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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

A For the 2019 calendar year, or tax year beginning 10-01-2019 , and ending 09-30-2020

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

C Name of organization
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
Doing business as
Number and street (or P.O. box if mail is not delivered to street address) Room/suite
114 WOODLAND STREET MS-510358
City or town, state or province, country, and ZIP or foreign postal code
HARTFORD, CT 06105

F Name and address of principal officer:
THOMAS BURKE
114 WOODLAND STREET MS-510358
HARTFORD, CT 06105

H(a) Is this a group return for subordinates?
☐ Yes ☒ No
H(b) Are all subordinates included?
☐ Yes ☐ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶ 0928

D Employer identification number
06-0646813
E Telephone number
(860) 714-4000
G Gross receipts \$ 978,941,717

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

J Website: ▶ WWW.TRINITYHEALTHOFNE.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1897

M State of legal domicile: CT

Part I Summary

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

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

3 Number of voting members of the governing body (Part VI, line 1a) 3 15

4 Number of independent voting members of the governing body (Part VI, line 1b) 4 12

5 Total number of individuals employed in calendar year 2019 (Part V, line 2a) 5 336

6 Total number of volunteers (estimate if necessary) 6 285

7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 2,119,794

7b Net unrelated business taxable income from Form 990-T, line 39 7b 0

Revenue

8 Contributions and grants (Part VIII, line 1h) 3,325,954 74,592,305

9 Program service revenue (Part VIII, line 2g) 958,657,597 865,728,876

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 4,949,280 8,421,156

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 27,544,151 24,423,565

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) 994,476,982 973,165,902

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) 554,457 394,215

14 Benefits paid to or for members (Part IX, column (A), line 4) 0 0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) 287,717,765 274,246,081

16a Professional fundraising fees (Part IX, column (A), line 11e) 0 0

16b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) 588,160,745 590,076,680

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) 876,432,967 864,716,976

19 Revenue less expenses. Subtract line 18 from line 12 118,044,015 108,448,926

Net Assets or Fund Balances

20 Total assets (Part X, line 16) 1,131,536,694 1,525,942,190

21 Total liabilities (Part X, line 26) 719,685,943 999,348,213

22 Net assets or fund balances. Subtract line 21 from line 20 411,850,751 526,593,977

Part II Signature Block

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

Sign Here

Signature of officer
JENNIFER SCHNEIDER SVP AND REGIONAL CFO
Type or print name and title

2021-08-10
Date

Paid Preparer Use Only

Print/Type preparer's name
Firm's name ▶
Firm's address ▶

Preparer's signature
Date

Check ☐ if self-employed
Firm's EIN ▶
Phone no.

PTIN

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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2019)

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

WE, TRINITY HEALTH OF NEW ENGLAND AND TRINITY HEALTH, SERVE TOGETHER IN THE SPIRIT OF THE GOSPEL AS A COMPASSIONATE AND TRANSFORMING HEALING PRESENCE WITHIN OUR COMMUNITIES. SAINT FRANCIS HOSPITAL AND MEDICAL CENTER IS A MEMBER OF TRINITY HEALTH OF NEW ENGLAND AND TRINITY HEALTH.

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

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

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

If "Yes," describe these changes on Schedule O.

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

| | | | | |
|---------------------|----------|--------------------------|----------------------------------|---------------------------|
| 4a | (Code:) | (Expenses \$ 764,792,408 | including grants of \$ 394,215) | (Revenue \$ 884,742,524) |
| 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 ▶ | 764,792,408 |
|-----------|---|-------------|

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

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

| | | Yes | No |
|-----------|--|-----|-----|
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable | 1a | 285 |
| 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 |

Part V **Statements Regarding Other IRS Filings and Tax Compliance** (continued)

| | | | | |
|--|---------------|-----|----|--|
| 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 336 | | | |
| 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 | | No | |
| b If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | | | |
| c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | | No | |
| d If "Yes," indicate the number of Forms 8282 filed during the year | 7d | | | |
| e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | 7e | | No | |
| f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | 7f | | No | |
| g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | 7g | | | |
| h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | 7h | | | |
| 8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | 8 | | | |
| 9 Sponsoring organizations maintaining donor advised funds. | | | | |
| a 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 720, Schedule N. | 15 | | No | |
| 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 15 | | |
| 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 12 | | |
| 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 | Yes | |
| 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes | |
| b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | Yes | |
| 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | | |
| a The governing body? | 8a | Yes | |
| b Each committee with authority to act on behalf of the governing body? | 8b | Yes | |
| 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | | No |

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

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

Section C. Disclosure

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

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:
 ▶ DONNA GILBERT 114 WOODLAND STREET MS-510358 HARTFORD, CT 06105 (860) 714-9632

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 ☐

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.

See instructions for the order in which to list the persons above.

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

[illegible]

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-Total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | 375,975 | 10,325,563 | 1,075,198 |

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 ▶ 13

| | Yes | No |
|--|-------|----|
| 3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> | 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? <i>If "Yes," complete Schedule J for such individual</i> | 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? <i>If "Yes," complete Schedule J for such person</i> | 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 |
|---|--------------------------------|---------------------|
| UCONN HEALTH CENTER 263 FARMINGTON AVENUE FARMINGTON, CT 060301921 | PHYSICIAN FEES | 19,410,281 |
| SLAM COLLABORATIVE INC 80 GLASTONBURY BLVD GLASTONBURY, CT 06033 | CONSTRUCTION SERVICES | 12,300,533 |
| SMILOW CANCER CENTER PO BOX 8149 NEW HAVEN, CT 06508 | HEALTH CARE SERVICES | 8,274,855 |
| US SECURITIES ASSOCIATES INC 161 WASHINGTON ST CONSHOHOCKEN, PA 19428 | SECURITY SERVICES | 2,814,973 |
| YALE UNIVERSITY SCHOOL OF MEDICINE 333 CEDAR ST NEW HAVEN, CT 06510 | HEALTH CARE SERVICES | 2,752,187 |

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 ▶ 113

| | | | | | | | | | | | | | |
|--|--|---|---------------|-------------|--|-------------|--|-------------|--|--------------------------|---|----------------------------------|---|
| Form 990 (2019) | | | | | | | | | | Page 9 | | | |
| Part VIII Statement of Revenue | | | | | | | | | | | | | |
| Check if Schedule O contains a response or note to any line in this Part VIII | | | | | | | | | | <input type="checkbox"/> | | | |
| | | | | | | | | | | (A) | (B) | (C) | (D) |
| | | | | | | | | | | Total revenue | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512 - 514 |
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | | 1a | | | | | | | | | | |
| | b Membership dues | | 1b | | | | | | | | | | |
| | c Fundraising events | | 1c | | | | | | | | | | |
| | d Related organizations | | 1d | 5,197,066 | | | | | | | | | |
| | e Government grants (contributions) | | 1e | 65,229,548 | | | | | | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | | 1f | 4,165,691 | | | | | | | | | |
| | g Noncash contributions included in lines 1a - 1f:\$ | | 1g | | | | | | | | | | |
| | h Total. Add lines 1a-1f ▶ | | 74,592,305 | | | | | | | | | | |
| Program Service Revenue | 2a NET PATIENT SERVICE REVENUE | | Business Code | 622110 | | 865,728,876 | | 863,674,589 | | 2,054,287 | | | |
| | b | | | | | | | | | | | | |
| | c | | | | | | | | | | | | |
| | d | | | | | | | | | | | | |
| | e | | | | | | | | | | | | |
| | f All other program service revenue. | | | | | | | | | | | | |
| | g Total. Add lines 2a-2f. ▶ | | 865,728,876 | | | | | | | | | | |
| | Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | | | 6,313,036 | | | | | | 6,313,036 | |
| 4 Income from investment of tax-exempt bond proceeds ▶ | | | | | | | | | | | | | |
| 5 Royalties ▶ | | | | | | | | | | | | | |
| | | (i) Real | (ii) Personal | | | | | | | | | | |
| 6a Gross rents | | 6a | 6,236,287 | | | | | | | | | | |
| b Less: rental expenses | | 6b | 5,763,749 | | | | | | | | | | |
| c Rental income or (loss) | | 6c | 472,538 | | | | | | | | | | |
| d Net rental income or (loss) ▶ | | | | 472,538 | | | | | | 472,538 | | | |
| | | (i) Securities | (ii) Other | | | | | | | | | | |
| 7a Gross amount from sales of assets other than inventory | | 7a | 2,120,186 | | | | | | | | | | |
| b Less: cost or other basis and sales expenses | | 7b | 0 | 12,066 | | | | | | | | | |
| c Gain or (loss) | | 7c | 2,120,186 | -12,066 | | | | | | | | | |
| d Net gain or (loss) ▶ | | | | 2,108,120 | | | | | | 2,108,120 | | | |
| 8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18 | | 8a | | | | | | | | | | | |
| b Less: direct expenses | | 8b | | | | | | | | | | | |
| c Net income or (loss) from fundraising events ▶ | | | | | | | | | | | | | |
| 9a Gross income from gaming activities. See Part IV, line 19 | | 9a | | | | | | | | | | | |
| b Less: direct expenses | | 9b | | | | | | | | | | | |
| c Net income or (loss) from gaming activities ▶ | | | | | | | | | | | | | |
| 10a Gross sales of inventory, less returns and allowances | | 10a | | | | | | | | | | | |
| b Less: cost of goods sold | | 10b | | | | | | | | | | | |
| c Net income or (loss) from sales of inventory ▶ | | | | | | | | | | | | | |
| Miscellaneous Revenue | | Business Code | | | | | | | | | | | |
| 11a OTHER PATIENT SERVICES | | 622110 | | 12,321,908 | | 12,321,908 | | | | | | | |
| b INTERCOMPANY ALLOCATION REV | | 561000 | | 5,461,979 | | 5,461,979 | | | | | | | |
| c CAFETERIA | | 722514 | | 2,033,323 | | | | | | 2,033,323 | | | |
| d All other revenue | | | | 4,133,817 | | 3,284,048 | | 65,507 | | 784,262 | | | |
| e Total. Add lines 11a-11d ▶ | | | | 23,951,027 | | | | | | | | | |
| 12 Total revenue. See instructions ▶ | | | | 973,165,902 | | 884,742,524 | | 2,119,794 | | 11,711,279 | | | |

Form 990 (2019)

