITE, 3 41% BLACK, 3 31% HISPANIC, 1 46% ASIAN, 2 02% OTHER POPULATION BY AGE 0-19, 27 05%, 20 - 64, 59 87%, 65+, 13 08% (SOURCE ANNUAL COUNTY RESIDENT POPULATION ESTIMATES BY AGE, SEX, RACE, AND HISPANIC ORIGIN APRIL 1, 2010 TO JULY 1, 2015 POPULATION DIVISION, U S CENSUS BUREAU UPDATED JUNE 23 2016) PERSONS BELOW POVERTY LEVEL IN NKY, PERCENT 2009-2013 ALL AGES 17 01% DUE TO THE ENACTMENT OF THE AFFORDABLE CARE ACT, IT IS ESTIMATED THAT APPROXIMATELY 26 0% OF THE NORTHERN KENTUCKY POPULATION REMAINS UNINSURED THERE ARE SIX (6) OTHER HOSPITALS THAT SERVE THE NORTHERN KENTUCKY COMMUNITY 1 GATEWAY REHABILITATION HOSPITAL IN BOONE COUNTY, 2 CARROLL COUNTY MEMORIAL HOSPITAL IN CARROLL COUNTY, 3 HARRISON MEMORIAL HOSPITAL IN HARRISON COUNTY, 4 HEALTHSOUTH REHABILITATION HOSPITAL IN KENTON COUNTY, 5 MEADOWVIEW REGIONAL MEDICAL CENTER IN MASON COUNTY, AND 6 SUN BEHAVORIAL HEALTH IN ERLANGER THERE IS ONE (1) HOSPITAL THAT SERVES THE SOUTHERN INDIANA COMMUNITY - DEARBORN COUNTY HOSPITAL IN DEARBORN COUNTY THERE ARE A NUMBER OF HOSPITALS THAT SERVE THE SOUTHERN OHIO COMMUNITY, INCLUDING, THE CHRIST HOSPITAL, TRIHEALTH, MERCY HEALTH, AND THE UNIVERSITY OF CINCINNATI MEDICAL CENTER THERE ARE IS A FEW FEDERALLY DESIGNATED - MEDICALLY UNDERSERVED AREAS OR POPULATIONS IN THE COMMUNITIES
Schedule H, Part VI, Line 5 Promotion of community health	ST ELIZABETH HEALTHCARE FURTHERS ITS EXEMPT PURPOSES IN IMPROVING COMMUNITY HEALTH STATUS BY 1) ENCOURAGING AND SUPPORTING STAFF TO PARTICIPATE ON VARIOUS COMMUNITY BOARDS/ACTIVITIES THAT SUPPORT AND/OR DEVELOP PROGRAMS THAT ADDRESS COMMUNITY HEALTH NEEDS AND WORKFORCE DEVELOPMENT 2) ST ELIZABETH HEALTHCARE'S BOARD OF TRUSTEES IS MADE UP OF COMMUNITY REPRESENTATIVES TO ENSURE THAT ST ELIZABETH HEALTHCARE ADHERES TO ITS MISSION TO IMPROVE THE HEALTH OF THE PEOPLE WE SERVE THE MAJORITY OF THE GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE WITHIN ST ELIZABETH'S PRIMARY SERVICE AREA ST ELIZABETH EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY FOR SOME OR ALL OF ITS DEPARTMENTS OR SPECIALTIES 3) THROUGH ITS PRIMEWISE SENIOR SERVICES FOR AGE 50+ PERSONS, ST ELIZABETH HEALTHCARE SUBSIDIZES COURSE OFFERINGS TO SENIOR CITIZENS INCLUDING DRIVER'S SAFETY, LOW IMPACT EXERCISE, COMPUTER SKILLS, MEDICATION REVIEW AND HEALTH SCREENINGS, ALONG WITH PROVIDING LITERATURE PERTINENT TO THIS AGE GROUP 4) Each year, St Elizabeth Healthcare produces and distributes more than 600,000 different pieces of health-related information or invitations to health-related educational events throughout the community - which is an average of nearly 4 pieces of information per Northern Kentucky household 5) PERIODICALLY, ST ELIZABETH HEALTHCARE WILL PARTNER WITH COMMUNITY ORGANIZATIONS AND BUSINESS AGENCIES TO PRESENT HEALTH RELATED PROGRAMS AND HEALTH SCREENINGS 6) ST ELIZABETH APPLIES SURPLUS FUNDS TO IMPROVE PATIENT CARE BY IMPROVING FACILITIES, ACCESS TO CARE, TECHNOLOGY, RECRUITING AND RETAINING TOP TALENT, AND CONTINUING EDUCATION OF OUR STAFF THROUGH EITHER RESIDENCY OR COLLEGE EDUCATIONAL PROGRAMS EXAMPLES OF HOW SURPLUS FUNDS WERE APPLIED IN 2018 ARE AS FOLLOWS A) ST ELIZABETH HEALTHCARE CONTINUES TO PARTNER WITH THE MAYO CLINIC CARE NETWORK TO ENHANCE THE QUALITY OF CARE AND IMPROVE THE ACCESS FOR THE PEOPLE WE SERVE TO THE MAYO CLINIC'S SPECIALISTS AND PROTOCOLS B) ST ELIZABETH HEALTHCARE PROVIDED OUTREACH TO THE COMMUNITIES THROUGH THE MOBILE MAMMOGRAPHY AND MOBILE HEART PROGRAMS C) ST ELIZABETH HEALTHCARE PROVIDED COHORT EDUCATIONAL PROGRAMS WITH THE NORTHERN KENTUCKY UNIVERSITY (NKU), THOMAS MORE COLLEGE (TMC), AND MT SAINT JOSEPH UNIVERSITY (MSJU) TO PROVIDE FOR CONTINUING AND/OR ADDITIONAL EDUCATION FOR OUR STAFF D) THE CONTINUED FINANCIAL ASSISTANCE AND SUPPORT FOR THE FAMILY PRACTICE RESIDENCY PROGRAM WHICH IS COMPRISED OF TWENTY-FOUR (24) FAMILY PRACTICE RESIDENTS WHO LIVE AND STAY IN THE COMMUNITY TO IMPROVE AND ENHANCE THE ACCESS TO PRIMARY CARE FOR THE PEOPLE WE SERVE E) ST ELIZABETH HEALTHCARE CONTINUES FINANCIAL SUPPORT FOR OUR PARISH NURSING PROGRAM WHICH PROVIDES OUTREACH, EDUCATION, AND PREVENTION INFORMATION TO OVER EIGHTY-ONE (81) CHURCHES AND NINE (9) COMMUNITY SITES F) ST ELIZABETH HEALTHCARE CONTINUES FINANCIAL SUPPORT FOR PREVENTION AND INJURY TREATMENT FOR ATHLETES ATTENDING SCHOOLS IN OUR COMMUNITIES G) ST ELIZABETH HEALTHCARE SPONSORS COMMUNITY BENEFITS TO ADDRESS THE HEALTHCARE NEEDS FOR DISEASES SUCH AS OBESITY, DIABETES, AND HEART DISEASE FOR THE PEOPLE WE SERVE H) ST ELIZABETH PHYSICIANS PRIMARY CARE PROVIDED ENHANCED SERVICES FOR EDUCATION AND RESOURCES TO THOSE IN THE COMMUNITY WE SERVE WHO STRUGGLE WITH OBESITY AND ENSUING CO-MORBIDITIES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6 Affiliated health care system	ST ELIZABETH HEALTHCARE IS A SYSTEM THAT FEATURES FOUR (4) FACILITIES THROUGHOUT NORTHERN KENTUCKY WHICH ARE (I) ST ELIZABETH - EDGEWOOD, (II) ST ELIZABETH - FLORENCE, (III) ST ELIZABETH - FORT THOMAS, AND, (IV) ST ELIZABETH - GRANT EACH OF THESE FACILITIES ADDRESSES THE SPECIFIC NEEDS OF ITS LOCALE AS IDENTIFIED BY THE PATIENTS IN THE COMMUNITY THE SERVICE AREAS VARY FROM RURAL AREAS TO SUBURBAN AREAS TO URBAN AREAS ST ELIZABETH HEALTHCARE OFFERS ALMOST 1,100 LICENSED BEDS, APPROXIMATELY 8,900 EMPLOYEES , 1,300 PHYSICIAN PROVIDERS AND A WHOLLY OWNED PHYSICIAN ORGANIZATION (SEP) WHICH INCLUDES OVER 108 PRIMARY CARE AND SPECIALTY OFFICE LOCATIONS ST ELIZABETH HEALTHCARE IS SPONSORED BY THE DIOCESE OF COVINGTON
Schedule H, Part VI, Line 7 State filing of community benefit report	KY

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** 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	ST ELIZABETH EDGEWOOD 1 MEDICAL VILLAGE DRIVE EDGEWOOD, KY 41017 www stelizabeth com 100500	X	X					X			A
2	ST ELIZABETH FLORENCE 4900 HOUSTON ROAD FLORENCE, KY 41042 www stelizabeth com 100273	X	X					X			A
3	ST ELIZABETH FORT THOMAS 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075 www stelizabeth com 100059	X	X					X			A
4	ST ELIZABETH GRANT 238 BARNES ROAD WILLIAMSTOWN, KY 41097 www stelizabeth com 600062	X	X			X		X			A