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|------------------------------|--|---|------------------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 338,467 | 338,467 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 55,748 | 55,748 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 2,248,420 | 75,000 | 2,173,420 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 35,950 | 35,950 | | |
| 7 Other salaries and wages | 225,211,520 | 181,763,854 | 43,447,666 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 9,479,814 | 7,620,605 | 1,859,209 | |
| 9 Other employee benefits | 19,529,351 | 15,708,635 | 3,820,716 | |
| 10 Payroll taxes | 17,741,026 | 14,192,821 | 3,548,205 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | | | | |
| b Legal | | | | |
| c Accounting | | | | |
| d Lobbying | | | | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | 259,497 | | 259,497 | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 97,765,086 | 93,054,870 | 4,710,216 | |
| 12 Advertising and promotion | 207,847 | 207,847 | | |
| 13 Office expenses | 9,040,420 | 8,778,171 | 262,249 | |
| 14 Information technology | 377,000 | 375,635 | 1,365 | |
| 15 Royalties | | | | |
| 16 Occupancy | 30,841,313 | 28,913,573 | 1,927,740 | |
| 17 Travel | 486,161 | 437,545 | 48,616 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 6,183 | 4,947 | 1,236 | |
| 20 Interest | 10,862,947 | 10,862,947 | | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 35,044,282 | 31,546,325 | 3,497,957 | |
| 23 Insurance | 7,101,784 | 6,392,917 | 708,867 | |
| 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 | 152,903,113 | 152,903,113 | | |
| b I/C PURCHASED SERVICES | 140,682,423 | 127,461,012 | 13,221,411 | |
| c HOSPITAL PROVIDER TAX | 52,687,044 | 52,687,044 | | |
| d BAD DEBT EXPENSE | 19,913,903 | 19,913,903 | | |
| e All other expenses | 31,897,677 | 11,461,479 | 20,436,198 | |
| 25 Total functional expenses. Add lines 1 through 24e | 864,716,976 | 764,792,408 | 99,924,568 | 0 |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). | | | | |

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

| | | | | (A) Beginning of year | | (B) End of year | |
|------------------------------------|--|--|---------------|--------------------------|---------------|--------------------|-------------|
| Assets | 1 | Cash—non-interest-bearing | | 10,780,389 | 1 | 3,892,040 | |
| | 2 | Savings and temporary cash investments | | | 2 | | |
| | 3 | Pledges and grants receivable, net | | | 3 | | |
| | 4 | Accounts receivable, net | | 119,414,845 | 4 | 92,442,923 | |
| | 5 | Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | | 5 | | |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) | | | 6 | | |
| | 7 | Notes and loans receivable, net | | 668,222 | 7 | 668,222 | |
| | 8 | Inventories for sale or use | | 6,449,439 | 8 | 8,489,669 | |
| | 9 | Prepaid expenses and deferred charges | | 2,336,735 | 9 | 3,254,982 | |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 502,120,030 | | | |
| | b | Less: accumulated depreciation | 10b | 189,327,610 | 331,320,778 | 10c | 312,792,420 |
| | 11 | Investments—publicly traded securities | | 156,192,445 | 11 | 283,484,319 | |
| | 12 | Investments—other securities. See Part IV, line 11 | | 41,205,174 | 12 | 76,199,126 | |
| | 13 | Investments—program-related. See Part IV, line 11 | | | 13 | | |
| | 14 | Intangible assets | | 9,004,504 | 14 | 8,638,556 | |
| | 15 | Other assets. See Part IV, line 11 | | 454,164,163 | 15 | 736,079,933 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 1,131,536,694 | 16 | 1,525,942,190 | | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 307,381,584 | 17 | 286,549,695 | |
| | 18 | Grants payable | | | 18 | | |
| | 19 | Deferred revenue | | 26,905 | 19 | 248,926 | |
| | 20 | Tax-exempt bond liabilities | | | 20 | | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | 21 | | |
| | 22 | Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | | 22 | | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 2,211,129 | 23 | 1,948,241 | |
| | 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 | | 410,066,325 | 25 | 710,601,351 | |
| | 26 | Total liabilities. Add lines 17 through 25 | | 719,685,943 | 26 | 999,348,213 | |
| Net Assets or Fund Balances | Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33. | | | | | | |
| | 27 | Net assets without donor restrictions | | 318,041,544 | 27 | 420,679,707 | |
| | 28 | Net assets with donor restrictions | | 93,809,207 | 28 | 105,914,270 | |
| | Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33. | | | | | | |
| | 29 | Capital stock or trust principal, or current funds | | | 29 | | |
| | 30 | Paid-in or capital surplus, or land, building or equipment fund | | | 30 | | |
| | 31 | Retained earnings, endowment, accumulated income, or other funds | | | 31 | | |
| | 32 | Total net assets or fund balances | | 411,850,751 | 32 | 526,593,977 | |
| 33 | Total liabilities and net assets/fund balances | | 1,131,536,694 | 33 | 1,525,942,190 | | |

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

| | | | |
|-----------|--|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 973,165,902 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 864,716,976 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 108,448,926 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 411,850,751 |
| 5 | Net unrealized gains (losses) on investments | 5 | 12,898,617 |
| 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 | -6,604,317 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 526,593,977 |

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

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

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

Form 990 (2019)

Form 990, Part III, Line 4a:

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER HAS BEEN AN ANCHOR INSTITUTION IN NORTH CENTRAL CONNECTICUT SINCE 1897. SAINT FRANCIS HOSPITAL AND MEDICAL CENTER IS LICENSED FOR 617 BEDS AND 65 BASSINETS, IS A MAJOR TEACHING HOSPITAL AND THE LARGEST CATHOLIC HOSPITAL IN NEW ENGLAND.SAINT FRANCIS HOSPITAL AND MEDICAL CENTER IS COMMITTED TO EXCEEDING THE EXPECTATIONS OF OUR PATIENTS AND FAMILIES BY PROVIDING WORLD-CLASS SERVICE IN A PROGRESSIVE, PEOPLE-CENTERED, COMPASSIONATE HEALTH CARE ENVIRONMENT.AT SAINT FRANCIS HOSPITAL AND MEDICAL CENTER WE REMAIN COMMITTED TO THE MISSION THAT HAS BEEN VIRTUALLY UNCHANGED DURING OUR 120-YEAR HISTORY - TO IMPROVE AND ENRICH THE LIVES OF INDIVIDUALS AND FAMILIES IN OUR REGION. COMPASSIONATE CARE, SUPERIOR TECHNOLOGY AND PREVENTION-ORIENTED EDUCATION WILL COMBINE IN CENTERS OF CLINICAL EXCELLENCE. DEDICATION TO OUR FOUNDING CORE VALUES WILL CREATE A SPIRITUAL AND HEALING ENVIRONMENT.PLEASE VISIT SCHEDULE H AND OUR WEBSITE FOR ADDITIONAL INFORMATION ABOUT SERVICES, RECOGNITIONS AND AWARDS: WWW.TRINITYHEALTHOFNE.ORG/LOCATION/SAINT-FRANCIS-HOSPITAL

| 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 | Insttutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| BENJAMIN CARTER DIRECTOR; TRINITY HEALTH EVP & COO | 1.00 54.00 | X | | | | | | 0 | 1,736,940 | 69,299 |
| REGINALD EADIE MD DIRECTOR; TH OF NE PRESIDENT/CEO | 1.00 54.00 | X | | | | | | 0 | 1,389,729 | 294,091 |
| JOHN RODIS MD PRESIDENT THROUGH 5/20 | 53.00 2.00 | | | X | | | | 0 | 1,311,465 | 65,718 |
| CHRISTOPHER DADLEZ FORMER OFFICER | 0.00 0.00 | | | | | | X | 0 | 885,406 | 22,817 |
| DAVID BITTNER TREASURER THROUGH 12/19; TRINITY SVP | 1.00 54.00 | | | X | | | | 0 | 647,439 | 44,849 |
| ROBERT ANTHONY SECRETARY; TH OF NE GENERAL COUNSEL | 1.00 49.00 | | | X | | | | 0 | 508,296 | 105,678 |
| PHILLIP ROLAND CMO AS OF 11/19; PHYSICIAN | 45.00 5.00 | | | | X | | | 0 | 535,039 | 50,979 |
| MICHAEL GREY MD FORMER KEY EMP; CHAIR OF MED | 0.00 50.00 | | | | | | X | 0 | 542,505 | 16,216 |
| PETER EAMRANOND CHIEF MEDICAL OFFICER THROUGH 11/19 | 50.00 0.00 | | | | | X | | 0 | 473,104 | 35,254 |
| JENNIFER SCHNEIDER TREAS AS OF 1/20; SVP & REG CFO | 2.00 48.00 | | | X | | | | 0 | 373,219 | 62,504 |

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 | | | |
| KATHLEEN LUCZYK REGIONAL DIR LAB SERVICES | 50.00 0.00 | | | | | X | | 300,975 | 0 | 87,538 |
| THOMAS BURKE VP OPS THRU 5/20; PRES AT 5/20 | 33.00 22.00 | | | X | | | | 0 | 334,580 | 40,691 |
| LINDA SHANLEY FORMER KE; REGIONAL CIO CLIENT SVCS | 0.00 50.00 | | | | | | X | 0 | 345,907 | 16,078 |
| KIMBERLEE RICHARD CHIEF NURSING OFFICER | 50.00 0.00 | | | | | X | | 0 | 327,115 | 20,831 |
| RICHARD BRODY PHYSICIAN | 50.00 0.00 | | | | | X | | 0 | 285,535 | 45,290 |
| JEFFREY SCHLOSSER REGIONAL DIR OCCUP HLTH AND SAFETY | 50.00 0.00 | | | | | X | | 0 | 280,892 | 39,938 |
| JAMES HARRIS FMR OFFICER; TH OF NE DIR OF REIM | 0.00 50.00 | | | | | | X | 0 | 235,981 | 44,584 |
| SHERI LEMIEUX ASST SECRETARY; EXECUTIVE ASST | 1.00 39.00 | | | X | | | | 0 | 112,411 | 12,843 |
| GWENDOLYN MORASKI DIRECTOR; MEDICAL STAFF PRESIDENT | 3.00 8.00 | X | | | | | | 75,000 | 0 | 0 |
| KEVIN O'CONNOR DIRECTOR, CHAIR | 1.00 5.00 | X | | 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 | | | |
| JAMES SMITH DIRECTOR, VICE CHAIR | 1.00 5.00 | X | | X | | | | 0 | 0 | 0 |
| MOST REV JUAN MIGUEL BETANCOURT DIRECTOR AS OF 1/20 | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| MARY CARITAS SP DIRECTOR THROUGH 12/19 | 1.00 12.00 | X | | | | | | 0 | 0 | 0 |
| GREGORY DAVIS DIRECTOR AS OF 1/20 | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| NAKIA HALL DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| WALTER HARRISON DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| PAUL MANCINONE DIRECTOR | 1.00 11.00 | X | | | | | | 0 | 0 | 0 |
| JOYCE MANDELL DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| ANGELA MATTIE DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| JOSEPH MENGACCI DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| BARBARA MULLEN CSJ DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| JOANN PRICE DIRECTOR | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |
| CURTIS ROBINSON DIRECTOR THROUGH 12/19 | 1.00 5.00 | X | | | | | | 0 | 0 | 0 |