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
Schedule H, Part V, Section B, Line 5 Facility A, 1	Facility A, 1 - St Elizabeth Healthcare - Florence, Edgewood, Grant & Ft Thomas For the 2013 - 2015 CHNA, ST ELIZABETH HEALTHCARE INVITED 349 COMMUNITY LEADERS, BUSINESS PERSON S, AND RESIDENTS TO PARTICIPATE IN EITHER A FOCUS GROUP OR SURVEY PARTICIPANTS IN THE ASS ESSMENT INCLUDED REPRESENTATION FROM ST ELIZABETH HEALTHCARE, STATE LEGISLATURE, FISCAL C OURTS, LAW ENFORCEMENT, HEALTH DEPARTMENTS, CITY OFFICIALS, AREA SCHOOL SYSTEMS, AND OTHER HEALTHCARE & SOCIAL SERVICE PROVIDERS ORGANIZATIONS AND OTHER GROUPS CONSULTED INCLUDE -TRACY MANN, EXECUTIVE DIRECTOR OF ACADEMIC & STUDENT SUPPORT SERVICES KENTON COUNTY SCHOO LS -JOHN SCHICKEL, SENATOR OF THE STATE OF KENTUCKY -SHAWN CARROLL, EXECUTIVE DIRECTOR OF NEW PERCEPTIONS -DR KATHY BURKHARDT, SUPERINTENDENT OF ERLANGER ELSMERE SCHOOLS -MARY BUR CH, RN, HEALTH COORDINATOR OF ERLANGER ELSMERE SCHOOLS -CRAIG RICE, PRESIDENT OF BOYS & GI RLS CLUBS OF GREATER CINCINNATI -RICK SKINNER, MAYOR OF THE CITY OF WILLIAMSTOWN -NANCY AT KINSON, COUNCIL MEMBER OF THE CITY OF EDGEWOOD -SR JEAN HOFFMAN, DIOCESAN CATHOLIC CHILDR EN'S HOME -MARK KREIMBORG, KENTON COUNTY FISCAL COURT -ED HUGHES, PRESIDENT OF GATEWAY COM MUNITY COLLEGE -ROSANA AYDT, EXECUTIVE DIRECTOR/DIRECTOR OF PHARMACY OF FAITH COMMUNITY PH ARMACY -KEN RECHTIN, SENIOR SERVICES OF NORTHERN KENTUCKY -CHARLES KORZENBORN, SHERIFF OF KENTON COUNTY -STEVE STEVENS, PRESIDENT AND CEO OF NORTHERN KENTUCKY CHAMBER OF COMMERCE - TOM SZURLNSKI, CHIEF OF POLICE OF FLORENCE KENTUCKY -CATHY VOETER, CITY OF DAYTON -LINDA Y OUNG, EXECUTIVE DIRECTOR OF WELCOME HOUSE OF NORTHERN KENTUCKY -DENISE BINGHAM, DIRECTOR O F NURSING OF THREE RIVERS DISTRICT HEALTH -DEBBIE JONES, THREE RIVERS DISTRICT HEALTH -TON Y KRAMER, CHIEF OF POLICE OF EDGEWOOD KENTUCKY -DR LYNNE SADDLER, NORTHERN KENTUCKY HEALT H DEPARTMENT -Transitions, Inc DURING 2015, ST ELIZABETH HEALTHCARE CONDUCTED ITS NEXT R EQUIRED CHNA FOR YEARS 2016 -2018 -PRIMARY DATA WAS COLLECTED FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY, INCLUDING THOSE WITH EXPERTISE IN PUBLIC HEALTH REP RESENTATION INCLUDED AREA HEALTH DEPARTMENTS, LOCAL GOVERNMENTAL/CIVIC AGENCIES, HEALTHCAR E PROVIDERS, COMMUNITY BASED SOCIAL SERVICE AGENCIES AND AREA SCHOOL DISTRICTS - THE METH ODOLOGY USED TO COLLECT THE DATA INCLUDED ONE-ON-ONE MEETINGS, PRESENTATIONS TO GROUPS, PH ONE CALLS, AND AN ON-LINE SURVEY THE PROCESS INCLUDED AN EXPLANATION OF THE CHNA REQUIREM ENTS AND HOW THE DATA GARNERED WILL BE USED TO DEVELOP THE CHNA PLAN PARTICIPANTS WERE TH EN ASKED TO LIST IN ORDER FROM MOST IMPORTANT TO LEAST IMPORTANT WHAT THEY BELIEVE ARE THE TOP FIVE COMMUNITY HEALTH NEEDS THAT NEED TO BE ADDRESSED AND/OR CONSIDERED IN THIS ASSES SMENT THIS PRIMARY DATA WAS SUMMARIZED AND TABULATED -CONCENTRATING ON SOCIAL SERVICE AG ENCIES, SCHOOL DISTRICTS AND CIVIC SERVICES ENSURED THAT THE CHNA IDENTIFIED AND RECEIVED DATA ON THE MOST PRESSING HEALTH NEEDS WITHIN THE COMMUNITY SERVED TWO LOCAL COMMUNITY OR GANIZATIONS THAT WORK IN COLLA

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
Schedule H, Part V, Section B, Line 5 Facility A, 1	BORATION WITH LIKE COMMUNITY PROVIDERS ARE THE SAFETY NET ALLIANCE AND THE NORTHERN KENTUC KY EDUCATION COUNCIL THEY PERMITTED ST ELIZABETH TO USE THEIR MEMBERSHIP EMAIL LISTING T O SEND INFORMATION ABOUT THE CHNA AND THE REQUEST FOR INPUT THE FOLLOWING IS A LISTING OF THE COMMUNITY PARTICIPANTS SOCIAL SERVICE AGENCIES -AHEC HISPANIC HEALTH EDU SURVEY -AP PRISEN -BE CONCERNED -BRIGHTON CENTER, INC -CAMPBELL CTY FISCAL COURT - ASSISTANCE PROGRA M -CATHOLIC CHARITIES -CHILDREN HOME OF NKY -CHILDREN INC -CHILDREN'S LAW CENTER -CINCINN ATI VA -CITY HEIGHTS HEALTH CENTER -FAITH COMMUNITY PHARMACY -HOSEA HOUSE -INTERACT FOR HE ALTH -ITN GREATER CINCINNATI -JACC, INC -KY Office for the Blind -Life Learning Center -L ife Point Solutions -NKU NACU Ctr City Heights -Rosedale Green -The Butler Foundation -Tra nsitions, Inc -Welcomed House of NKY Inc BUSINESSES -ANTHEM MEDICAID -CARESOURCE & HUMA NA -NKY CHAMBER OF COMMERCE -BUSINESS BENEFITS SCHOOLS -BELLEVUE INDEPENDENT SCHOOLS -BOO NE CTY SCHOOLS- NORTH POINTE -CAMPBELL COUNTY SCHOOLS -CAYWOOD ELEMENTARY -COLLINS ELEMENT ARY SCHOOL -COVINGTON INDEPENDENT PUBLIC SCHOOLS -DAYTON HIGH SCHOOL -ERLANGER-ELSMERE IND EPENDENT SCHOOLS -GRANT COUNTY MIDDLE SCHOOL -GRANT COUNTY SCHOOLS -KENTON COUNTY SCHOOL D ISTRICT -LARRY A RYLE HIGH SCHOOL -LAWRENCEBURG COMMUNITY SCHOOL -LLOYD MEMORIAL HIGH SCH OOL -NORTHERN KENTUCKY UNIVERSITY -OCKERMAN MIDDLE SCHOOL -PENDLETON COUNTY HIGH SCHOOL -P INER ELEMENTARY -REILEY ELEMENTARY HEALTH DEPARTMENTS -NKY INDEPENDENT HEALTH DEPARTMENT -THREE RIVERS DISTRICT HEALTH DEPT -DEARBORN COUNTY HEALTH DEPARTMENT CIVIC SERVICES -KE NTON COUNTY DETENTION CENTER -BOONE COUNTY DETENTION CENTER -CAMPBELL COUNTY DETENTION CEN TER -NKY AREA DEVELOPMENT DISTRICT -KENTON COUNTY FISCAL COURT -CAMPBELL COUNTY FISCAL COU RT CITIES -EDGEWOOD -FORT WRIGHT -INDEPENDENCE HEALTHCARE -HEALTHPOINT FAMILY CARE (FQHC) -ST ELIZABETH HEALTHCARE (SEH) -SEH CARE COORDINATION -SEH COVINGTON EMERGENCY DEPARTME NT -SEH EDGEWOOD EMERGENCY DEPARTMENT -SEH FAMILY MEDICAL RESIDENCY PROGRAM -SEH GRANT EME RGENCY DEPARTMENT -SEH HEALTH MINISTRIES PROGRAM -ST ELIZABETH PHYSICIANS (73 RESPONDENTS MULTIPLE OFFICE LOCATIONS)

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
Schedule H, Part V, Section B, Line 6a Facility A, 1	Facility A, 1 - ST ELIZABETH HEALTHCARE ST ELIZABETH - EDGEWOOD ST ELIZABETH - FLORENCE ST ELIZABETH - FT THOMAS ST ELIZABETH - GRANT COUNTY

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
Schedule H, Part V, Section B, Line 11 Facility A, 1	Facility A, 1 - St Elizabeth Healthcare - Florence, Edgewood, Grant & Ft Thomas From the 2018 CHNA, primary data was collected from persons who represent the broad interests of the community, including those with expertise in public health Representation included area health departments, local governmental/civic agencies, other healthcare providers, community-based social service agencies and area school districts The methodology used to collect the data included presentations to groups, phone calls and an online survey The process included an explanation of the CHNA requirements and how the data garnered would be used to develop the CBIP Participants were then asked to list in order from most important to least important what they believed were the top five community health needs that should be addressed and/or considered in the assessment/ Concentrating on social service agencies, school districts and civic services ensured that the CHNA identified and received data on the most pressing health needs within the community served The following is a listing of the community participants Social Service Agencies Brighton Center Catholic Charities Children's Home of NKY Children's Law Center Covington Partners Faith Community Pharmacy Henry Hosea House Interact for Health Life Learning Center NKU NACU Butler Foundation (Corporex) NKY Community Action Commission Schools Kenton County Schools Notre Dame Academy Beechwood Schools Erlanger-Elsmere Schools Covington Schools Fort Thomas Schools Newport Schools Southgate School Health Departments NKY Health Department Three Rivers District Health Department Civic Services Grant County Fiscal Court Pendleton County Fiscal Court Gallatin County Fiscal Court Cities Alexandria Butler Crittenden First Responders First Responders Campbell Co Fire District #1 Dry Ridge Fire/EMS Petersburg Fire District Ludlow Fire Department Newport Fire/EMS Pendleton County EMS Owen County EMS Union Fire District Burlington Fire/EMS Central Campbell Co Fire District Southgate/Wilder EMS Erlanger Fire/EMS St Elizabeth St Elizabeth Healthcare (81 respondents) St Elizabeth Physicians (63 respondents)

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
Schedule H, Part V, Section B, Line 11 Facility A, 2	Facility A, 2 - St Elizabeth Healthcare - Florence, Edgewood, Grant & Ft Thomas Priorit ization of Identified Health Needs Like many communities in Kentucky, heart disease, cance r, stroke, obesity, diabetes, mental health and substance abuse, are prevalent in all of t he NKADD counties After the assessment data was gathered, it was summarized into categori es and tabulated The findings were presented to the System's Community Benefits Steering Committee for review and thoroughly discussed The committee was tasked with ranking the c ommunity's most important health needs and providing suggestions for hospital priorities Many of the needs listed are currently being addressed by St Elizabeth Healthcare or comm unity providers A vote was taken to determine which of the needs identified should be add ressed in the new Plan The three top needs identified to be addressed were Mental Health, Drug Addiction/Treatment and Heart Disease The prioritized list along with the assessmen t findings were presented to the Strategic Planning Committee of the Board for review, dis cussion and a combination of the identified priorities This step in the CHNA process is s ignificant because the priorities identified drive the development of an implementation st rategy and the related goals The top three significant health needs were Mental Health, Drug Addiction/Treatment, and Heart Disease St Elizabeth plan to address these needs is a s follows Mental Health Goal * Collaborate with community partners to develop programs/s ervices to educate, treat, prevent and assist residents of Northern Kentucky, with mental health issues * Develop comprehensive behavioral health care services based on proven bes t practice models Measure * Increase treatment capacity both inpatient and outpatient se rvices Strategies/Tactics * Add 5-7 new providers * Develop a child\teen program * Int egrate behavioral health services within primary care physician offices * Improve coordin ation with community partners such as social services, schools, and county officials to ex tend the continuum of care * Improve access to education in the community Drug Addiction /Treatment Goal * Reduce substance abuse to protect the health, safety and quality of li fe for all * Take a leadership role in education and data distribution Measure * Increa se treatment capacity for inpatient and outpatient services * Reduce overdoses in Norther n Kentucky * Reduce drug induced deaths Strategies/Tactics * Work with community partne rs to educate residents on the dangers of the use/addiction of heroin and prescription opi oid painkillers * Increase access to substance abuse treatment services, including Medica tion-Assisted Treatment (MAT), for opioid addiction * Expand access to and training for a dministering naloxone to reduce opioid overdose deaths * Help local jurisdictions to put these effective practices to work in communities where drug addiction is common, e g , loc al detention centers * Work c