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 instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

Employer identification number
06-0646813

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

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

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

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

Part II

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

| | | | | | | |
|---|----------|----------|----------|----------|----------|-----------|
| Section A. Public Support | | | | | | |
| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
| 7 Amounts from line 4. . . | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . . | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on. . | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . . | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/> | | | | | | |
| Section C. Computation of Public Support Percentage | | | | | | |
| 14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) | | | | | 14 | |
| 15 Public support percentage for 2018 Schedule A, Part II, line 14 | | | | | 15 | |
| 16a 33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | | |
| b 33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | | |
| 17a 10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | | |
| b 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | | | | | |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/> | | | | | | |

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6. . . | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975. | | | | | | |
| c Add lines 10a and 10b. | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on. | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) . . | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2018 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2018 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2019. 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—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV

Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

| | | | |
|---|--|----------------|--------------------------------|
| Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations | | | |
| 1 <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E. | | | |
| Section A - Adjusted Net Income | | (A) Prior Year | (B) Current Year (optional) |
| 1 | Net short-term capital gain | 1 | |
| 2 | Recoveries of prior-year distributions | 2 | |
| 3 | Other gross income (see instructions) | 3 | |
| 4 | Add lines 1 through 3 | 4 | |
| 5 | Depreciation and depletion | 5 | |
| 6 | Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | |
| 7 | Other expenses (see instructions) | 7 | |
| 8 | Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) | 8 | |
| Section B - Minimum Asset Amount | | (A) Prior Year | (B) Current Year (optional) |
| 1 | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year): | 1 | |
| a | Average monthly value of securities | 1a | |
| b | Average monthly cash balances | 1b | |
| c | Fair market value of other non-exempt-use assets | 1c | |
| d | Total (add lines 1a, 1b, and 1c) | 1d | |
| e | Discount claimed for blockage or other factors (explain in detail in Part VI): | | |
| 2 | Acquisition indebtedness applicable to non-exempt use assets | 2 | |
| 3 | Subtract line 2 from line 1d | 3 | |
| 4 | Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions). | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |
| Section C - Distributable Amount | | | Current Year |
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | |
| 2 | Enter 85% of line 1 | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | |
| 4 | Enter greater of line 2 or line 3 | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | |
| 7 | <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) | | |

Part V

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

| Section D - Distributions | Current Year |
|---|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI). See instructions | |
| 7 Total annual distributions. Add lines 1 through 6. | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions | |
| 9 Distributable amount for 2019 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-2019 | (iii) Distributable Amount for 2019 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2019 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2019: | | | |
| a From 2014. | | | |
| b From 2015. | | | |
| c From 2016. | | | |
| d From 2017. | | | |
| e From 2018. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2019 distributable amount | | | |
| i Carryover from 2014 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| 4 Distributions for 2019 from Section D, line 7: | | | |
| \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2019 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from 4. | | | |
| 5 Remaining underdistributions for years prior to 2019, 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 2019. 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 2020. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2015. | | | |
| b Excess from 2016. | | | |
| c Excess from 2017. | | | |
| d Excess from 2018. | | | |
| e Excess from 2019. | | | |

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

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

Facts And Circumstances Test

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

2019

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 SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | Employer identification number 06-0646813 |
|--|--|

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

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

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

| | | |
|----|---|--|
| 1 | Enter the amount of any excise tax incurred by the organization under section 4955 | \$ |
| 2 | Enter the amount of any excise tax incurred by organization managers under section 4955 | \$ |
| 3 | If the organization incurred a section 4955 tax, did it file Form 4720 for this year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4a | Was a correction made? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV. | |

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

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. | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | |
| Not over \$500,000 | 20% of the amount on line 1e. | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000. | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000. | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000. | |
| Over \$17,000,000 | \$1,000,000. | |
| g Grassroots nontaxable amount (enter 25% of line 1f) | | |
| h Subtract line 1g from line 1a. If zero or less, enter -0- | | |
| i Subtract line 1f from line 1c. If zero or less, enter -0- | | |
| j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|---|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (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) | | (b) |
|-----------|---|-----|----|--------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of: | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | Yes | | 74,777 |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | | No | |
| j | Total. Add lines 1c through 1i | | | 74,777 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

Part IV Supplemental Information

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

| Return Reference | Explanation |
|--------------------|--|
| PART II-B, LINE 1: | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER HAS MADE GRANTS TO OTHER ORGANIZATIONS FOR LOBBYING PURPOSES. THESE GRANTS HAVE BEEN IN THE FORM OF MEMBERSHIP DUES PAID TO REGIONAL AND NATIONAL HEALTH CARE ORGANIZATIONS, WHERE THE ORGANIZATIONS HAVE PROVIDED SAINT FRANCIS HOSPITAL AND MEDICAL CENTER WITH AN ESTIMATED PERCENTAGE OF DUES PAYMENTS WHICH ARE USED FOR LOBBYING ACTIVITIES. |

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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 instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

Employer identification number
06-0646813

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 ► \$

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

Cat. No. 52283D Schedule D (Form 990) 2019

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

| | Amount |
|----|--------|
| 1c | |
| 1d | |
| 1e | |
| 1f | |

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds.

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | 67,470,460 | 81,680,669 | 77,617,503 | 69,463,359 | 65,802,167 |
| b Contributions | 521,000 | 77,000 | | | |
| c Net investment earnings, gains, and losses | 4,737,199 | -2,287,209 | 4,063,166 | 8,154,144 | 3,661,192 |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | 12,000,000 | | | |
| f Administrative expenses | | | | | |
| g End of year balance | 72,728,659 | 67,470,460 | 81,680,669 | 77,617,503 | 69,463,359 |

2

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

a

Board designated or quasi-endowment ▶ 1.300 %

b

Permanent endowment ▶ 91.700 %

c

Temporarily restricted endowment ▶ 7.000 %

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

3a

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

(i) unrelated organizations

3a(i)

☐ Yes

☐ No

(ii) related organizations

3a(ii)

☐ Yes

☐ No

b

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

3b

☐ Yes

☐ No

4

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

Part VI

Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 8,471,217 | | 8,471,217 |
| b Buildings | | 301,967,793 | 62,335,667 | 239,632,126 |
| c Leasehold improvements | | 1,770,000 | 533,235 | 1,236,765 |
| d Equipment | | 186,778,620 | 126,458,708 | 60,319,912 |
| e Other | | 3,132,400 | | 3,132,400 |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶ | | | | 312,792,420 |

Schedule D (Form 990) 2019

Part VII

Investments—Other Securities.

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

| (a) Description of security or category (including name of security) | (b) Book value | (c) Method of valuation: Cost or end-of-year market value |
|---|----------------|--|
| (1) Financial derivatives | | |
| (2) Closely-held equity interests | | |
| (3) Other _____ | | |
| (A) | | |
| (B) | | |
| (C) | | |
| (D) | | |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶ | | |

Part VIII

Investments—Program Related.

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

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

Part IX

Other Assets.

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

| (a) Description | (b) Book value |
|---|----------------|
| (1)INTERCOMPANY ACCOUNTS RECEIVABLE | 669,458,710 |
| (2)MISCELLANEOUS RECEIVABLES | 12,576,553 |
| (3)INVESTMENT IN AFFILIATES | 18,983,377 |
| (4)INTERCOMPANY OTHER ASSETS | 11,756,243 |
| (5)REINSURANCE RECOVERY | 7,235,819 |
| (6)OTHER LONG TERM ASSETS | 2,664,721 |
| (7)OPERATING LEASE RIGHT-OF-USE ASSETS | 13,404,510 |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) ▶ | 736,079,933 |

Part X

Other Liabilities.

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

| 1. (a) Description of liability | (b) Book value |
|---|----------------|
| (1) Federal income taxes | |
| (2) INTERCOMPANY ACCOUNTS PAYABLE | 326,781,471 |
| (3) ASSET RETIREMENT OBLIGATION | 7,617,644 |
| (4) OTHER CURRENT LIABILITIES | 7,235,819 |
| (5) INTERCOMPANY NOTES PAYABLE | 261,436,185 |
| (6) OTHER LONG TERM LIABILITIES | 1,295,000 |
| (7) OPERATING LEASE LIABILITIES | 13,655,042 |
| (8) OVERDRAFT IN POOLED INVESTMENT | 960,473 |
| (9) MEDICARE CASH ADVANCES | 91,619,717 |
| (10) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶ | 710,601,351 |

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

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

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

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

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART V, LINE 4: | ENDOWMENT FUNDS ARE USED FOR EDUCATION AND RESEARCH, BUILDING AND EQUIPMENT, PATIENT CARE, CANCER CENTER/RESEARCH, AND OTHER. |

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

2019

Open to Public Inspection

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

Employer identification number
06-0646813

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

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) | | | 4,160,770 | | 4,160,770 | 0.490 % |
| b Medicaid (from Worksheet 3, column a) | | | 209,672,989 | 151,192,088 | 58,480,901 | 6.920 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 213,833,759 | 151,192,088 | 62,641,671 | 7.410 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4). | 14 | 9,103 | 1,078,292 | 14,027 | 1,064,265 | 0.130 % |
| f Health professions education (from Worksheet 5) | 1 | | 32,886,172 | 9,820,913 | 23,065,259 | 2.730 % |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | 1 | | 313,700 | | 313,700 | 0.040 % |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 2 | 2,756 | 432,006 | | 432,006 | 0.050 % |
| j Total. Other Benefits | 18 | 11,859 | 34,710,170 | 9,834,940 | 24,875,230 | 2.950 % |
| k Total. Add lines 7d and 7j | 18 | 11,859 | 248,543,929 | 161,027,028 | 87,516,901 | 10.360 % |

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | 1 | 245 | 7,013 | | 7,013 | 0 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | 1 | 245 | 7,013 | | 7,013 | 0 % |

Part III Bad Debt, Medicare, & Collection Practices**Section A. Bad Debt Expense**

| | | Yes | No |
|--|----------|------------|----|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 | Yes | |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | 19,913,903 | |
| 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | 0 | |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | |

Section B. Medicare

| | | |
|--|----------|-------------|
| 5 Enter total revenue received from Medicare (including DSH and IME) | 5 | 141,279,863 |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 154,766,162 |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | -13,486,299 |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | | |

Section C. Collection Practices

| | | | |
|--|-----------|-----|--|
| 9a Did the organization have a written debt collection policy during the tax year? | 9a | Yes | |
| b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | Yes | |