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
Schedule H, Part V, Section B, Line 11 Facility A, 2	ollaboratively with community partners in the continuity of care and wraparound services * Recruit additional addictionologists * Develop support services for addicted mother and babies born with neonatal abstinence syndrome Heart Disease Goal * To develop a Heart & Vascular Institute which encompasses a comprehensive integrated approach to the preventi on, diagnosis and treatment of heart disease with a focus on research Measure * Reduce he art-related deaths in Northern Kentucky by 25 percent by the end of 2025 * Work collabora tively with physicians, community stakeholders and industry to identify new treatments and technology through initiation of research activities Strategies/Tactics * Provide preve ntion and wellness services to the community with the goal of catching heart and vascular disease early or preventing it all together * Support ongoing research for the community * Implement strategies identified by St Elizabeth Physicians * Improve information rece ived from EMS prior to arrival at the hospital * Increase community education on heart at tack symptoms, the importance of timely response to symptoms and the importance of calling 911 * Promote development of walkable and active communities Community Healthcare Resou rces St Elizabeth Healthcare has and will continue to work collaboratively with the vario us healthcare resources that are accessible to the residents of Northern Kentucky when app licable 2017 Accomplishments towards the 2016-2018 Community Health Needs Assessment Plan Mental Health * Provided four community talks addressing separate mental illness topics * Expanded the number or Medicine Assisted Therapy (MAT) providers to 6, including 3 MDs a nd 3 APPs * Developed a telemedicine therapy project to service outlying St Elizabeth Ph ysician (SEP) medical practices * With the coordination of the Behavioral Health provider s and staff, redesigned the entire intake process to provide a seamless entry point for ou r patients and referral sources * Partnered with SUN Behavioral Health and started buildi ng a new comprehensive behavioral health center for Northern Kentucky Drug Addiction/Trea tment * Expanded current services offered at SEP Addiction Medicine and Recovery Center to provide increased access to current services and expand new services * Recruited 1 2 FTE more prescribers * Developed a system of inpatient rounding providers at all three SEH h ospitals These providers will be able to provide services to addicted patients with exist ing medical conditions * Developed an educational program providing guidance to physician s on new prescription guidelines * Added a program to address the needs of pregnant women with SUD and their newborns called Baby Steps * Distributed Narcan to first responders, including training on use * Distributed Narcan to families of patients with overdoses * Partnered with Northern Kentucky Counties to establish a Helpline Heart Disease * Increas ed cardiovascular screening pr

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
Schedule H, Part V, Section B, Line 11 Facility A, 2	ovided to 230 dates through the Cardiovascular Mobile Health Unit (CVMHU) * Increased ind ividuals reached through prevention education by the CVMHU department to 1,563 * Increase d participation in smoking cessation programs to 76 individuals * Increased My Heart Rock s (MHR) programs for local elementary schools reaching 21 schools and 1,867 students * In creased participation in the Take Time for your Heart (TTFYH) prevention and wellness clas s to 70 individuals * Increase participation in the Women Take Heart program to 1,038 wom en * Increased the number of active research studies to 18 * Decreased inpatient heart a ttack mortality to 3 8% by improving information received from EMS prior to arrival and in creasing community education on heart attack symptoms/911 * Increased community education on hands only CPR reaching 3,636 individuals 2018 ACCOMPLISHMENTS TOWARDS THE 2016-2018 COMMUNITY HEALTH NEEDS ASSESSMENT PLAN HEART * Completed 226 screenings with the CardioVa scular Mobile Health Unit (CVMHU) * Reached 4,219 individuals through education efforts fr om the CVMHU * Held 20 My Heart Rocks events in local schools * Reached 169 individuals th rough Take Time for Your Heart prevention & wellness classes * Evaluated 5 new Heart and V ascular research studies * Instructed 1,536 individuals in hands-only CPR * Maintained hea rt attack mortality rate of 2 0% which is below national avg of 5 96% SUD * Provided educa tional opportunities to interested parties on how they can develop, improve and implement a SUD service line by speaking at Beckers National Convention, Kentucky MGMA, Catholic Con ference, and National Opioid Legation Summit * Implemented policy governing the prescribin g and management of controlled substances * Added physicians, therapists, and a case manag er to focus on patients with addiction * Implemented an Intensive Outpatient Program MENTA L HEALTH * Provided physician coverage for SUN Behavioral Health * Added Behavioral Health providers to PCP offices in Walton, Greendale, and Fort Thomas * Developed telemedicine t herapy project to support Crestview Hills PCP office

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	ST ELIZABETH HEALTHCARE - ORTHOPEDIC - EDGEWOOD 560 SOUTH LOOP DRIVE 2ND FLOOR EDGEWOOD, KY 41017	ORTHOPEDIC
1	ST ELIZABETH HEALTHCARE - HOSPICE CENTER - EDGEWOOD 483 SOUTH LOOP DRIVE EDGEWOOD, KY 41017	INPATIENT HOSPICE
2	ST ELIZABETH HEALTHCARE - SURGERY CENTER - EDGEWOOD 580 SOUTH LOOP ROAD EDGEWOOD, KY 41017	AMBULATORY SURGERY CENTER
3	ST ELIZABETH HEALTHCARE - SURGERY CENTER - CRESTVIEW HILLS 2845 CHANCELLOR DRIVE CRESTVIEW HILLS, KY 41017	AMBULATORY SURGERY CENTER
4	ST ELIZABETH HEALTHCARE - COVINGTON 1500 JAMES SIMPSON JR WAY COVINGTON, KY 41011	AMBULATORY CARE CENTER
5	ST ELIZABETH HEALTHCARE - WOMEN'S CENTER 610 MEDICAL VILLAGE DR EDGEWOOD, KY 41017	HEALTH SCREENING
6	ST ELIZABETH HEALTHCARE - BUSINESS HEALTH 4123 OLYMPIC BLVD ERLANGER, KY 41018	BUSINESS HEALTH SERVICES
7	ST ELIZABETH HEALTHCARE - PHYSICAL THERAPY AND IMAGING - HEBRON 2200 CONNER ROAD HEBRON, KY 41048	PHYSICAL THERAPY AND IMAGING CENTER
8	ST ELIZABETH HEALTHCARE - SPORTS MEDICINE - EDGEWOOD 830 THOMAS MORE PARKWAY SUITE 101 EDGEWOOD, KY 41017	SPORTS MEDICINE
9	ST ELIZABETH HEALTHCARE - PHYSICAL THERAPY AND IMAGING - ALEXANDRIA 7200 ALEXANDRIA PIKE ALEXANDRIA, KY 41001	PHYSICAL THERAPY AND IMAGING CENTER
10	ST ELIZABETH HEALTHCARE - SPORTS MEDICINE - FLORENCE 10095 INVESTMENT WAY FLORENCE, KY 41042	SPORTS MEDICINE
11	ST ELIZABETH HEALTHCARE - CARDIAC REHAB - EDGEWOOD 830 THOMAS MORE PARKWAY SUITE 102 EDGEWOOD, KY 41017	CARDIAC REHAB CENTER
12	BLUEGRASS DIALYSIS LLC 1500 JAMES SIMPSON JR WAY SUITE 302 COVINGTON, KY 41011	RENAL DIALYSIS
13	ST ELIZABETH HEALTHCARE - HIGHPOINT MED CANCER SUITE 606 Wilson Creek Rd Lawrenceburg, IN 47025	INFUSION
14	ST ELIZABETH HEALTHCARE - PHYSICAL THERAPY AND SPORTS MEDICINE - WILDER 106 CROSSING DRIVE WILDER, KY 41076	PHYSICAL THERAPY AND SPORTS MEDICINE

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	ST ELIZABETH HEALTHCARE - PHYSICAL THERAPY - GRANT COUNTY 300 BARNES ROAD WILLIAMSTOWN, KY 41097	PHYSICAL THERAPY
1	ST ELIZABETH HEALTHCARE - OWENTON 120 PROGRESS WAY Owenton, KY 40359	AMBULATORY CARE CENTER
2	ST ELIZABETH HEALTHCARE - HEART & VASCULAR - EDGEWOOD 900 MEDICAL VILLAGE DRIVE EDGEWOOD, KY 41017	CARDIOLOGY DIAGNOSTIC TESTS
3	ST ELIZABETH HEALTHCARE - CARDIAC & THORACIC SURGERY - EDGEWOOD 20 MEDICAL VILLAGE DRIVE SUITE 105 EDGEWOOD, KY 41017	CARDIAC DIAGNOSTICS AND CATHETERIZATION
4	ST ELIZABETH HEALTHCARE - HEART & VASCULAR - CRESTVIEW HILLS 380 CENTRE VIEW BLVD CRESTVIEW HILLS, KY 41017	CARDIOLOGY DIAGNOSTIC TESTS
5	ST ELIZABETH HEALTHCARE - HEART & VASCULAR - CRESTVIEW HILLS 350 THOMAS MORE PARKWAY SUITE 280 CRESTVIEW HILLS, KY 41017	CARDIOLOGY DIAGNOSTIC TESTS
6	ST ELIZABETH HEALTHCARE - PHYSICAL THERAPY - WALTON 1 SERVICE ROAD WALTON, KY 41094	PHYSICAL THERAPY
7	ST ELIZABETH HEALTHCARE - INDEPENDENCE DIAGNOSTIC 135 COURTHOUSE CROSSING INDEPENDENCE, KY 41051	PHYSICAL THERAPY
8	ST ELIZABETH HEALTHCARE - LABORATORY - FLORENCE 8726 US 42 FLORENCE, KY 41042	DIAGNOSTICS
9	ST ELIZABETH HEALTHCARE - HEART & VASCULAR - FLORENCE 7370 TURFWAY ROAD SUITE 109 FLORENCE, KY 41042	CARDIOLOGY DIAGNOSTIC TESTS
10	ST ELIZABETH HEALTHCARE - FALMOUTH (DONATED ON 5-1-18) 512 SOUTH MAPLE AVENUE FALMOUTH, KY 41040	ALCOHOL AND DRUG TREATMENT CENTER
11	ST ELIZABETH HEALTHCARE - FAMILY PRACTICE CENTER - EDGEWOOD 413 SOUTH LOOP ROAD EDGEWOOD, KY 41017	FAMILY MEDICINE

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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.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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 . . . . . ▶ 81

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 5

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)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
Schedule I, Part I, Line 2 Procedures for monitoring use of grant funds	St Elizabeth has an established and standardized review and approval process used to monitor grant requests First, all requests for sponsorship must be submitted on a completed Sponsorship Request Form, including a letter of request on the organization's letterhead and a breakdown of all sponsorship levels that include benefits St Elizabeth asks that all organizations submit requests a minimum of 60 days prior to the publication of any marketing materials for the event and/or their sponsorship deadline All requests that are received less than 60 days in advance risk being excluded from consideration All sponsorships are subject to an annual review and evaluation The St Elizabeth Sponsorship Committee meets monthly to evaluate and make sponsorship recommendations All decisions are based on consistency with the criteria mentioned above However, due to the overwhelming number of requests and limited availability of funds, a request may be denied, even if it fits the criteria An official notification of approval or denial comes in the form of a letter or email