Part IV Management Companies and Joint Ventures

| (a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions) | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|--|---|--|--|---|
| 1 SAINT FRANCIS GI ENDOSCOPY LLC | HEALTH CARE SERVICES - ENDOSCOPY | 49.000 % | | 51.000 % |
| 2 LIGHTHOUSE SURGERY CENTER LLC | HEALTH CARE SERVICES | 26.000 % | | 74.000 % |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

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

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

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

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

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

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

1

Community Health Needs Assessment

| | Yes | No |
|---|------------|-----|
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply): | 3 | Yes |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes |
| 6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | Yes |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply): | 7 | Yes |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u> | | |
| b <input type="checkbox"/> Other website (list url): _____ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| a If "Yes" (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u> | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

| | | | |
|---|--|----|-----|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTE | | | |
| Name of hospital facility or letter of facility reporting group | | | |
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP: | 13 | Yes |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 % | | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | | |
| c <input checked="" type="checkbox"/> Asset level | | | |
| d <input checked="" type="checkbox"/> Medical indigency | | | |
| e <input checked="" type="checkbox"/> Insurance status | | | |
| f <input checked="" type="checkbox"/> Underinsurance discount | | | |
| g <input checked="" type="checkbox"/> Residency | | | |
| h <input checked="" type="checkbox"/> Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes |
| 15 | Explained the method for applying for financial assistance? 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): | 15 | Yes |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e <input type="checkbox"/> Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | 16 | Yes |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): SEE PART V, PAGE 8 | | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): SEE PART V, PAGE 8 | | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 8 | | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j <input type="checkbox"/> Other (describe in Section C) | | | |

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

SAINT FRANCIS HOSPITAL AND MEDICAL CENTE

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

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

SAINT FRANCIS HOSPITAL AND MEDICAL CENTE

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

| | Yes | No |
|-----------|-----|----|
| | | |
| 23 | | No |
| 24 | | No |

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, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

[illegible]

Part V **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 23

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

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART I, LINE 6A: | SAINT FRANCIS HOSPITAL REPORTS ITS COMMUNITY BENEFIT INFORMATION AS PART OF THE CONSOLIDATED COMMUNITY BENEFIT INFORMATION REPORTED BY TRINITY HEALTH (EIN 35-1443425) IN ITS AUDITED FINANCIAL STATEMENTS, AVAILABLE AT WWW.TRINITY-HEALTH.ORG. IN ADDITION, SAINT FRANCIS HOSPITAL INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON BOTH ITS OWN WEBSITE AND TRINITY HEALTH'S WEBSITE. |

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART I, LN 7 COL(F): | THE FOLLOWING NUMBER, \$19,913,903, REPRESENTS THE AMOUNT OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990, PART IX, LINE 25. PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H, PART I, LINE 7, COLUMN (F). |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| PART II, COMMUNITY BUILDING ACTIVITIES: | IN FISCAL YEAR 2020, WE WORKED WITH AREA YOUTH WHO WANTED TO COME TO SAINT FRANCIS HOSPITAL TO EXPLORE CAREERS IN THE VAST FIELD OF HEALTH CARE. OUR JOB SHADOWING PROGRAM ENABLED LOCAL STUDENTS TO EXPERIENCE A VARIETY OF JOB SETTINGS TO HELP THEM BETTER UNDERSTAND THE VARIED ROLES THAT EXIST IN A HEALTH CARE INSTITUTION. WE ALSO WORKED WITH THE AMERICAN RED CROSS TO ENSURE THAT THE REGION HAS AN ADEQUATE BLOOD SUPPLY. WE ARRANGED ROOM RESERVATIONS ON THE HOSPITAL CAMPUS FOR THE RED CROSS TO RUN THEIR BLOOD DRIVES. WE HELPED TO ADVERTISE THE DRIVES BY PUTTING UP FLYERS, POSTING ELECTRONIC BULLETIN BOARD MESSAGING AND SENDING OUT EMAIL ANNOUNCEMENTS. HOSPITAL STAFF ACTIVELY HELPED AND DONATED ALONG WITH THE MEMBERS FROM OUR LOCAL COMMUNITY. |

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART III, LINE 4: | <p>SAINT FRANCIS HOSPITAL IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH. THE FOLLOWING IS THE TEXT OF THE PATIENT ACCOUNTS RECEIVABLE, ESTIMATED RECEIVABLES FROM AND PAYABLES TO THIRD-PARTY PAYERS FOOTNOTE FROM PAGE 13 OF THOSE STATEMENTS: "AN UNCONDITIONAL RIGHT TO PAYMENT, SUBJECT ONLY TO THE PASSAGE OF TIME IS TREATED AS A RECEIVABLE. PATIENT ACCOUNTS RECEIVABLE, INCLUDING BILLED ACCOUNTS AND UNBILLED ACCOUNTS FOR WHICH THERE IS AN UNCONDITIONAL RIGHT TO PAYMENT, AND ESTIMATED AMOUNTS DUE FROM THIRD-PARTY PAYERS FOR RETROACTIVE ADJUSTMENTS, ARE RECEIVABLES IF THE RIGHT TO CONSIDERATION IS UNCONDITIONAL AND ONLY THE PASSAGE OF TIME IS REQUIRED BEFORE PAYMENT OF THAT CONSIDERATION IS DUE. FOR PATIENT ACCOUNTS RECEIVABLE, THE ESTIMATED UNCOLLECTABLE AMOUNTS ARE GENERALLY CONSIDERED IMPLICIT PRICE CONCESSIONS THAT ARE A DIRECT REDUCTION TO PATIENT SERVICE REVENUE AND ACCOUNTS RECEIVABLE. THE CORPORATION HAS AGREEMENTS WITH THIRD-PARTY PAYERS THAT PROVIDE FOR PAYMENTS TO THE CORPORATION'S HEALTH MINISTRIES AT AMOUNTS DIFFERENT FROM ESTABLISHED RATES. ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYERS AND OTHER CHANGES IN ESTIMATES ARE INCLUDED IN NET PATIENT SERVICE REVENUE AND ESTIMATED RECEIVABLES FROM AND PAYABLES TO THIRD-PARTY PAYERS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS, AS FINAL SETTLEMENTS ARE DETERMINED." PART III, LINE 5: TOTAL MEDICARE REVENUE REPORTED IN PART III, LINE 5 HAS BEEN REDUCED BY THE TWO PERCENT SEQUESTRATION REDUCTION FOR THE PERIOD OCTOBER 1, 2019 THROUGH APRIL 30, 2020.</p> |

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

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
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| PART VI, LINE 2: | NEEDS ASSESSMENT - THE CURTIS D. ROBINSON CENTER FOR HEALTH EQUITY WAS CREATED AT SAINT FRANCIS HOSPITAL TO SERVE AS A BRIDGE BETWEEN THE COMMUNITY AND THE HEALTH CARE SYSTEM. SINCE 2008, THE CENTER HAS PROVIDED MUCH NEEDED COMMUNITY OUTREACH AND ENGAGEMENT ACTIVITIES WITH A FOCUS ON ADDRESSING HEALTH DISPARITIES AND SUPPORTING COMMUNITY MEMBERS AS THEY ENGAGE WITH THE HEALTH CARE SYSTEM. EVENTS INCLUDED COMMUNITY CONVERSATIONS; COLLABORATIVE PROGRAMS WITH THE FAITH COMMUNITY; PARTNERSHIPS WITH LOCAL NON-PROFIT AGENCIES; AND EVALUATION OF PROGRAM ACTIVITIES WHICH ALL PROVIDE FURTHER OPPORTUNITIES TO LEARN MORE ABOUT THE NEEDS OF THE COMMUNITY. |