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

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
CINCINNATI REDS COMMUNITY FUND 100 JOE NUXHALL WAY GREAT AMERICAN BALL PARK CINCINNATI, OH 452024109	31-1002055	501(c)(3)	250,000				Program Support
THE CINCINNATI REDS LLC 100 JOE NUXHALL WAY GREAT AMERICAN BALL PARK CINCINNATI, OH 452024109	31-1002055		60,342				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
SLAM DUNK SPORTS MARKETING 1012 N UNIVERSITY BLVD MIDDLETOWN, OH 45042	86-1101514		155,217				Program Support
POINTARC OF NORTHERN KENTUCKY INC 104 W PIKE ST COVINGTON, KY 41011	23-7259409	501(c)(3)	25,000				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
SPECIAL OLYMPICS KY INC 105 LAKEVIEW CT FRANKFORT, KY 40601	61-0954571	501(c)(3)	5,500				Program Support
KENTON COUNTY BOARD OF EDUCATION 1055 EATON DR FT WRIGHT, KY 41017	61-6001301	Kenton County	61,500				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
MARCH OF DIMES INC 10806 KENWOOD RD CINCINNATI, OH 45242	13-1846366	501(c)(3)	20,000				Program Support
NEW DAY RANCH INC 10830 BIG BONE CHURCH RD UNION, KY 41091	27-4722366	501(c)(3)	5,417				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
ROMAN CATHOLIC DIOCESE OF COVINGTON 1125 MADISON AVE COVINGTON, KY 41011	61-0458380	501(c)(3)	414,558				Program Support
NEWPORT CENTRAL CATHOLIC HIGH SCHOOL 13 CAROTHERS RD NEWPORT, KY 41071	61-0447243	501(c)(3)	10,250				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
HEALTHPOINT FAMILY CARE INC 1401 MADISON AVE COVINGTON, KY 41011	61-0729915	501(c)(3)	5,000				Program Support
NATIONAL COMPASSION FUND 1450 DUKE ST ALEXANDRIA, VA 22314	83-0924922	501(c)(3)	53,000				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
KENTUCKY CENTER FOR PUBLIC SERVICE 644 BRADDOCK CT EDGEWOOD, KY 41017	46-3464828	501(c)(3)	15,000				Program Support
NOTRE DAME ACADEMY 1699 HILTON DR PARK HILLS, KY 41011	61-0476695	501(c)(3)	5,250				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
BLUEGRASS BUCKEYE CHARITY CLASSIC INC 1727 TUXWORTH AVE CINCINNATI, OH 452384014	45-4194109	501(c)(3)	20,000				Program Support
FINITURA INC 1801 AIRPORT RD STE A WAUKESHA, WI 53188	47-1878675	501(c)(3)	7,646				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
CHILDREN'S HOME OF NORTHERN KENTUCKY INC 200 HOME RD COVINGTON, KY 41011	23-7068704	501(c)(3)	401,750				Program Support
WELCOME HOUSE OF NORTHERN KENTUCKY INC 205 PIKE ST COVINGTON, KY 41011	61-1020382	501(c)(3)	53,000				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
SUPT OF SCHOOLS OF BELLEVUE 219 CENTER ST BELLEVUE, KY 41073	61-6001387	Bellevue	12,600				Program Support
SUPT OF SCHOOLS 219 CENTER ST BELLEVUE, KY 41073	61-6001387	Bellevue	10,100				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
NORTHERN KENTUCKY AREA DEVELOPMENT 22 SPIRAL DR FLORENCE, KY 41042	61-0719369	Florence	35,000				Program Support
STEPHEN SILLER TUNNEL TO TOWERS FDN 2361 HYLAN BLVD STATEN ISLAND, NY 10306	20-0554654	501(c)(3)	5,000				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
HISPANIC CHAMBER CINCINNATI USA 2637 ERIE AVE STE 206 CINTI, OH 45208	31-1458839	501(c)(3)	5,000				Program Support
ADVENTURE CREW 2692 MADISON RD STE N1-414 CINCINNATI, OH 45208	47-4230979	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
COOPER HIGH SCHOOL 2855 LONGBRANCH RD UNION, KY 41091	61-6001252	Union	10,500				Program Support
REDI CINCINNATI LLC 3 E 4TH ST CINCINNATI, OH 45202	47-2090230		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
CINCINNATI USA REGIONAL CHAMBER 3 E 4TH ST STE 200 CINTI, OH 45202	31-0239310	501(c)(3)	25,000				Program Support
NEWPORT INDEPENDENT SCHOOLS 30 W 8TH ST NEWPORT, KY 41071	61-3001336	Newport	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
THOMAS MORE UNIVERSITY INC 333 THOMAS MORE PARKWAY CRESTVIEW HILLS, KY 41017	61-0448560	501(c)(3)	560,310				Program Support
ZOOLOGICAL SOCIETY OF CINCINNATI 3400 VINE ST CINCINNATI, OH 45220	31-0537171	501(c)(3)	7,000				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
WOMEN'S CRISIS CENTER INC 3580 HARGRAVE DR HEBRON, KY 41048	61-0908752	501(c)(3)	10,500				Program Support
HOLY CROSS HIGH SCHOOL 3617 CHURCH ST COVINGTON, KY 41015	62-1577563	501(c)(3)	10,460				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
CATHOLIC CHARITIES DIOCESE OF COVINGTON 3629 CHURCH ST COVINGTON, KY 41015	61-0461728	501(c)(3)	10,300				Program Support
ST HENRY DISTRICT HIGH SCHOOL 3755 SCHEBEN DR ERLANGER, KY 41018	61-0458380	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
AMERICAN CANCER SOCIETY INC 402 COOMER ST SOMERSET, KY 42503	13-1788491	501(c)(3)	30,200				Program Support
THE LEUKEMIA & LYMPHOMA SOCIETY INC 4370 GLENDALE-MILFORD RD CINCINNATI, OH 45242	13-5644916	501(c)(3)	5,000				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
NORTHERN KY FOOTBALL COACHES ASSOCIATION 458 GENERAL DR FT WRIGHT, KY 41011	61-1106788	501(c)(3)	15,000				Program Support
ARTHRITIS FOUNDATION INC 4665 CORNELL RD STE 109 CINCINNATI, OH 45241	58-1341679	501(c)(3)	35,000				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
NORTHERN KENTUCKY REGIONAL ALLIANCE INC 50 E RIVERCENTER BLVD COVINGTON, KY 41011	31-1489316	501(c)(3)	75,000				Program Support
CATALYTIC DEVELOPMENT FUNDING CORP OF NKY 50 E RIVERCENTER BLVD SUITE 429 COVINGTON, KY 41011	26-3389252	501(c)(3)	25,000				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
COVINGTON BUSINESS COUNCIL 50 E RIVERCENTER BLVD SUITE 160 COVINGTON, KY 41011	31-0963057	501(c)(3)	24,500				Program Support
BB&T ARENA AT NORTHERN KY UNIVERSITY 500 NUNN DR HIGHLAND HEIGHTS, KY 41099	23-2511871	Northern Kentucky	75,000				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
GATEWAY COMMUNITY AND TECHNICAL 500 TECHNOLOGY WAY FLORENCE, KY 41042	61-1239550	Florence	15,000				Program Support
AMERICAN HEART ASSOCIATION INC 5211 MADSION AVE CINCINNATI, OH 45227	13-5613797	501(c)(3)	410,000				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
LUDLOW BOARD OF EDUCATION 525 ELM ST LUDLOW, KY 41016	61-6001318	Ludlow	10,500				Program Support
NATIONAL FOOTBALL LEAGUE ALUMNI INC 5725 WHITE BIRCH LN LIBERTY TOWNSHIP, OH 45044	59-1782262	501(c)(3)	30,000				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
THE HEALTH COLLABORATIVE 615 ELSINORE PL STE 500 CINCINNATI, OH 45202	31-1449807	501(c)(3)	5,000				Program Support
HONOR RUN FOUNDATION 6297 REMINGTON COVE BURLINGTON, KY 41005	46-5547770	501(c)(3)	20,000				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
COVINGTON LADIES HOME 702 GARRARD ST COVINGTON, KY 41011	61-0461759	501(c)(3)	13,000				Program Support
NORTHERN KENTUCKY EDUCATION COUNCIL 7310 TURFWAY RD STE 115 FLORENCE, KY 41042	20-3105862	501(c)(3)	21,000				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
BRAIN INJURY ALLIANCE OF KENTUCKY 7321 NEW LAGRANGE RD STE 100 LOUISVILLE, KY 402224871	61-1128496	501(c)(3)	100,000				Program Support
FAMILY NURTURING CENTER OF KENTUCKY 8275 EWING BLVD FLORENCE, KY 41042	31-1011326	501(c)(3)	11,500				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
CONNER HIGH SCHOOL 8330 US HWY 42 FLORENCE, KY 41042	61-6001252	Florence	10,420				Program Support
BOONE COUNTY BOARD OF EDUCATION 99 CENTER STREET FLORENCE, KY 41042	61-6001252	Boone County	22,419				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
PRICHARD COMMITTEE FOR ACADEMIC EXCELLENCE 271 W SHORT ST LEXINGTON, KY 40507	61-1026214	501(c)(3)	10,000				Program Support
HORIZON COMMUNITY FUNDS OF NORTHERN KENTUCKY INC 50 E RIVERCENTER BLVD STE 434 COVINGTON, KY 41011	82-1388190	501(c)(3)	10,500				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
NORTHERN KENTUCKY UNIVERSITY NUNN DR HC206 COLLEGE OF HEALTH PROFESSIONS HIGHLAND HEIGHTS, KY 41099	61-1010545	Northern Kentucky	229,437				Program Support
NEW PERCEPTIONS INC ONE SPERTI DR EDGEWOOD, KY 41017	61-0705047	501(c)(3)	6,000				Program Support

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

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NORTHERN KENTUCKY CHAMBER OF COMMERCE PO BOX 17416 FT MITCHELL, KY 41017	61-0679408	501(c)(3)	148,539				Program Support
NORTHERN KY CHAMBER OF COMMERCE FDN INC PO BOX 17416 FT MITCHELL, KY 41017	61-0679408	501(c)(3)	50,000				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
NORTHERN KENTUCKY OHIO VOLLEYBALL CLUB PO BOX 188071 ERLANGER, KY 41018	14-1858651	501(c)(3)	10,000				Program Support
KENTUCKY HOSPITAL ASSOCIATION PO BOX 24163 LOUISVILLE, KY 402240163	61-0574577	501(c)(4)	25,844				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
BRIGHTON CENTER INC PO BOX 325 NEWPORT, KY 41072	61-0673886	501(c)(3)	11,406				Program Support
EMERGENCY SHELTER OF NORTHERN KENTUCKY PO BOX 332 COVINGTON, KY 41012	26-0851019	501(c)(3)	20,300				Program Support

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

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BOY SCOUTS OF AMERICA- COUNCIL 438 PO BOX 36273 LOUISVILLE, KY 40233	61-6034017	501(c)(3)	110,000				Program Support
CANCER SUPPORT COMMUNITY PO BOX 4061 LOUISVILLE, KY 40204	31-1287785	501(c)(3)	15,000				Program Support

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

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PARTNERS FOR MEDICAL RELIEF PO BOX 43254 CINCINNATI, OH 45243	82-1748297	501(c)(3)	12,300				Program Support
FITNESS FOR LIFE AROUND GRANT COUNTY PO BOX 518 WILLIAMSTON, KY 41097	20-2576615	501(c)(3)	10,250				Program Support

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

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HEALTH MINISTRIES ASSOCIATION INC PO BOX 60042 DAYTON, OH 45406	42-1351520	501(c)(3)	6,298				Program Support
CINCINNATI INSTITUTE OF FINE ARTS PO BOX 630561 CINCINNATI, OH 452630561	31-0537138	501(c)(3)	10,000				Program Support

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

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RENEWPORT INC PO BOX 72366 NEWPORT, KY 41072	81-2051757	501(c)(3)	60,000				Program Support
FORT THOMAS EDUCATION FOUNDATION PO BOX 75090 FT THOMAS, KY 41075	61-1393646	Fort Thomas	35,000				Program Support

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

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NKYHATESHEROINCOMINC PO BOX 75273 FT THOMAS, KY 41075	46-4779369	501(c)(3)	5,000				Program Support
PADDLING FOR CANCER AWARENESS PO BOX 76213 HIGHLAND HEIGHTS, KY 41076	26-3552805	501(c)(3)	10,000				Program Support

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

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KENTUCKY SCIENCE AND TECHNOLOGY PO BOX 1049 LEXINGTON, KY 405881049	61-1135362	501(c)(3)	10,000				Program Support
LIFE LEARNING CENTER 20 W 18TH ST COVINGTON, KY 41011	20-3454261	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
NORTHERN KENTUCKY INDEPENDENT HEALTH DEPARTMENT 610 MEDICAL VILLAGE DR EDGEWOOD, KY 41017	61-1008505	Northern Kentucky	8,300				Program Support
NORTHERN KENTUCKY INDEPENDENT DISTRICT HEALTH DEPARTMENT 610 MEDICAL VILLAGE DR EDGEWOOD, KY 41017	61-1008505	Northern Kentucky	6,700				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
GRANT COUNTY BOARD OF EDUCATION 820 ARNIE RISEN BLVD WILLIAMSTOWN, KY 41097	61-6001380	Grant County	6,250				Program Support
CARMEL MANOR INC 100 CARMEL MANOR RD FT THOMAS, KY 41075	61-0523290	501(c)(3)	5,494				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
CITY OF FORT THOMAS 130 N FT THOMAS AVE FT THOMAS, KY 41075	61-6001825	Fort Thomas	5,000				Program Support
GREATER CINCINNATI FOUNDATION 200 W 4TH ST CINCINNATI, OH 45202	31-0669700	501(c)(3)	5,000				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
HIGHLANDS SOCCER CLUB INC PO BOX 75311 FT THOMAS, KY 41075	45-4110460	501(c)(3)	5,000				Program Support
KAREN WELLINGTON MEMORIAL FOUNDATION FOR LIVING WITH BREAST CANCER PO BOX 6464 CINTI, OH 45201	26-3768567	501(c)(3)	5,000				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
THE CARNEGIE VISUAL AND PERFORMING 1028 SCOTT BLVD COVINGTON, KY 41011	61-0897319	501(c)(3)	5,000				Program Support
HEALTHCARE ADVOCATES OF NORTHERN KENTUCKY INC 1 MEDICAL VILLAGE DRIVE EDGEWOOD, KY 41017	83-2875231	501(C)(4)	354,221				PROGRAM SUPPORT

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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.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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**	Yes	
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**	Yes	
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							

Part III Supplemental Information

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

Return Reference	Explanation
Schedule J, Part I, Line 1a Travel for companions	THIS IS PROVIDED TO BOARD MEMBERS AND OFFICERS BOARD RETREAT COMPANION TRAVEL IS TREATED AS TAXABLE COMPENSATION

Return Reference	Explanation
Schedule J, Part I, Line 1a Housing allowance or residence for personal use	WILLIAM BANKS IS PROVIDED A HOUSING ALLOWANCE THAT IS TREATED AS TAXABLE COMPENSATION

Return Reference	Explanation
Schedule J, Part I, Line 4b Supplemental nonqualified retirement plan	Certain individuals listed in part Part VII participated in a split dollar life insurance plan Please refer to Schedule L for participants, premiums and outstanding loan amounts

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
GARREN COLVIN	(I)	949,135	263,530	2,622	18,500	33,235	1,267,022	0
PRESIDENT/CEO	(II)	0	0	0	0	0	0	0
ROBERT BAKER MD	(I)	0	0	0	0	0	0	0
PHYSICIAN / DIRECTOR	(II)	139,466	29,550	5,584	23,900	25,050	223,550	0
DOUG FLORA MD	(I)	0	0	0	0	0	0	0
TRUSTEE	(II)	737,233	45,242	1,710	23,900	32,663	840,748	0
HEIDI MURLEY MD	(I)	0	0	0	0	0	0	0
TRUSTEE	(II)	476,653	44,942	2,355	5,400	31,781	561,131	0
GARY BLANK	(I)	595,012	53,725	4,902	8,661	15,902	678,202	0
EXECUTIVE VP & COO, CNE	(II)	0	0	0	0	0	0	0
LISA FREY	(I)	343,563	17,960	1,745	18,500	12,884	394,651	0
VP LEGAL SERVICES/GENERAL COUNSEL/CORPORATE SECRETARY	(II)	0	0	0	0	0	0	0
LAROY KENDALL	(I)	383,669	84,635	3,696	23,900	25,383	521,282	0
VP Medical Services, CMO	(II)	0	0	0	0	0	0	0
ROBERT PRICHARD MD	(I)	681,397	178,945	4,902	18,500	26,837	910,581	0
Chief Clinical Integration Officer, SEP President & CEO	(II)	0	0	0	0	0	0	0
LORI RITCHEY-BALDWIN	(I)	553,925	145,209	4,902	23,900	33,785	761,721	0
Senior Vice President/CFO/Treasurer	(II)	0	0	0	0	0	0	0
MARTIN OSCADAL	(I)	346,200	34,110	10,660	18,500	24,332	433,802	0
FORMER SVP HUMAN RESOURCES	(II)	0	0	0	0	0	0	0
BENITA ANDERSON	(I)	266,533	35,679	3,834	18,500	17,092	341,639	0
VP Nursing - Florence/Ft Thomas	(II)	0	0	0	0	0	0	0
WILLIAM BANKS	(I)	322,758	58,471	30,473	18,500	30,199	460,401	0
VP MANAGED CARE	(II)	0	0	0	0	0	0	0
JACOB BAST	(I)	401,508	47,889	1,362	5,400	27,816	483,974	0
SEP COO / SECRETARY	(II)	0	0	0	0	0	0	0
JOSEPH BOZZELLI	(I)	181,248	24,343	2,513	12,985	13,125	234,214	0
VP MISSION SVCS & PASTORAL CARE	(II)	0	0	0	0	0	0	0
CHRISTOPER CARLE	(I)	372,435	82,490	3,599	18,500	14,640	491,664	0
PRESIDENT & CEO SEPN	(II)	0	0	0	0	0	0	0
CARRI CHANDLER	(I)	233,130	29,502	753	4,338	24,109	291,832	0
VP - FOUNDATION	(II)	0	0	0	0	0	0	0
PAMELA DEETER	(I)	278,742	49,836	1,407	23,900	13,121	367,006	0
VP FINANCE	(II)	0	0	0	0	0	0	0
BRUNO GIACOMUZZI	(I)	333,074	85,433	3,732	23,828	24,115	470,182	0
COO Flo FT Cov & SVP Prof Svcs	(II)	0	0	0	0	0	0	0
SARAH GIOLANDO	(I)	395,436	87,190	2,040	5,400	29,109	519,175	0
SVP/CHIEF STRATEGY OFFICER	(II)	0	0	0	0	0	0	0
VERA HALL	(I)	314,251	17,475	1,044	17,567	30,617	380,955	0
SVP System CNE	(II)	0	0	0	0	0	0	0

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				
ANTHONY HELTON	(I)	226,817	41,767	2,164	5,400	33,023	309,171	0
VP Revenue Cycle	(II)	0	0	0	0	0	0	0
BRUCE HENLEY	(I)	281,922	30,276	4,832	23,475	26,883	367,388	0
SEP CFO / TREASURER	(II)	0	0	0	0	0	0	0
MATTHEW HOLLENKAMP	(I)	197,968	33,845	421	4,181	28,683	265,098	0
VP MARKETING AND CONSUMER RELATIONS	(II)	0	0	0	0	0	0	0
JAMES HORN	(I)	348,362	27,016	788	5,400	31,540	413,105	0
VP/CHIEF QUALITY OFFICER/ PHYSICIAN	(II)	0	0	0	0	0	0	0
KATHY LYNN JENNINGS	(I)	213,732	28,149	1,968	7,880	27,325	279,054	0
VP PATIENT CARE/ONCOLOGY	(II)	0	0	0	0	0	0	0
JAMES McCARVILLE	(I)	212,311	27,766	1,974	4,514	28,948	275,514	0
VP - QUALITY	(II)	0	0	0	0	0	0	0
SUSAN MCDONALD	(I)	278,322	37,432	4,045	23,900	13,080	356,779	0
VP Nursing - Edgewood	(II)	0	0	0	0	0	0	0
JOHN MITCHELL	(I)	231,743	33,319	1,265	18,500	12,266	297,092	0
SVP - COO FT THOMAS	(II)	0	0	0	0	0	0	0
ROSANNA NIELDS	(I)	195,408	34,794	1,776	0	24,916	256,894	0
VP PLANNING & GOVT RELATIONS	(II)	0	0	0	0	0	0	0
JAMES PARSONS	(I)	196,222	0	430	0	7,275	203,927	0
SVP HUMAN RESOURCES	(II)	0	0	0	0	0	0	0
ALEXANDER RODRIGUEZ	(I)	389,165	70,428	3,821	0	31,769	495,183	0
VP CIO	(II)	0	0	0	0	0	0	0
HARRY WATSON	(I)	275,342	59,945	3,924	10,179	3,718	353,107	0
Sr VP Facilities	(II)	0	0	0	0	0	0	0
JASON WESSEL	(I)	198,471	19,777	653	4,274	29,881	253,056	0
VP OF PROFESSIONAL SERVICES	(II)	0	0	0	0	0	0	0
DARRYL DIAS MD	(I)	1,079,380	86,356	2,622	23,900	33,319	1,225,578	0
PHYSICIAN	(II)	0	0	0	0	0	0	0
JEROME SCHUTZMAN MD	(I)	1,297,073	82,172	4,902	23,900	34,292	1,442,339	0
PHYSICIAN	(II)	0	0	0	0	0	0	0
MOHAMAD SINNO MD	(I)	883,095	102,790	1,140	23,900	33,105	1,044,030	0
PHYSICIAN	(II)	0	0	0	0	0	0	0
JON HAYS MD	(I)	959,069	92,790	1,710	23,900	32,367	1,109,837	0
PHYSICIAN	(II)	0	0	0	0	0	0	0
JEFFREY REICHARD MD	(I)	871,511	141,540	2,622	23,900	35,543	1,075,116	0
PHYSICIAN	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009B	52-1643102		12-09-2009	38,150,000	PARTIAL REFUNDING OF BONDS ISSUED 6/11/03		X		X		X
B	KENTUCKY BOND DEVELOPMENT CORPORATION - 2015A	47-2650498		12-30-2015	50,000,000	RENOVATIONS TO HOSPITAL		X		X		X
C	KENTUCKY BOND DEVELOPMENT CORPORATION - 2015B	47-2650498		12-30-2015	50,000,000	RENOVATIONS TO HOSPITAL		X		X		X
D	KENTUCKY BOND DEVELOPMENT CORPORATION - SERIES 2016	47-2650498	491210AW0	05-12-2016	98,494,028	ADVANCE REFUNDING OF SERIES 2009A BONDS ISSUED ON 12/09/09		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	10,925,000	3,575,000	1,275,000	5,050,000
2	Amount of bonds legally defeased	0	0	0	0
3	Total proceeds of issue	38,150,000	50,483,846	50,011,339	98,494,028
4	Gross proceeds in reserve funds	0	0	0	0
5	Capitalized interest from proceeds	0	0	0	0
6	Proceeds in refunding escrows	0	0	0	94,985,984
7	Issuance costs from proceeds	360,000	245,000	222,000	0
8	Credit enhancement from proceeds	0	0	0	0
9	Working capital expenditures from proceeds	0	0	0	0
10	Capital expenditures from proceeds	0	26,825,710	49,793,015	0
11	Other spent proceeds	37,790,000	0	0	2,475,000
12	Other unspent proceeds	0	1,265	0	0
13	Year of substantial completion	2003	2018	2018	2009

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X			X		X		X
15	Were the bonds issued as part of an advance refunding issue?		X		X		X	X	
16	Has the final allocation of proceeds been made?	X			X		X		X
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X			X		X	X	
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X						X	
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X	X			X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?			X		X			
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		0 %		0 %		0 04 %		0 %
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		0 %		0 %		0 %		0 %
6	Total of lines 4 and 5		0 %		0 %		0 04 %		0 %
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X		X		X		X	

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X	X		X			X
b	Exception to rebate?		X		X		X		X
c	No rebate due?	X			X		X		X
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X			X	X			X
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X	X			X
b	Name of provider					PNC BANK NATIONAL ASSOCIATION			
c	Term of hedge						3000 %		
d	Was the hedge superintegrated?						X		
e	Was the hedge terminated?						X		

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X	X	
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X		X	

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation
Schedule K, Part V Procedures to Undertake Corrective Action	St Elizabeth Medical Center, Inc d/b/a St Elizabeth Healthcare has written procedures to ensure that violations of federal tax requirements are timely identified If self-remediation is not available under applicable regulations, St Elizabeth Healthcare would contact its bond counsel regarding the IRS' voluntary closing agreement program