990 Schedule H, Supplemental Information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
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| PART VI, LINE 4: | <p>COMMUNITY INFORMATION - GREATER HARTFORD IS GENERALLY DEFINED AS THE AREA SERVED BY THE CAPITOL REGION COUNCIL OF GOVERNMENTS WHICH CONSISTS OF 38 CITIES AND TOWNS: THE CITY OF HARTFORD, THE CITY OF NEW BRITAIN, BERLIN, BLOOMFIELD, EAST HARTFORD, ENFIELD, MANCHESTER, NEWINGTON, PLAINVILLE, ROCKY HILL, VERNON, WEST HARTFORD, WETHERSFIELD, WINDSOR, AND WINDSOR LOCKS, AND THE 23 SUBURBS FURTHER OUT FROM THE CITY CENTER INCLUDING: ANDOVER, AVON, BOLTON, CANTON, COLUMBIA, COVENTRY, EAST GRANBY, EAST WINDSOR. AGE DISTRIBUTION - GREATER HARTFORD'S OLDER POPULATION IS CONTINUING TO GROW AND THE DEMAND FOR HEALTH SERVICES IS EXPECTED TO INCREASE AS A RESULT OF THIS AGING POPULATION. BETWEEN 2000 AND 2017, THE MEDIAN AGE IN GREATER HARTFORD INCREASED FROM 37.2 TO 40.1. THIS INCREASE IS IN LINE WITH CONNECTICUT'S OTHER MORE URBAN COUNTIES, WHILE THE STATE'S RURAL COUNTIES GENERALLY EXPERIENCED STEEPER INCREASES. OVERALL, THE MEDIAN AGE IN GREATER HARTFORD IS SLIGHTLY YOUNGER THAN THAT OF THE STATE (40.8), BUT OLDER THAN THAT OF THE U.S. FROM 1990 TO 2015, GREATER HARTFORD'S POPULATION OF YOUNG ADULTS AGES 18 TO 34 DECLINED BY 15 PERCENT, OR 39,985 PEOPLE. THE POPULATION OF OLDER SENIORS AGES 80 AND OVER INCREASED BY 55 PERCENT, OR 15,525 PEOPLE, AND THE POPULATION OF CHILDREN AGES 5 TO 17 INCREASED BY 14 PERCENT. THE POPULATION IS MUCH YOUNGER IN THE CITY OF HARTFORD. RACIAL AND ETHNIC DIVERSITY - THE TOWNS IN THE REGION VARY IN TERMS OF THEIR RACIAL AND ETHNIC COMPOSITION, WITH HARTFORD AND NEW BRITAIN HAVING THE LARGEST PERCENTAGE CHANGE IN NON-WHITE POPULATIONS. BELOW IS THE ETHNIC MAKE-UP OF THE 5 LARGEST CITIES & TOWNS: HARTFORD -15% WHITE, 35% BLACK, 44% HISPANIC, 3% OTHER NEW BRITAIN - 42% WHITE, 12% BLACK, 41% HISPANIC, 3% OTHER EAST HARTFORD - 34% WHITE, 25% BLACK, 34% HISPANIC, 4% OTHER MANCHESTER - 58% WHITE, 14% BLACK, 14% HISPANIC, 11% OTHER WEST HARTFORD -73% WHITE, 6% BLACK, 11% HISPANIC, 8% OTHER POVERTY - THERE ARE WIDE GAPS IN HOUSEHOLD INCOME WITHIN THE REGION, AND LOW-INCOME RATES ARE INCREASING AMONG FAMILIES WITH CHILDREN. THOSE WITH LOWER INCOMES HAVE INCREASED BARRIERS TO TRANSPORTATION AND OTHER ISSUES RELATED TO ACCESSING SERVICES. BELOW IS THE INDICATOR WITH THE PERCENTAGE OF HARTFORD RESIDENTS VERSUS CONNECTICUT AS A WHOLE: POVERTY RATE - 24%, 7% FOOD INSECURITY - 33%, 12% HOUSING INSECURITY - 12%, 6% IN EXCELLENT HEALTH - 48%, 62% WITHIN HARTFORD COUNTY THE FEDERAL HEALTH RESOURCES & SERVICES ADMINISTRATION HAS DESIGNATED SEVEN MEDICALLY UNDERSERVED AREAS/POPULATIONS. THERE ARE SEVEN OTHER HOSPITALS SERVING THIS COMMUNITY.</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 5: | <p>PROMOTION OF COMMUNITY HEALTH - FREE LECTURES AND SEMINARS WERE OFFERED BY CLINICAL STAFF IN RESPONSE TO COMMUNITY REQUESTS; HOSPITAL STAFF SERVED ON NUMEROUS LOCAL AND STATE LEVEL BOARDS AND COMMITTEES; COMMUNITY BENEFIT DOLLARS WERE ALLOCATED TO SUPPORT PARTNERSHIPS WITH STATE AGENCIES AND LOCAL HEALTH CARE PROVIDERS ALONG WITH THE LOCAL TRANSFORMING COMMUNITIES INITIATIVE CALLED WELL BEING 360 WHICH ALL SERVED TO SUPPORT OUR COMMITMENT TO IMPROVE COMMUNITY HEALTH. WELL BEING 360 IS PART OF THE NATIONAL TRINITY HEALTH TRANSFORMING COMMUNITIES INITIATIVE (TCI) EFFORT TO ENCOURAGE POLICY, SYSTEM AND ENVIRONMENTAL CHANGE THAT PROMOTE HEALTHY BEHAVIORS IN THE COMMUNITIES SERVED BY TRINITY HEALTH HOSPITALS. THE TCI PROGRAM IS MANAGED OUT OF THE CURTIS D. ROBINSON CENTER FOR HEALTH EQUITY AT SAINT FRANCIS HOSPITAL IN PARTNERSHIP WITH THE WELL BEING 360 STEERING COMMITTEE, WHICH IS A MULTI-SECTOR GROUP OF LEADERS INCLUDING THE CITY OF HARTFORD, TRINITY HEALTH OF NEW ENGLAND, WELLSILE AND COMMUNITY SOLUTIONS LEADERSHIP. UNDER THE DIRECTION OF THE STEERING COMMITTEE, WE LL BEING 360 IS INVESTED RESOURCES TO SUPPORT EVIDENCE-BASED AND INNOVATIVE SOLUTIONS TO REDUCE OBESITY, INCREASE ACCESS TO CARE AND ADDRESS PRIORITIES OUTLINED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT. WELL BEING 360 ALSO INVESTED IN THE DEVELOPMENT TO SUPPORT THE PROGRAM ITSELF AND OTHER POPULATION HEALTH IMPROVEMENT WORK IN THE CATCHMENT AREA. THE NORTH HARTFORD TRIPLE AIM COLLABORATIVE INCLUDES STEERING COMMITTEE ORGANIZATIONS PLUS OTHER CRITICAL PARTNERS INCLUDING NORTH END RESIDENTS, CONNECTICUT CHILDREN'S MEDICAL CENTER, THE UNITED WAY OF CENTRAL AND SOUTHEASTERN CONNECTICUT, THE UNIVERSITY OF CONNECTICUT, AND THE CONNECTICUT HEALTH FOUNDATION. TO IMPROVE THE HEALTH OF COMMUNITY MEMBERS, SAINT FRANCIS HOSPITAL PROVIDED EDUCATION TO DIFFERENT POPULATION GROUPS TO SPREAD AWARENESS OF THE IMPORTANCE OF PHYSICAL ACTIVITY AND GOOD NUTRITION. A COMMUNITY HEALTH CHALLENGE WAS CONDUCTED, CALLED THE "STEP UP, EAT UP, & DRINK UP HEALTH CHALLENGE". IT CONSISTED OF THREE PARTS: INCREASE DAILY STEPS AND PHYSICAL ACTIVITY; INCREASE DAILY SERVINGS OF FRUIT & VEGETABLES; AND INCREASE DAILY WATER INTAKE. IT ENCOURAGED INDIVIDUALS AND GROUPS TO PARTICIPATE AND TO LEARN HOW TO MAKE SMART CHOICES AND TO DEVELOP HEALTHY BEHAVIORS. PARTICIPANTS IN THE CHALLENGE PROMISED TO START TAKING THE STEPS TO A HEALTHIER LIFESTYLE. THE HOSPITAL SYSTEM OFFERED A VARIETY OF CLASSES AND PROGRAMS TO HELP INDIVIDUALS EAT HEALTHY, STAY ACTIVE AND MAKE POSITIVE CHANGES. DOZENS OF COMMUNITY ORGANIZATIONS, BUSINESS, SCHOOLS, CHURCHES AND STATE OFFICES PARTNERED WITH OUR HEALTH SYSTEM IN THE CHALLENGE. A FOLLOW-UP SURVEY SENT TO OVER 3,000 PARTICIPANTS REVEALED A POSITIVE INCREASE IN RESPONDENTS' OVERALL HEALTH & WELL-BEING. BABY FRIENDLY - SAINT FRANCIS HOSPITAL IS ON THE PATH OF RECEIVING BABY FRIENDLY STATUS. BABY FRIENDLY HOSPITALS ARE RECOGNIZED FOR ENCOURAGING BREASTFEEDING AND MOTHER/BABY BONDING, WHICH IS KNOWN TO PROVIDE HEALTH BENEFITS FOR INFANTS, CHILDREN, AND MOTHERS. WE ARE A CENTER OF SUPPORT IN WHICH EVIDENCED-BASED CARE IS PROVIDED, EDUCATION IS FREE FROM COMMERCIAL INTERESTS, ALL INFANT FEEDING OPTIONS ARE POSSIBLE, AND INDIVIDUAL PREFERENCES ARE RESPECTED. WE AIM TO ENSURE THAT EVERY MOTHER IS FULLY INFORMED OF THE IMPORTANCE OF BREASTFEEDING AND THE HELP SHE NEEDS TO ACHIEVE HER BREASTFEEDING GOAL. SAINT FRANCIS HOSPITAL, AS PART OF THE TRINITY HEALTH OF NEW ENGLAND HEALTH SYSTEM, WAS INVOLVED IN A MULTIFACETED PUBLIC HEALTH AWARENESS MEDIA CAMPAIGN REGARDING COVID-19 PREVENTION, TESTING AND TREATMENT WHICH INTENTIONALLY INCLUDED SPECIFIC MESSAGING FOR CHILDREN AND DIVERSE COMMUNITIES. AS PART OF A BROAD EMERGENCY HEALTH RESPONSE TO THE CORONAVIRUS, THE HOSPITAL SET UP A FURI (FEVER UPPER RESPIRATORY INFECTION) CLINIC. THIS DEDICATED FACILITY'S PURPOSE IS TO KEEP PEOPLE WHO ARE EXPERIENCING SYMPTOMS OF AN UPPER RESPIRATORY TRACT ILLNESS OUT OF THE EMERGENCY DEPARTMENT AND PHYSICIAN OFFICES. THIS HELPS TO LIMIT THE SPREAD OF DISEASE AMONG VULNERABLE POPULATIONS, SUCH AS THE ELDERLY. THE FURI CLINIC CAN ASSESS AND TREAT POTENTIALLY LARGE NUMBERS OF PEOPLE WITH APPROPRIATE LEVELS OF INFECTION CONTROL. ITS STAFFERS ARE DEDICATED TO THIS ONE TASK, SO EXPERTISE IS CONCENTRATED IN ONE LOCATION. SAINT FRANCIS HOSPITAL OFFERED A DRIVE-THROUGH COVID-19 TESTING SITE AT THE HOSPITAL. COVID-19 TESTING WAS AVAILABLE TO ALL MEMBERS OF THE COMMUNITY WHO WERE 6 MONTHS AND OLDER, REGARDLESS IF THE INDIVIDUAL HAD BEEN A PATIENT WITHIN THE HOSPITAL SYSTEM OR NOT. NO APPOINTMENT WAS NECESSARY AS TESTING WAS PERFORMED ON A FIRST COME, FIRST SERVE BASIS. IF AN INDIVIDUAL WANTED TO SCHEDULE AN APPOINTMENT, A COVID-19 TESTING CALL CENTER WAS ACTIVATED THAT ASSISTED COMMUNITY MEMBERS WHO WANTED TO MAKE AN APPOINTMENT FOR THE DRIVE-THROUGH TESTING SITE. TRINITY HEALTH OF NEW ENGLAND WAS ALSO ONE OF JUST FOUR HEALTH SYSTEMS IN THE UNITED STATES TO GAIN INITIAL APPROVAL FROM THE U.S. FOOD AND</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 5: | <p>DRUG ADMINISTRATION (FDA) TO RUN A COVID-19 CONVALESCENT PLASMA PHASE TWO CLINICAL TRIAL IN APRIL 2020. THE PROSPECTIVE, INTERVENTIONAL STUDY EVALUATED THE SAFETY AND EFFICACY OF CONVALESCENT PLASMA TRANSFUSION IN CRITICALLY ILL COVID-19 PATIENTS. CONVALESCENT PLASMA WAS OBTAINED FROM RECOVERED DONORS AND ADMINISTERED TO ADULT PATIENTS WITH EITHER SEVERE OR CRITICAL COVID-19 ILLNESS. THE RESULTS WERE PUBLISHED FOR ALL MEDICAL PROFESSIONALS TO SEE IN THE INFECTIOUS DISEASES AND THERAPY JOURNAL. THE STUDY FOUND THAT CONVALESCENT PLASMA IS SAFE AND HAS THE POTENTIAL FOR POSITIVE IMPACT ON CLINICAL OUTCOMES INCLUDING RECOVERY AND SURVIVAL IF GIVEN TO PATIENTS EARLY IN THE COURSE OF COVID-19.</p> |