Return Reference	Explanation
Schedule K, Part III, Line 4 Research Agreement Revenue	The amount of revenue from the Research Agreements is de minimis representing less than 0 0433% of the Total Operating Revenue

Return Reference	Explanation
Schedule K, Part I, Column (f) KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009A	CONSTRUCTION OF HOSPITAL FACILITY/PARTIAL REFUNDING OF BOND ISSUED 6/11/03

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN A	Issuer name KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009B The calculation for computing no rebate due was performed on 06/04/2014

Return Reference	Explanation
Schedule K, Part IV, Line 2c COLUMN A	Issuer name KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009A The calculation for computing no rebate due was performed on 06/04/2014

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

Return Reference	Explanation
Schedule K, Part V Procedures to Undertake Corrective Action	St Elizabeth Medical Center, Inc d/b/a St Elizabeth Healthcare has written procedures to ensure that violations of federal tax requirements are timely identified If self-remediation is not available under applicable regulations, St Elizabeth Healthcare would contact its bond counsel regarding the IRS' voluntary closing agreement program
Schedule K, Part III, Line 4 Research Agreement Revenue	The amount of revenue from the Research Agreements is de minimis representing less than 0 0433% of the Total Operating Revenue
Schedule K, Part I, Column (f) KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009A	CONSTRUCTION OF HOSPITAL FACILITY/PARTIAL REFUNDING OF BOND ISSUED 6/11/03
Schedule K, Part IV, Line 2c COLUMN A	Issuer name KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009B The calculation for computing no rebate due was performed on 06/04/2014
Schedule K, Part IV, Line 2c COLUMN A	Issuer name KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009A The calculation for computing no rebate due was performed on 06/04/2014

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	KENTUCKY ECONOMIC DEVELOPMENT FINANCE AUTHORITY - SERIES 2009A	52-1643102	49126KGH8	12-09-2009	101,960,448	SEE STATEMENT	X			X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	20,250,000			
2	Amount of bonds legally defeased	81,600,000			
3	Total proceeds of issue	101,960,448			
4	Gross proceeds in reserve funds	0			
5	Capitalized interest from proceeds	0			
6	Proceeds in refunding escrows	0			
7	Issuance costs from proceeds	1,430,179			
8	Credit enhancement from proceeds	0			
9	Working capital expenditures from proceeds	0			
10	Capital expenditures from proceeds	29,195,269			
11	Other spent proceeds	71,335,000			
12	Other unspent proceeds	0			
13	Year of substantial completion	2009			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X							
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X							
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X							
c	Are there any research agreements that may result in private business use of bond-financed property?		X						
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0 %							
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	0 %							
6	Total of lines 4 and 5	0 %							
7	Does the bond issue meet the private security or payment test?		X						
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X							

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X						
b	Exception to rebate?		X						
c	No rebate due?	X							
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X						
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X						
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X							

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X							

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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

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
See Additional Data Table												
Total				▶ $		9,368,104						

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) BEST UPON REQUEST	BOARD MEMBER TILLIE HIDALGO LIMA OWNS BEST UPON REQUEST	321,944	CONCIERGE SERVICES		No
(2) Substantial Contributor	Substantial Contributor	8,127,155	Independent Contractor Arrangement		No

Part V Supplemental Information

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

Return Reference	Explanation
Schedule L, Part IV BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS	BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS WERE AT ARM'S LENGTH (FMV) AND APPROVED BY DISINTERESTED MEMBERS OF THE BOARD
Schedule L, Part II To fund split dollar life Insurance premiums for supplemental life insurance	The Organization has entered into a split-dollar life insurance with a number of its executive and key employees in order to provide supplemental life insurance benefits Premiums under the arrangement, as opposed to contributions to a standard non-qualified plan, are not an expense for accounting purposes In addition, all of the premiums, treated as split-dollar loans in accordance with IRS rules, will be recovered by the Organization with interest at the death of the individual(s), which will help further the Organization's charitable mission (see the associated receivable in Part X)

Additional Data

Software ID: 18007697
Software Version: 2018v3.1
EIN: 61-0445850
Name: St Elizabeth Medical Center Inc

Form 990, Schedule L, Part II - Loans to and from Interested Persons

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
Bill Banks	VP Revenue Cycle/Managed Care	To fund split dollar life Insurance premiums for supplemental life insurance		X	319,023	327,548		No	Yes		Yes	
Jacob Bast	SVP & COO - SEP	To fund split dollar life Insurance premiums for supplemental life insurance		X	235,336	242,064		No	Yes		Yes	
Gary Blank	Exec VP 7 COO	To fund split dollar life Insurance premiums for supplemental life insurance		X	537,543	554,140		No	Yes		Yes	
Tom Boggs	President & CEO - HSN	To fund split dollar life Insurance premiums for supplemental life insurance		X	130,062	134,516		No	Yes		Yes	
Joseph Bozzelli	VP Mission Svcs & Pastoral Care	To fund split dollar life Insurance premiums for supplemental life insurance		X	79,372	80,900		No	Yes		Yes	
Chris Carle	President & CEO - SEPN	To fund split dollar life Insurance premiums for supplemental life insurance		X	407,048	420,930		No	Yes		Yes	
Garren Colvin	President & CEO	To fund split dollar life Insurance premiums for supplemental life insurance		X	1,711,252	1,766,748		No	Yes		Yes	
Pam Deeter	VP Finance	To fund split dollar life Insurance premiums for supplemental life insurance		X	70,213	72,457		No	Yes		Yes	
Lisa Frey	VP Legal Svcs/General Counsel	To fund split dollar life Insurance premiums for supplemental life insurance		X	124,070	127,496		No	Yes		Yes	
Bruno Giacomuzzi	VP COO Flo Grant & Prof Svcs	To fund split dollar life Insurance premiums for supplemental life insurance		X	224,889	231,694		No	Yes		Yes	
Sarah Giolando	VP COO Flo Grant & Prof Svcs	To fund split dollar life Insurance premiums for supplemental life insurance		X	317,774	328,257		No	Yes		Yes	
Vera Hall	SVP System CNE	To fund split dollar life Insurance premiums for supplemental life insurance		X	126,161	129,285		No	Yes		Yes	
Anthony Helton	VP Revenue Cycle	To fund split dollar life Insurance premiums for supplemental life insurance		X	101,922	105,443		No	Yes		Yes	
Bruce Henley	CFO - SEP	To fund split dollar life Insurance premiums for supplemental life insurance		X	203,497	209,960		No	Yes		Yes	
Matt Hollenkamp	VP Marketing & Public Relation	To fund split dollar life Insurance premiums for supplemental life insurance		X	38,204	39,352		No	Yes		Yes	

Form 990, Schedule L, Part II - Loans to and from Interested Persons

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
James Horn	VP, Chief Quality Officer	To fund split dollar life Insurance premiums for supplemental life insurance		X	106,269	109,509		No	Yes		Yes	
Kathy Jennings	SVP Patient Care Svcs/Cancer Care	To fund split dollar life Insurance premiums for supplemental life insurance		X	52,108	53,850		No	Yes		Yes	
LaRoy Kendall	SVP Chief Medical Officer	To fund split dollar life Insurance premiums for supplemental life insurance		X	126,818	130,986		No	Yes		Yes	
Jim McCarville	VP Quality	To fund split dollar life Insurance premiums for supplemental life insurance		X	38,312	39,455		No	Yes		Yes	
Susan McDonald	VP CNO Edgewood/Cov/Grant	To fund split dollar life Insurance premiums for supplemental life insurance		X	127,124	131,551		No	Yes		Yes	
John Mitchell	SVP COO Ft Thomas/Covington	To fund split dollar life Insurance premiums for supplemental life insurance		X	77,763	79,810		No	Yes		Yes	
Rosanne Nields	VP Planning & Govt Relations	To fund split dollar life Insurance premiums for supplemental life insurance		X	118,430	122,446		No	Yes		Yes	
Marty Oscadal	SVP Human Resources	To fund split dollar life Insurance premiums for supplemental life insurance		X	334,523	345,922		No	Yes		Yes	
Robert Prichard	EVP/CEO - SEP/CCIO	To fund split dollar life Insurance premiums for supplemental life insurance		X	734,880	760,153		No	Yes		Yes	
Lori Ritchey-Baldwin	Sr VP Finance/CFO	To fund split dollar life Insurance premiums for supplemental life insurance		X	288,403	298,336		No	Yes		Yes	
Alex Rodriguez	VP/Chief Information Officer	To fund split dollar life Insurance premiums for supplemental life insurance		X	344,766	356,620		No	Yes		Yes	
Benita Anderson	VP, CNO Florence/Ft Thomas/Falmouth	To fund split dollar life Insurance premiums for supplemental life insurance		X	158,614	162,747		No	Yes		Yes	
Harry Watson	SVP Facilities	To fund split dollar life Insurance premiums for supplemental life insurance		X	108,450	111,911		No	Yes		Yes	
Mohan Brar	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	67,500	68,311		No	Yes		Yes	
Carri Chandler	VP, Foundation	To fund split dollar life Insurance premiums for supplemental life insurance		X	35,691	36,478		No	Yes		Yes	

Form 990, Schedule L, Part II - Loans to and from Interested Persons

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
Darryl Dias	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	200,000	202,217		No	Yes		Yes	
Saadeddine Dughman	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	50,000	50,493		No	Yes		Yes	
Kevin Fitzgerald	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	300,000	304,014		No	Yes		Yes	
Kevin Miller	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	120,000	121,470		No	Yes		Yes	
Mohamad Sinno	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	150,000	151,480		No	Yes		Yes	
Robert Strickmeyer	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	300,000	303,325		No	Yes		Yes	
Damodhar Suresh	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	400,000	405,190		No	Yes		Yes	
Saeb Khoury	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	48,000	48,588		No	Yes		Yes	
Paul Houlihan	Physician	To fund split dollar life Insurance premiums for supplemental life insurance		X	200,000	202,452		No	Yes		Yes	

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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	6,300	Cost
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded	X	13	109,073	Market value
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (FOOD/PRIZES)	X	158	41,430	Cost
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement — 29: 0

		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?		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?	Yes	
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		No
b	If "Yes," describe in Part II		
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II		

Part II **Supplemental Information.**

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

Return Reference	Explanation
Schedule M, Part I Explanations of reporting method for number of contributions	Securities - Publicly traded - ST ELIZABETH HEALTHCARE IS REPORTING THE 13 ITEMS BASED ON CONTRIBUTIONS RECEIVED Other - FOOD/PRIZES ST ELIZABETH HEALTHCARE IS REPORTING THE 158 ITEMS BASED ON CONTRIBUTIONS RECEIVED Art - Works of art - ST ELIZABETH HEALTHCARE IS REPORTING THE 1 ITEM BASED ON CONTRIBUTIONS RECEIVED

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 13 WHISTLEBLOWER POLICY	ST ELIZABETH HEALTHCARE DOES NOT HAVE A SPECIFIC WHISTLEBLOWER POLICY HOWEVER, THERE IS A SECTION OF ST ELIZABETH HEALTHCARE'S CORPORATE RESPONSIBILITY PROGRAM THAT ADDRESSES COMPLIANCE WITH THE FEDERAL FALSE CLAIMS ACT AND WITHIN THAT SECTION, PROTECTION FOR WHISTLEBLOWERS IS SPECIFICALLY ADDRESSED

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 1a Delegate broad authority to a committee	The members of the following committees act in an advisory capacity to the Board of Trustees and make recommendations to the Board, they are Investment, Strategic Planning, Audit, Finance, Governance and Quality/Patient Care In addition, the Compensation Committee members have actual voting and decision power such that they are an "authorized body" of the Board of Trustees

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7a Members or stockholders electing members of governing body	MOST REVEREND CATHOLIC BISHOP OF COVINGTON KENTUCKY HAS CERTAIN RESERVED POWERS IN REGARD TO MAJOR TRANSACTIONS THE BOARD OF TRUSTEES OF ST ELIZABETH HEALTHCARE WILL BE APPOINTED ACCORDING TO THE FOLLOWING SUMMARIZED PROCEDURE (I) THE BOARD SHALL SUBMIT TO THE BISHOP UP TO THREE NAMES OF CANDIDATES FOR EACH VACANCY, (II) ORDINARILY THE BISHOP WILL CHOOSE TRUSTEES TO FILL THE VACANCIES OR OPENINGS FROM THE RECOMMENDED CANDIDATES AFTER PERSONAL CONSULTATION WITH THE PRESIDENT IF THE BISHOP DOES NOT CHOOSE ANYONE FROM THE LIST, THE BOARD WILL SUBMIT NEW NAMES AS SOON AS PRACTICAL, (III) THE BISHOP RESERVES THE RIGHT TO SUBMIT OTHER NAMES TO THE BOARD FOR REVIEW AND COMMENT, (IV) IN CONSULTATION WITH THE PRESIDENT OF THE MEDICAL CENTER OR THE BOARD CHAIR, THE BISHOP MAY REMOVE ANY MEMBER OF THE BOARD IF CERTAIN ACTIONS ARE COMMITTED, (V) IF THE BISHOP DECLINES A CANDIDATE OR THE CANDIDATE DECLINES, THE LIST OF CANDIDATES WILL BE REVISITED ACCORDING TO PROCEDURES (I) THROUGH (III) ABOVE

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 7b Decisions requiring approval by members or stockholders	MOST REVEREND CATHOLIC BISHOP OF COVINGTON KENTUCKY HAS CERTAIN RESERVED POWERS IN REGARD TO MAJOR TRANSACTIONS THE FOLLOWING ACTIONS REQUIRE PRIOR APPROVAL OF THE BISHOP (I) THE AMENDMENT OR REPEAL OF SECTIONS 2(B) OR 2(C) OF THE BYLAWS OR ANY PROVISIONS OF THE GOVERNING DOCUMENTS RELATING TO THE AUTHORITY OF THE BISHOP OR BOARD OF TRUSTEES OF ST ELIZABETH HEALTHCARE, (II) ANY ACTION THAT RESULTS IN A SUBSTANTIAL CHANGE, AS DETERMINED BY THE BISHOP OR THE BOARD, IN THE PHILOSOPHY OR MISSION OF ST ELIZABETH HEALTHCARE, OR IN THE USE OF A ST ELIZABETH HEALTHCARE HOSPITAL FACILITY, (III) THE DISSOLUTION, CONSOLIDATION, MERGER, OR TERMINATION OF EXISTENCE OF ST ELIZABETH HEALTHCARE, AND (IV) A BORROWING, LEASE, TRANSFER, OR ENCUMBRANCE OF ANY REAL ESTATE OF ST ELIZABETH HEALTHCARE EXCEEDING $5,000,000

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 11b Review of form 990 by governing body	ST ELIZABETH HEALTHCARE'S PROCESS TO REVIEW THE FORM 990 CONSISTS OF REVIEW AND APPROVAL BY CERTAIN MEMBERS OF MANAGEMENT AND THE ST ELIZABETH HEALTHCARE'S BOARD OF TRUSTEES THE FORM 990 IS REVIEWED WITH AND APPROVED BY THE FINANCE COMMITTEE SUBSEQUENT TO THE FINANCE COMMITTEE'S APPROVAL, BUT PRIOR TO FILING WITH THE IRS, THE FORM 990 IS PROVIDED TO THE BOARD OF TRUSTEES FOR THEIR REVIEW AND MANAGEMENT IS AVAILABLE FOR ANY QUESTIONS OR COMMENTS

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 12c Conflict of interest policy	ST ELIZABETH HEALTHCARE REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES COMPLIANCE WITH ITS CONFLICT OF INTEREST POLICY IN THAT ANY DIRECTOR, PRINCIPAL OFFICER, OR A MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS, WHO HAS A DIRECT OR INDIRECT FINANCIAL INTEREST, MUST DISCLOSE THE EXISTENCE OF THE FINANCIAL INTEREST AND BE GIVEN THE OPPORTUNITY TO DISCLOSE ALL MATERIAL FACTS TO THE DIRECTORS AND MEMBERS OF THE COMMITTEE WITH THE GOVERNING BOARD DELEGATED POWERS CONSIDERING THE PROPOSED TRANSACTION OR ARRANGEMENT THE REMAINING INDIVIDUALS ON THE GOVERNING BOARD OR COMMITTEE MEETING WILL DECIDE IF CONFLICTS OF INTEREST EXISTS EACH DIRECTOR, PRINCIPAL OFFICER, AND MEMBER OF A COMMITTEE WITH GOVERNING BOARD DELEGATED POWERS ANNUALLY SIGNS A STATEMENT WHICH AFFIRMS THAT SUCH PERSON (I) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY, (II) HAS READ AND UNDERSTANDS THE POLICY, (III) HAS AGREED TO COMPLY WITH THE POLICY, AND (IV) UNDERSTANDS THAT ST ELIZABETH HEALTHCARE IS CHARITABLE AND IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION, IT MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ITS TAX EXEMPT PURPOSE WHEN BUSINESS MATTERS COME BEFORE THE BOARD IN WHICH A MEMBER IS INVOLVED AND A POTENTIAL CONFLICT OF INTEREST MAY EXIST (I) THE MEMBER SHOULD AGAIN MAKE A VERBAL DISCLOSURE TO THE MEMBERSHIP PRESENT (II) THE BOARD SHALL ASK THE INTERESTED MEMBER TO LEAVE THE MEETING DURING DISCUSSION OF THE MATTER THAT GIVES RISE TO THE POTENTIAL CONFLICT, (III) THE INTERESTED MEMBER SHALL NOT VOTE ON NOR USE HIS OR HER PERSONAL INFLUENCE ON THE MATTER THAT GIVES RISE TO THE POTENTIAL CONFLICT, (IV) THE INTERESTED MEMBER SHALL NOT BE COUNTED IN DETERMINING THE EXISTENCE OF A QUORUM AT SUCH MEETING, AND (V) THE MINUTES OF THE MEETING SHALL REFLECT THE DISCLOSURE MADE, THE VOTE TAKEN, AND WHICH MEMBERS WERE PRESENT AND VOTING

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Process to establish compensation of top management official	IN DETERMINING THE COMPENSATION OF ST ELIZABETH HEALTHCARE'S CHIEF EXECUTIVE OFFICER, AN EVALUATION IS DONE BY THE COMPENSATION COMMITTEE AND EXECUTIVE COMMITTEE USING APPROPRIATE COMPARABLE DATA, AND THEN A COMPENSATION RECOMMENDATION IS PRESENTED TO THE BOARD FOR APPROVAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b Process to establish compensation of other employees	OTHER KEY EXECUTIVES ARE REVIEWED, AND THE CHIEF EXECUTIVE OFFICER MAKES RECOMMENDATIONS FOR THEIR COMPENSATION TO THE COMPENSATION COMMITTEE THE COMPENSATION COMMITTEE THEN EVALUATES AND APPROVES THE COMPENSATION FOR THE OTHER KEY EXECUTIVES FOR BOTH THE CHIEF EXECUTIVE OFFICER AND OTHER KEY EXECUTIVES, THE PROCESS INCLUDED A REVIEW AND APPROVAL BY INDEPENDENT PERSONS, REVIEW OF COMPARABILITY DATA, AND CONTEMPORANEOUS SUBSTANTIATION OF THE DELIBERATION AND DECISION THE EXTERNAL REVIEW OF EXECUTIVE COMPENSATION IS PERFORMED ANNUALLY AND APPROVED BY THE BOARD THIS WAS LAST PERFORMED IN 2018

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 19 Required documents available to the public	UPON REQUEST, ST ELIZABETH HEALTHCARE WILL MAKE AVAILABLE THE FORM 990 AND THE RELATED APPLICABLE SCHEDULES, OF WHICH ARE SUBJECT TO AND OPEN TO PUBLIC INSPECTION

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IX, Line 11g Other Fees	CONTRACT LABOR - Total Expense 1796919, Program Service Expense 203705, Management and G eneral Expenses 1593214, Fundraising Expenses 0, AMBULANCE SERVICE - Total Expense 3477 43, Program Service Expense 347743, Management and General Expenses 0, Fundraising Expen ses 0, ANESTHESIOLOGY SERVICE - Total Expense 2622498, Program Service Expense 2622498, Management and General Expenses 0, Fundraising Expenses 0, LABORATORY SERVICES - Total Expense 12961563, Program Service Expense 12961563, Management and General Expenses 0, Fundraising Expenses 0, LAUNDRY EXPENSE - Total Expense 2971748, Program Service Expense 314875, Management and General Expenses 2656873, Fundraising Expenses 0, PERFUSION SER VICE - Total Expense 913301, Program Service Expense 913301, Management and General Expe nses 0, Fundraising Expenses 0, RADIATION SERVICE - Total Expense 875094, Program Servi ce Expense 875094, Management and General Expenses 0, Fundraising Expenses 0, PHYSICIAN FEES - Total Expense 8274650, Program Service Expense 8322143, Management and General E xpenses -47493, Fundraising Expenses 0, CONSULTING SERVICE - Total Expense 6625084, Pro gram Service Expense 697901, Management and General Expenses 5921620, Fundraising Expens es 5563, COLLECTION SERVICE - Total Expense 1019444, Program Service Expense 1943, Mana gement and General Expenses 1017501, Fundraising Expenses 0, OTHER FEES - Total Expense 284998, Program Service Expense 1506, Management and General Expenses 283492, Fundraisi ng Expenses 0, PURCHASED SERVICE - PATIENT ACCT - Total Expense 3245167, Program Service Expense 0, Management and General Expenses 3245167, Fundraising Expenses 0, ORGANIZED DEVELOP SERVICES - Total Expense 67262, Program Service Expense 0, Management and Genera l Expenses 67262, Fundraising Expenses 0, PURCHASED SERVICES - Total Expense 24519695, Program Service Expense 8594676, Management and General Expenses 15934480, Fundraising E xpenses -9461, HARDWARE MAINTENANCE - Total Expense 2324, Program Service Expense 0, Ma nagement and General Expenses 2324, Fundraising Expenses 0, RESEARCH PARTICIPATION - Tot al Expense 10324, Program Service Expense 9593, Management and General Expenses 731, Fu ndraising Expenses 0, RECRUITMENT ADVERTISING - Total Expense 78258, Program Service Exp ense 19676, Management and General Expenses 58582, Fundraising Expenses 0, VEHICLE OPER ATION MAINT - Total Expense 9725, Program Service Expense 7200, Management and General E xpenses 2525, Fundraising Expenses 0, CONSUMABLES - HARDWARE - Total Expense 36365, Pro gram Service Expense 5753, Management and General Expenses 30612, Fundraising Expenses 0, BUSINESS TRANSPORTATION - Total Expense 405, Program Service Expense 100, Management and General Expenses 305, Fundraising Expenses 0, JANITORIAL SERVICES - Total Expense 3 91779, Program Service Expense 119817, Management and General Expenses 271962, Fundraisi ng Expenses 0, BUILDING MAINT