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| Form and Line Reference | Explanation |
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| PART VI, LINE 6: | <p>SAINT FRANCIS HOSPITAL IS A MEMBER OF TRINITY HEALTH, ONE OF THE LARGEST CATHOLIC HEALTH CARE DELIVERY SYSTEMS IN THE COUNTRY. TRINITY HEALTH ANNUALLY REQUIRES THAT ALL MEMBER HOSPITALS DEFINE - AND ACHIEVE - SPECIFIC COMMUNITY HEALTH AND WELL-BEING GOALS. IN FISCAL YEAR 2020, EVERY TRINITY HEALTH ENTITY FOCUSED ON: 1. REDUCING TOBACCO USE 2. REDUCING OBESITY PREVALENCE3. ADDRESSING AT LEAST ONE SOCIAL INFLUENCER OF HEALTH 4. ADDRESSING AT LEAST ONE SIGNIFICANT HEALTH NEED IDENTIFIED BY THEIR HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENTADDITIONALLY, IN RESPONSE TO COVID-19, TRINITY HEALTH MEMBER HOSPITALS MOBILIZED NATIONAL INFRASTRUCTURE TO ASSESS THE MOST URGENT NEEDS IN THEIR COMMUNITIES. TRINITY HEALTH MEMBER HOSPITALS STRENGTHENED PARTNERSHIPS WITH COMMUNITY-BASED ORGANIZATIONS AND COLLABORATED WITH MEDICAL GROUPS AND CLINICALLY INTEGRATED NETWORKS PROVIDING DIRECT PATIENT CARE TO ENSURE THAT PATIENT SOCIAL NEEDS WERE MET IN THE COMMUNITY. LIKEWISE, MEMBER HOSPITALS ACCELERATED THEIR SOCIAL SERVICES RESPONSE BY ESTABLISHING SOCIAL CARE PROGRAMS TO CONNECT PATIENTS, COLLEAGUES AND COMMUNITY MEMBERS TO LOCAL SOCIAL SERVICES SUCH AS: FOOD, HOUSING, FINANCIAL ASSISTANCE AND ACCESS TO HEALTH CARE. FROM MARCH THROUGH JUNE, SOCIAL CARE MADE OVER 103,000 CONNECTIONS, AND TRINITY HEALTH PROVIDED OVER 44,000 MEDICAL SERVICES TO THOSE WHO ARE HOMELESS AND THROUGH COMMUNITY TESTING EVENTS. SOCIAL INFLUENCERS OF HEALTH - SUCH AS ADEQUATE HOUSING, PERSONAL SAFETY AND ACCESS TO FOOD, EDUCATION, INCOME, AND HEALTH COVERAGE - HAVE A SIGNIFICANT IMPACT ON THE HEALTH OF COMMUNITIES. IN AN EFFORT TO ADDRESS SOME OF THESE INFLUENCERS, TRINITY HEALTH INVESTED \$3.7 MILLION IN THE TRANSFORMING COMMUNITIES INITIATIVE (TCI), WHICH INITIALLY LAUNCHED IN FISCAL YEAR 2016. TCI IS A SHARED FUNDING MODEL AND TECHNICAL-ASSISTANCE INITIATIVE SUPPORTING EIGHT TRINITY HEALTH HOSPITALS, AND THEIR COMMUNITY PARTNERS, TO IMPLEMENT POLICY, SYSTEM, AND ENVIRONMENTAL CHANGE STRATEGIES TO PREVENT TOBACCO USE AND CHILDHOOD OBESITY, AND TO AFFECT CHANGE RELATED TO THE SOCIAL INFLUENCERS OF HEALTH. IN ADDITION TO TRINITY HEALTH'S INVESTMENT, TCI HAS LEVERAGED OVER \$12.4 MILLION IN COMMUNITY MATCH FUNDING TO DATE. IN FISCAL YEAR 2020, IN RESPONSE TO COVID-19, TCI SWIFTLY SHIFTED THEIR FOCUS IN MARCH TO ADDRESSING FOOD INSECURITY, HEALTH CARE WORKER PROTECTIVE EQUIPMENT, SUPPORTING CLOSED SCHOOLS TO EFFECTIVELY REACH CHILDREN, MENTAL HEALTH INTERVENTIONS, AND EMERGENCY AID/FINANCIAL ASSISTANCE DIRECTLY TO INDIVIDUALS IN NEED. OVERALL, TCI COMMUNITIES REDIRECTED NEARLY \$520,000 TO SUPPORT COVID-19 RELATED NEEDS.TRINITY HEALTH CONTINUES TO EXPAND THE NATIONAL DIABETES PREVENTION PROGRAM (NDPP) THROUGH THE SUPPORT OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND HELPED 2,374 PARTICIPANTS COLLECTIVELY LOSE 15,382 POUNDS FROM JANUARY 2018 THROUGH SEPTEMBER 2020. IN MARCH 2020, WITH THE SURGE OF COVID-19 SPREADING ACROSS THE COUNTRY, TRINITY HEALTH MEMBER HOSPITALS TRANSITIONED NEARLY 90% OF ALL IN-PERSON NDPP COHORTS TO AN ONLINE VERSION OF THE LIFESTYLE CHANGE PROGRAM.TRINITY HEALTH DEPLOYED \$5.1 MILLION IN NEW AND RENEWED LOANS FOR PLACE-BASED INVESTING TO IMPROVE ACCESS TO AFFORDABLE HOUSING, HEALTHY FOODS, EDUCATIONAL SCHOLARSHIPS, AND ECONOMIC DEVELOPMENT. ADDITIONALLY, TRINITY HEALTH WORKED WITH ALL OF ITS BORROWERS THAT HAD LOANS COMING DUE IN THE MIDST OF THE SPRING COVID-19 SURGE TO EXTEND THEIR LOANS FOR SIX MONTHS. THIS ACTION ALLOWED MORE THAN \$2.9 MILLION IN INVESTMENTS TO REMAIN IN THE FIELD AND PROVIDED BREATHING ROOM TO OUR COMMUNITY DEVELOPMENT FINANCIAL INSTITUTION PARTNERS THAT WERE SERVING OUR COMMUNITIES DURING THE CRISIS. THE COMMUNITY-INVESTING PROGRAM ALSO HAS OUTSTANDING LOAN COMMITMENTS OF \$9.6 MILLION TO COMMUNITY INFRASTRUCTURE PROJECTS, WHICH WILL BE DEPLOYED IN FUTURE YEARS.TRINITY HEALTH AND ITS MEMBER HOSPITALS ARE COMMITTED TO THE DELIVERY OF PEOPLE-CENTERED CARE AND SERVING AS A COMPASSIONATE AND TRANSFORMING HEALING PRESENCE WITHIN THE COMMUNITIES THEY SERVE. AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO THE COMMUNITIES AND IS COMMITTED TO ADDRESSING THE UNIQUE NEEDS OF EACH COMMUNITY. IN FISCAL YEAR 2020, TRINITY HEALTH INVESTED OVER \$1.3 BILLION IN COMMUNITY BENEFIT, SUCH AS INITIATIVES SUPPORTING THOSE WHO ARE POOR AND VULNERABLE, HELPING TO MANAGE CHRONIC CONDITIONS LIKE DIABETES, PROVIDING HEALTH EDUCATION, AND MOVING FORWARD POLICY, SYSTEM, AND ENVIRONMENTAL CHANGE. COVID-19 ACCOUNTED FOR NEARLY \$4.9 MILLION IN PROGRAMMATIC COMMUNITY BENEFIT EXPENSES AND ACTIVITIES, INCLUDING COMMUNITY TESTING AND EDUCATION, INCIDENT COMMAND CENTERS, SUPPORT FOR LOCAL ORGANIZATIONS (PROVIDING PPE, OTHER SUPPLIES, STAFF TIME), SOCIAL SUPPORTS (FOOD, HOUSING, MENTAL HEALTH, CHILDCARE), AND OTHER COMMUNITY DISASTER PREPAREDNESS EFFORTS.FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT WWW.TRINITY-HEALTH.ORG.</p> |

Additional Data**Software ID:****Software Version:****EIN:** 06-0646813**Name:** SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER**Form 990 Schedule H, Part V Section A. Hospital Facilities**

| Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1 | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (Describe) | Facility reporting group |
|--|--|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| 1 | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER 114 WOODLAND STREET MS-510358 HARTFORD, CT 06105 WWW.TRINITYHEALTHOFNE.ORG LICENSE #54 | X | X | | X | | | X | | | |

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

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

| Form and Line Reference | Explanation |
|---|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | PART V, SECTION B, LINE 3J: N/APART V, SECTION B, LINE 3E: SAINT FRANCIS HOSPITAL AND MEDICAL CENTER (SAINT FRANCIS HOSPITAL) INCLUDED IN ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WRITTEN REPORT A PRIORITIZED LIST AND DESCRIPTION OF THE COMMUNITY'S SIGNIFICANT HEALTH NEEDS, WHICH WERE IDENTIFIED THROUGH THE MOST RECENTLY CONDUCTED CHNA. THE FOLLOWING COMMUNITY HEALTH NEEDS WERE DEEMED SIGNIFICANT AND WERE PRIORITIZED THROUGH A COMMUNITY-INVOLVED SELECTION PROCESS: HEALTH ISSUES: - ASTHMA - OBESITY & DIABETES - MENTAL HEALTH - SUBSTANCE ABUSE SOCIAL DETERMINANT OF HEALTH ISSUES: - ACCESS TO HEALTHY FOODS - STABLE HOUSING - NEIGHBORHOOD SAFETY |