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IX, Line 11g Other Fees	ENANCE - INTERIOR - Total Expense 411331, Program Service Expense 107570, Management and General Expenses 303761, Fundraising Expenses 0, GROUNDS MAINTENANCE - Total Expense 2 53244, Program Service Expense 12258, Management and General Expenses 238918, Fundraisin g Expenses 2068, VEHICLE MAINTENANCE - Total Expense 226452, Program Service Expense 10 2684, Management and General Expenses 123768, Fundraising Expenses 0, MAINTENANCE & REPA IRS - Total Expense 12806409, Program Service Expense 2107112, Management and General Ex penses 10679567, Fundraising Expenses 19730, MAINT & REPAIR - HVAC - Total Expense 6183 4, Program Service Expense 22124, Management and General Expenses 39710, Fundraising Exp enses 0, MAINT & REPAIR - MEDICAL EQUIP - Total Expense 2595, Program Service Expense 2 595, Management and General Expenses 0, Fundraising Expenses 0, MAINT & REPAIR - OFFICE EQUIP - Total Expense 425, Program Service Expense 350, Management and General Expenses 75, Fundraising Expenses 0, LATE PAYMENT FEES - Total Expense 29919, Program Service Ex pense 0, Management and General Expenses 29919, Fundraising Expenses 0, MAINT & REPAIR HARDWARE - Total Expense 935, Program Service Expense 130, Management and General Expens es 805, Fundraising Expenses 0, PEST CONTROL - Total Expense 11627, Program Service Exp ense 2053, Management and General Expenses 9574, Fundraising Expenses 0, FACILITIES - S MALL EQUIP - Total Expense 685, Program Service Expense 0, Management and General Expens es 685, Fundraising Expenses 0, IC MARKET ADJ EXPENSE - Total Expense 103081053, Progra m Service Expense 0, Management and General Expenses 103081053, Fundraising Expenses 0, IC PHYSICIAN FEES - Total Expense 14200653, Program Service Expense 13925590, Managemen t and General Expenses 275063, Fundraising Expenses 0, IC STAFF LEASING EXPENSE - Total Expense 62061, Program Service Expense 62061, Management and General Expenses 0, Fundra ising Expenses 0, IC ADMIN SERVICES EXPENSE - Total Expense 478288, Program Service Expe nse 491292, Management and General Expenses -13004, Fundraising Expenses 0, IC PHYSICIA N FEES - MEDICAL DIR - Total Expense 513755, Program Service Expense 438691, Management and General Expenses 75064, Fundraising Expenses 0, PHYSICIAN INCOME GUARANTEES - Total Expense 75000, Program Service Expense 0, Management and General Expenses 75000, Fundra ising Expenses 0, PHYSICIAN FEES-CMA - Total Expense 2852262, Program Service Expense 8 1419, Management and General Expenses 2770843, Fundraising Expenses 0, PHYSICIAN SERVICE S - Total Expense 54194, Program Service Expense 0, Management and General Expenses 541 94, Fundraising Expenses 0, RADIOLOGY SERVICES - Total Expense 457, Program Service Expe nse 457, Management and General Expenses 0, Fundraising Expenses 0, PLP ELIMINATION - T otal Expense -3986296, Program Service Expense 0, Management and General Expenses -3986 296, Fundraising Expenses 0,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part IX, Line 11g Other Fees	NETWORK /DATA CONNECTION - Total Expense 247, Program Service Expense 0, Management and General Expenses 247, Fundraising Expenses 0, MAINT AND REPAIR TELECOM - Total Expense 37525, Program Service Expense 37525, Management and General Expenses 0, Fundraising Exp enses 0, HOS PURCHASES SERVICES - Total Expense -62113, Program Service Expense 0, Mana gement and General Expenses -62113, Fundraising Expenses 0,

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9 Other changes in net assets or fund balances	CHANGE IN FMV OF INTEREST RATE SWAP - -1883414, MINIMUM PENSION LIABILITY ADJUSTMENT - -7581421, CHANGE IN FMV OF SPLIT LIFE INSURANCE INTEREST - -9759, TRANSFERS DUE TO/FROM AFFILIATES - 22745352, NET ASSETS RELEASED FROM RESTRICTIONS - PPE - 388043, WRITE OFF OF UNCOLLECTIBLE PLEDGES - -29667, CHANGE TO INVESTMENT IN AMSURG - 6809, PAID IN CAPITAL/DISTRIBUTIONS TO EQUITY - FIVE LABS - 219111,

990 Schedule O, Supplemental Information

Return Reference	Explanation
ST ELIZABETH FLORENCE	(Continued) NEXT, THE LIST WAS ADVANCED TO THE STRATEGIC PLANNING COMMITTEE OF THE BOARD OF TRUSTEES TO REVIEW, IN WHICH THEY NARROWED THE LIST DOWN TO THE TOP THREE ISSUES TO FOC US ON THAT WILL HAVE THE GREATEST POSSIBLE IMPACT ON COMMUNITY HEALTH STATUS THE TOP THRE E PRIORITIES ARE OBESITY, HEART DISEASE, AND DIABETES THE FOLLOWING IS A LIST OF HEALTH N EEDS INDENTIFIED BY THE ASSESSMENT, BUT NOT INCLUDED AS ONE OF THE TOP THREE - ACCESS TO PRIMARY CARE - AVOIDABLE ED VISITS - CANCER - INFANT MORTALITY - LACK OF HEALTH INSURANCE - MEDICATION COSTS - MENTAL HEALTH - SMOKING - SUBSTANCE ABUSE - WELLNESS ST ELIZABETH HE ALTHCARE WILL CONTINUE PROVIDING SERVICES TO SUPPORT THESE IMPORTANT COMMUNITY HEALTH NEED S THE FOLLOWING IS A SUMMARY OF MANY OF THE PROGRAMS THAT ARE ALREADY PROVIDED FOR EACH O F THE ISSUES IDENTIFIED AVOIDABLE ED VISITS/ACCESS TO PRIMARY CARE - ESTABLISHING 100% OF ST ELIZABETH PHYSICIAN PRACTICES AS CERTIFIED MEDICAL HOMES - DEVELOPING WALK-IN CLINICS AND URGENT CARE OPTIONS THROUGH ST ELIZABETH PHYSICIANS - PROVIDING TRAINING AND CARE TH ROUGH THE FAMILY PRACTICE RESIDENCY PROGRAM - CONTINUING TO OFFER THE PARISH NURSING/HEALT H MINISTRY PROGRAM - RECRUITING ST ELIZABETH HEALTHCARE MEDICAL SPECIALISTS AS IDENTIFIED - TREATING DENTAL PATIENTS NEEDING EMERGENT CARE IN THE EMERGENCY DEPARTMENT - PROVIDING CAB AND BUS VOUCHERS FOR PATIENTS CANCER - PROVIDING CANCER SCREENINGS, SUPPORT GROUPS AND BREAST CANCER NAVIGATORS - PROVIDING DRUG REPLACEMENT SERVICES CHEMOTHERAPY PROVIDED TO T HOSE WHO ARE UNINSURED - PROVIDING MOBILE MAMMOGRAPHY VAN NO COST MAMMOGRAMS - OFFERING TH E COOPER CLAYTON SMOKING CESSATION PROGRAM - DONATING FINANCIAL / OPERATIONAL SUPPORT TO S EVERAL COMMUNITY HEALTH IMPROVEMENT ORGANIZATIONS INFANT MORTALITY - OFFERING MATERNAL CHI LD PROGRAMS FIRST STEPS POINT OF ENTRY AND NURSE-FAMILY PARTNERSHIPS - PROVIDING OBSTETRI CIANS TO HEALTHPOINT FOR PRENATAL CARE - ADMINISTERING IMMUNIZATIONS COCOONING PROJECT - O FFERING PRE-ADMISSION EDUCATION LACK OF HEALTH INSURANCE - SPONSORING A FINANCIAL ASSISTAN CE PROGRAM - ASSISTING PATIENTS ELIGIBLE FOR GOVERNMENT PROGRAMS TO REGISTER FOR THOSE PRO GRAMS, PLUS PROVIDES CHARITY CARE WHEN APPROPRIATE MEDICATION COSTS/ACCESS - PROVIDING MED ICATIONS UPON DISCHARGE FROM THE EMERGENCY DEPARTMENT OR INPATIENT AND REFERRAL TO ST VIN CENT DEPAUL PHARMACY MENTAL HEALTH - PROVIDING INPATIENT TREATMENT TO UNINSURED - PROVIDIN G MULTIPLE SUPPORT GROUPS FOR PATIENTS AND FAMILIES - WORKING WITH MENTAL HEALTH COURTS AN D JAILS TO COORDINATE CARE - IMPLEMENTING TELEPSYCHIATRY IN THE EMERGENCY DEPARTMENT TO AS SESS MENTAL HEALTH PATIENTS WELLNESS - PROVIDING TO THE COMMUNITY NUMEROUS PROGRAMS ON VAR IOUS HEALTH TOPICS AND SCREENINGS SUBSTANCE ABUSE - PROVIDING INPATIENT AND OUTPATIENT TRE ATMENT PROGRAMS FOR ADULTS - OFFERING 12-STEP PROGRAMS ON SITE BY COMMUNITY ORGANIZATIONS SMOKING CESSATIONS - ASSURING ALL OF ST ELIZABETH HEALTHCARE CAMPUSES ARE SMOKE FREE - OF FERING COOPER CLAYTON SMOKING

990 Schedule O, Supplemental Information

Return Reference	Explanation
ST ELIZABETH FLORENCE	CESSATION CLASSES

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Elizabeth Medical Center Inc

Employer identification number
61-0445850

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ST ELIZABETH PHYSICIAN SERVICES 334 THOMAS MORE PARKWAY STE 200 CRESTVIEW HILLS, KY 41017 61-1339639	PHYSICIAN MANAGEMENT SERVICES	KY	-995,872	10,941	ST ELIZABETH MEDICAL CENTER INC
(2) SEH Holdings Inc 1 Medical Village Dr Edgewood, KY 41017 83-0817636	Holding Company	KY	448,062	43,272	St Elizabeth Medical Center Inc
(3) Next Daybreak Inc 1 Medical Village Dr Edgewood, KY 41017 83-2843631	Physician Management Services	KY	0	0	St Elizabeth Medical Center Inc

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1) SUMMIT MEDICAL GROUP INC 1360 Dolwick Drive Suite 200 Erlanger, KY 41018 61-1300608	PHYSICIAN PRACTICE	KY	501(c)(3)	3	ST ELIZABETH MEDICAL CENTER INC	Yes	
(2) Healthcare Advocates of Northern Kentucky 1 Medical Village Drive Edgewood, KY 41017 83-2875231	Advance Healthcare quality and availability in Northern KY	KY	501(c)(4)		St Elizabeth Medical Center	Yes	

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

(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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) Health Care Solutions Network LLC 619 Oak Street Cincinnati, OH 45206 47-2103334	PHO	OH	HSN	Related	1,508,573	1,886,317		No		Yes		47 %
(2) Preferred Lab Partners LLC One Medical Village Drive Suite B Edgewood, KY 41707 82-4758763	Laboratory	KY	NA	Related	9,336,069	9,033,815		No		Yes		50 %
(3) Bioskills Lab LLC 4123 Olympic Blvd Erlanger, KY 41018 32-0571870	Bioskills Lab	KY	NA	Related	40,094	395,437		No		Yes		50 %

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	(i) No
(1) St Elizabeth Provider Network Inc One Medical Village Dr Edgewood, KY 41017 47-2862438	Physician-Hospital Org	KY	St Elizabeth Medical Center Inc	C Corporation	-995,872	10,941	100 %	Yes	
(2) Charitable Remainder Trust (3) One Medical Village Drive Edgewood, KY 41017	Trust	KY	N/A	Trust					

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		No
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r	Yes	
s Other transfer of cash or property from related organization(s)	1s	Yes	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)ST ELIZABETH PROVIDER NETWORK	L	2,873,695	CASH
(2)SUMMIT MEDICAL GROUP INC	R	103,081,053	CASH
(3)SUMMIT MEDICAL GROUP INC	O	14,783,911	CASH
(4)SUMMIT MEDICAL GROUP INC	J	301,414	CASH
(5)SUMMIT MEDICAL GROUP INC	M	987,842	CASH

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	

Part VII Supplemental Information

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

Return Reference	Explanation