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

| Form and Line Reference | Explanation |
|---|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | <p>PART V, SECTION B, LINE 5: THE INPUT OF THE COMMUNITY, ESPECIALLY FROM THE MEDICALLY UNDER SERVED, LOW-INCOME AND MINORITY POPULATIONS, WAS PRIORITIZED AS AN IMPORTANT PART OF THE C HNA PROCESS. BELOW ARE THE PRIMARY MECHANISMS FOR DATA COLLECTION AND COMMUNITY & STAKEHOL DER ENGAGEMENT: QUANTITATIVE AND QUALITATIVE DATA WAS COLLECTED AND REVIEWED THROUGHOUT TH E CHNA PROCESS. SECONDARY DATA SOURCES INCLUDED, BUT WERE NOT LIMITED TO, THE U.S. CENSUS, U.S. BUREAU OF LABOR STATISTICS, CENTERS FOR DISEASE CONTROL AND PREVENTION, STATE OF CON NECTICUT DEPARTMENT OF PUBLIC HEALTH, CONNECTICUT HEALTH INFORMATION MANAGEMENT EXCHANGE (CHIME), AS WELL AS LOCAL ORGANIZATIONS AND AGENCIES. TYPES OF DATA INCLUDED VITAL STATISTI CS BASED ON BIRTH AND DEATH RECORDS. SAINT FRANCIS HOSPITAL PARTNERED WITH DATAHAVEN AND, IN PART, SPONSORED THE 2018 DATAHAVEN COMMUNITY WELLBEING SURVEY (DCWS) ALONG WITH 80 OTHE R PUBLIC AND PRIVATE PARTNERS IN THE AREA. ORGANIZATIONS INVOLVED INCLUDED CAPITOL REGION COUNCIL OF GOVERNMENTS, UNIVERSITY OF HARTFORD, CONNECTICUT'S LEGISLATIVE COMMISSION ON AG ING, DEPARTMENT OF COMMUNITY MEDICINE AND HEALTH CARE, UCONN SCHOOL OF MEDICINE, AMERICAN HEART ASSOCIATION, MANCHESTER HEALTH DEPARTMENT, NORTH CENTRAL DISTRICT HEALTH DEPARTMENT, CENTRAL CONNECTICUT HEALTH DISTRICT, CITY OF BRISTOL, CAROLYN FOUNDATION, PLANNED PARENTH OOD OF SOUTHERN NEW ENGLAND, LIBERTY BANK FOUNDATION, STATE OF CONNECTICUT HEALTH EQUITY D ATA ANALYTICS PROJECT, AND URBAN INSTITUTE AND ROBERT WOOD JOHNSON FOUNDATION (THROUGH POW ERING HEALTH LIVES). THE SURVEY COMPLETED LIVE, IN-DEPTH INTERVIEWS WITH OVER 3,000 RESIDE NTS IN THE REGION VIA CELLULAR AND LANDLINE PHONE; ADDITIONAL INFORMATION ON SURVEY METHOD S ARE POSTED AT DATAHAVEN (CTDATAHAVEN.ORG). AS PART OF THE CREATION OF THIS REPORT, BETWE EN FEBRUARY AND JUNE 2019, DATAHAVEN, THE CITY OF HARTFORD DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAINT FRANCIS HOSPITAL, THE NORTH HARTFORD TRIPLE AIM COLLABORATIVE AT THE UNITE D WAY OF CENTRAL AND NORTHEASTERN CONNECTICUT, CONNECTICUT CHILDREN'S MEDICAL CENTER, AND THE HARTFORD FOUNDATION FOR PUBLIC GIVING COLLECTED ADDITIONAL QUALITATIVE INPUT ON THE HE ALTH AND HEALTH-RELATED CONCERNS THAT ARE MOST IMPORTANT TO THE GREATER HARTFORD COMMUNITY , AND TO THE RESIDENTS OF THE CITY OF HARTFORD IN PARTICULAR. THIS INPUT WAS GATHERED FROM : - A REGIONAL KEY INFORMANT MEETING HELD ON FEBRUARY 28, 2019 AT THE HARTFORD FOUNDATION FOR PUBLIC GIVING WITH OVER 70 PARTICIPANTS. THESE KEY INFORMANTS REPRESENTED VARIOUS SECT ORS, INCLUDING HEALTH CARE, EDUCATION, PUBLIC HEALTH, HOUSING, AND HUMAN SERVICES. AT THIS EVENT, DATAHAVEN ORGANIZED A "DATA WALK," WITH SMALL GROUPS CIRCULATING AMONG ABOUT A DOZ EN POSTERS ON DIFFERENT TOPICS AND PROVIDING COMMENTS TO A FACILITATOR. ADDITIONALLY, A BR IEF PAPER SURVEY WAS COLLECTED FROM MEETING ATTENDEES; - FOCUS GROUPS FOR HARTFORD NORTH E ND (HELD ON APRIL 2, 2019 WITH 13 PARTICIPANTS) AND SOUTH END (HELD ON JUNE 11, 2019 WITH 11 PARTICIPANTS) COMMUNITY MEM</p> |

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

| Form and Line Reference | Explanation |
|---|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | BERS; AND - A SURVEY OF SCHOOL HEALTH CARE PROVIDERS (HELD ON MARCH 8, 2019 WITH 29 RESPON DENTS). |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | PART V, SECTION B, LINE 6A: SAINT FRANCIS HOSPITAL COLLABORATED WITH THE FOLLOWING HOSPITAL FACILITIES IN CONDUCTING ITS MOST RECENT CHNA: CONNECTICUT CHILDREN'S MEDICAL CENTER, MOUNT SINAI REHABILITATION HOSPITAL, JOHNSON MEMORIAL HOSPITAL AND SAINT MARY'S HOSPITAL. |

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

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

| Form and Line Reference | Explanation |
|---|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | PART V, SECTION B, LINE 6B: SAINT FRANCIS HOSPITAL COLLABORATED WITH THE FOLLOWING COMMUNITY ORGANIZATIONS WHILE CONDUCTING ITS MOST RECENT CHNA: THE CITY OF HARTFORD HEALTH AND HUMAN SERVICES, THE UNITED WAY, DATAHAVEN AND THE HARTFORD FOUNDATION FOR PUBLIC GIVING. |

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | PART V, SECTION B, LINE 11: THE NEEDS IDENTIFIED IN THE CHNA ALONG WITH EFFORTS TO ADDRESS THE SOCIAL INFLUENCERS OF HEALTH (SIOH) ARE THE FOUNDATION FOR THE WELL BEING 360 TRANSFORMING COMMUNITIES INITIATIVE. THIS PROJECT INCLUDED A REALLOCATION OF COMMUNITY BENEFIT DOLLARS TO ADDRESS THE CHNA PRIORITIES BY INVESTING IN COMMUNITY RESOURCES ALREADY IN PLACE THAT HAVE SHOWN POSITIVE OUTCOMES. EVIDENCE BASED PROGRAMS, POLICY AND ADVOCACY, SYSTEM CHANGE APPROACHES AND COLLABORATIVE DEVELOPMENT WERE ALL STRATEGIES EMPLOYED BY THE WELL BEING 360 INITIATIVE TO MOVE THE NEEDLE ON HEALTH. WE CONTINUED DEVELOPMENT OF A HEALTH FOCUSED COLLABORATIVE, SUPPORT FOR LOCAL PARTNERS TO ADDRESS VIOLENCE PREVENTION, COLLABORATION WITH A LOCAL AGENCY TO ADDRESS ISSUES RELATED TO HOUSING INSECURITY, AND SUPPORT FOR A VARIETY OF PROGRAMS THAT ADDRESS ACCESS TO HEALTHY FOODS. PARTNERSHIPS AND INVESTMENTS IN LOCAL AGENCIES ENABLED THE HOSPITAL TO IMPACT THE NEEDS IDENTIFIED IN THE CHNA AND TO ADDRESS SIOH: NEIGHBORHOOD SAFETY - INVESTMENTS FROM WELL BEING 360 CONTINUED IN LOCAL ORGANIZATIONS THAT CAN HAVE AN IMPACT ON THIS ISSUE, INCLUDING GREATER HARTFORD HARM REDUCTION COALITION, AN OPIOID HARM REDUCTION AGENCY, HARTFORD COMMUNITIES THAT CARE, A VIOLENCE PREVENTION AND RETALIATION REDUCTION PROGRAM, AND NORTH HARTFORD TRIPLE AIM COLLABORATIVE, A HEALTH COLLABORATIVE DEVELOPED TO ADDRESS DISPARITIES IN THE NORTH END OF HARTFORD INCLUDING IMPROVEMENT OF NEIGHBORHOOD SAFETY. ACCESS TO HEALTHY FOODS - THE WELL BEING 360 INVESTMENTS CONTINUED TO FOCUS RESOURCES IN THIS AREA THROUGH COOKING MATTERS, A PROGRAM THAT WORKS TO ENSURE CHILDREN AND PARENTS WITH LOWER INCOMES LEARN TO ACCESS, SHOP, PREPARE, AND EAT HEALTHY FOODS ON A LIMITED BUDGET. THIS PROGRAM HELPS FAMILIES ATTAIN A HEALTHIER DIET THROUGH HANDS-ON, MULTI-SESSION COOKING AND SHOPPING COURSES. SUBSTANCE USE/TOBACCO/VAPING - SUPPORT FOR CHANGES IN POLICY AT THE STATE LEVEL TO ENHANCE LAWS TO PROTECT YOUTH FROM THE DANGERS OF TOBACCO AND VAPING ARE ALSO A PART OF THE WELL BEING 360 WORK. PARTNERING WITH THE GOVERNMENT RELATIONS DEPARTMENT AT THE REGIONAL HEALTH MINISTRY HAS ENABLED OUR HOSPITAL TO APPROACH THIS WORK AT A SYSTEM LEVEL. STAFF FROM THE REGIONAL OFFICE, AS PART OF THE MATCH (MOBILIZING AGAINST TOBACCO FOR CONNECTICUT'S HEALTH) COALITION CONTINUE TO PROPOSE POLICY CHANGES TO REDUCE SMOKING AND VAPING BEHAVIOR OF YOUTH. MENTAL HEALTH - THIS ISSUE WAS RECOGNIZED BY THE COMMUNITY AS A NEED TO HAVE BETTER ACCESS TO BEHAVIORAL HEALTH SERVICES AND SUPPORT FOR SOCIAL NEEDS. THESE ISSUES WERE ADDRESSED WITH SYSTEM CHANGES WITHIN THE HOSPITAL AND BY SUPPORTING AGENCIES THAT CAN FACILITATE ROBUST REFERRALS. OUR PARTNER AGENCIES INCLUDED: THE CHRYSALIS CENTER, WHO PROVIDED SOCIAL SUPPORT WRAP AROUND SERVICES FOR HIGH NEED BEHAVIORAL HEALTH CLIENTS; COMMUNITY CARE TEAM, A COLLABORATION WITH LOCAL HOSPITALS TO COORDINATE SUPPORT FOR BEHAVIORAL HEALTH PATIENTS THAT FREQUENTLY USE THE EMERGENCY DEPARTMENT; AND CATHOLIC |

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

| Form and Line Reference | Explanation |
|---|---|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | C CHARITIES, A SOCIAL SERVICE AGENCY THAT PARTNERED WITH OUR PRIMARY CARE CLINIC TO PROVIDE NAVIGATION SUPPORT FOR PATIENTS WHO NEED TO CONNECT TO COMMUNITY RESOURCES STABLE HOUSING - THIS IS A SIGNIFICANT ISSUE IN HARTFORD AND WAS IDENTIFIED BY THE COMMUNITY AS A CONCERN. THE HOSPITAL COLLABORATED WITH COMMUNITY SOLUTIONS, A LOCAL COMMUNITY-BASED ORGANIZATION THAT WORKED TO SUPPORT ECONOMIC DEVELOPMENT FOR IMPOVERISHED NEIGHBORHOODS AND HAS A NATIONAL REPUTATION FOR SUPPORTING THOSE IN NEED OF STABLE HOUSING. SAINT FRANCIS HOSPITAL ACKNOWLEDGES THE WIDE RANGE OF PRIORITY HEALTH ISSUES THAT EMERGED FROM THE CHNA PROCESS AND DETERMINED THAT IT COULD EFFECTIVELY FOCUS ON THE HEALTH NEEDS WHICH IT DEEMED MOST PRESSING, UNDER-ADDRESSED, AND WITHIN ITS ABILITY TO INFLUENCE. SAINT FRANCIS HOSPITAL IS ALSO COMMITTED TO PROVIDING HIGH QUALITY CLINICAL SERVICES TO THE COMMUNITY. IN ORDER TO BE GOOD STEWARDS OF THE RESOURCES AVAILABLE FOR THIS WORK, THE COMMUNITY BENEFIT ACTIVITIES INCLUDED IN THE HOSPITAL'S PORTFOLIO ARE DESIGNED TO LEVERAGE THE SKILLS AND EXPERTISE OF THE HOSPITAL AND ITS STAFF. FOR THAT REASON, OBESITY AND ASTHMA WERE NOT SPECIFICALLY ADDRESS ED. |

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

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

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

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| Form 990 Part V Section C Supplemental Information for Part V, Section B. | |
| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc. | |
| Form and Line Reference | Explanation |
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER - PART V, SECTION B, LINE 7A: | WWW.TRINITYHEALTHOFNE.ORG/ABOUT-US/COMMUNITY-BENEFIT/COMMUNITY-HEALTH-NEEDS-ASSESSMENTS |

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

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

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

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| Form 990 Part V Section C Supplemental Information for Part V, Section B. | |
| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc. | |
| Form and Line Reference | Explanation |
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER - PART V, SECTION B, LINE 10A: | WWW.TRINITYHEALTHOFNE.ORG/ABOUT-US/COMMUNITY-BENEFIT/COMMUNITY-HEALTH-NEEDS-ASSESSMENTS |

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

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

| Form and Line Reference | Explanation |
|--|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER - PART V, SECTION B, LINE 16A: | WWW.TRINITYHEALTHOFNE.ORG/FOR-PATIENTS/BILLING-AND-FINANCIAL-RESOURCES/ |

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

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

| Form and Line Reference | Explanation |
|--|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER - PART V, SECTION B, LINE 16B: | WWW.TRINITYHEALTHOFNE.ORG/FOR-PATIENTS/BILLING-AND-FINANCIAL-RESOURCES/ |

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

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

| Form and Line Reference | Explanation |
|--|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER - PART V, SECTION B, LINE 16C: | WWW.TRINITYHEALTHOFNE.ORG/FOR-PATIENTS/BILLING-AND-FINANCIAL-RESOURCES/ |

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

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

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

| Name and address | Type of Facility (describe) |
|--|--|
| 1 1 - ENFIELD ACCESS CENTER 7 ELM STREET ENFIELD, CT 06082 | MEDICAL OFFICES AND COMMUNITY EDUCATION SPACE / LABORATORY SERVICES |
| 1 2 - WINDSOR - SF GI ENDOSCOPY CENTER 360 BLOOMFIELD AVENUE WINDSOR, CT 06095 | ENDOSCOPY |
| 2 3 - WEST HARTFORD MEDICAL OFFICES 345 NORTH MAIN STREET WEST HARTFORD, CT 06109 | MEDICAL OFFICES AND IT TRAINING SPACE / LABORATORY SERVICES |
| 3 4 - AVON ACCESS CENTER 35 NOD RD SUITE 105 AVON, CT 06001 | MEDICAL OFFICES |
| 4 5 - FARMINGTON MEDICAL OFFICES 11 SOUTH ROAD SUITE 200/220 FARMINGTON, CT 06032 | MEDICAL OFFICES / LABORATORY SERVICES |
| 5 6 - GLASTONBURY ACCESS CENTER 31 SYCAMORE COMMONS GLASTONBURY, CT 06033 | MEDICAL OFFICES AND COMMUNITY EDUCATION SPACE / LABORATORY SERVICES |
| 6 7 - EAST HARTFORD ACCESS CENTER 893 MAIN STREET EAST HARTFORD, CT 06108 | MEDICAL OFFICES / LABORATORY SERVICES |
| 7 8 - ROCKY HILL 546 CROMWELL AVE SUITE 100 ROCKY HILL, CT 06067 | MEDICAL OFFICE |
| 8 9 - HARTFORD 500 BLUE HILLS AVE HARTFORD, CT 06112 | LABORATORY SERVICES |
| 9 10 - HARTFORD 1000 ASYLUM ST STE 3209 HARTFORD, CT 06103 | LABORATORY SERVICES |
| 10 11 - BLOOMFIELD 580 COTTAGE GROVE ROAD BLOOMFIELD, CT 06002 | LABORATORY SERVICES |
| 11 12 - ROCKY HILL 506 CROMWELL AVE ROCKY HILL, CT 06067 | LABORATORY SERVICES |
| 12 13 - ROCKY HILL 2301 SILAS DEANE HWY ROCKY HILL, CT 06067 | LABORATORY SERVICES |
| 13 14 - AVON 44 DALE RD STE 301 AVON, CT 06001 | LABORATORY SERVICES |
| 14 15 - HARTFORD 19 WOODLAND ST STE 22 HARTFORD, CT 06105 | LABORATORY SERVICES |

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

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

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

| Name and address | Type of Facility (describe) |
|---|---|
| 16 16 - BOLTON 291 BOSTON TURNPIKE BOLTON, CT 06043 | LABORATORY SERVICES |
| 1 17 - SOUTH WINDSOR 435 BUCKLAND RD SOUTH WINDSOR, CT 06074 | LABORATORY SERVICES |
| 2 18 - BARIATRIC CENTER AT SAINT FRANCIS 220 FARMINGTON AVE FARMINGTON, CT 06032 | MEDICAL OFFICES |
| 3 19 - CENTER FOR HEALTH ENHANCEMENT 95 WOODLAND STREET HARTFORD, CT 06105 | COMMUNITY SPACE |
| 4 20 - VERNON 428 HARTFORD TURNPIKE SUITE 201 VERNON, CT 06066 | LABORATORY SERVICES |
| 5 21 - ENFIELD 148 HAZARD AVE ENFIELD, CT 06082 | DIAGNOSTIC IMAGING/ RADIOLOGY / LABORATORY SERVICES |
| 6 22 - ENFIELD 140 HAZARD AVE SUITE 105 ENFIELD, CT 06082 | DIABETES AND ENDOCRINOLOGY CENTER |
| 7 23 - HARTFORD 1075 ASYLUM ST HARTFORD, CT 06105 | DIABETES AND ENDOCRINOLOGY CENTER |

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I
(Form 990)

Grants and Other Assistance to Organizations,
Governments and Individuals in the United States
Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public
Inspection

Department of the
Treasury
Internal Revenue Service

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

Employer identification number

06-0646813

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 ▶ 9
- 3 Enter total number of other organizations listed in the line 1 table ▶ 0

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.

Part III can be duplicated if additional space is needed.

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of noncash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of noncash assistance |
|-----------------------------------|--------------------------|--------------------------|----------------------------------|---|---------------------------------------|
| (1) NURSING AWARDS | 16 | 11,450 | | | |
| (2) EMPLOYEE CHILDREN SCHOLARSHIP | 14 | 14,000 | | | |
| (3) PATIENT ASSISTANCE | 45 | 30,298 | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

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

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|---|
| AMERICAN CANCER SOCIETY INC 825 BROOK STREET ROCKY HILL, CT 06067 | 13-1788491 | 501(C)(3) | 25,000 | | | | FUNDING & CONDUCTING RESEARCH RELATED TO CANCER |
| GOODWIN COLLEGE FOUNDATION INC ONE RIVERSIDE DRIVE EAST HARTFORD, CT 06118 | 06-1599388 | 501(C)(3) | 18,500 | | | | EXTEND EDUCATIONAL OPPORTUNITIES |

| 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 |
| PINK AID INC 670 POST RD E WESTPORT, CT 06880 | 47-1031835 | 501(C)(3) | 5,000 | | | | HELP UNDERSERVED LOCAL WOMEN SURVIVE BREAST CANCER TREATMENT WITH SUPPORT AND DIGNITY |
| SURVIVOR JOURNEYS INC PO BOX 60471 LONGMEADOW, MA 01116 | 47-3109711 | 501(C)(3) | 5,000 | | | | EMOTIONAL AND SUPPORT SERVICES FOR CANCER SURVIVORS |

| 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 |
| URBAN LEAGUE OF GREATER HARTFORD INC 140 WOODLAND STREET HARTFORD, CT 06105 | 06-6066491 | 501(C)(3) | 30,000 | | | | SUPPORT ADULT EDUCATION YOUTH & WORKFORCE DEVELOPMENT |
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER FOUNDATION 114 WOODLAND ST HARTFORD, CT 06105 | 06-1008255 | 501(C)(3) | 5,000 | | | | GENERAL 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 CHARTIES INC ARCHDIOCESE OF HARTFORD 896 ASYLUM AVENUE HARTFORD, CT 06105 | 06-0667607 | 501(C)(3) | 38,662 | | | | GENERAL SUPPORT |
| COMMUNITY SOLUTIONS INTERNATIONAL INC 60 BROAD STREET STE 2510-A NEW YORK, NY 10004 | 27-3523909 | 501(C)(3) | 85,000 | | | | GENERAL 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 |
| UNITED WAY OF CENTRAL & NORTHEASTERN CONNECTICUT 30 LAUREL STREET HARTFORD, CT 06106 | 06-0646653 | 501(C)(3) | 114,000 | | | | GENERAL SUPPORT |

| | | |
|---|---|--|
| Schedule J (Form 990) | Compensation Information | OMB No. 1545-0047 |
| | | 2019 |
| | | |
| Department of the Treasury Internal Revenue Service | 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. | |
| Name of the organization SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | | Employer identification number 06-0646813 |

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

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

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

[illegible]

Part III Supplemental Information

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

| Return Reference | Explanation |
|--------------------|---|
| PART I, LINE 3 | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER IS A SUBSIDIARY IN THE TRINITY HEALTH SYSTEM. SAINT FRANCIS HOSPITAL AND MEDICAL CENTER'S PRESIDENT IS PAID DIRECTLY BY THE SYSTEM'S PARENT ENTITY, TRINITY HEALTH CORPORATION. TRINITY HEALTH CORPORATION USED THE FOLLOWING METHODS TO ESTABLISH THE COMPENSATION OF SAINT FRANCIS HOSPITAL AND MEDICAL CENTER'S PRESIDENT: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - WRITTEN EMPLOYMENT CONTRACT - COMPENSATION SURVEY OR STUDY, AND - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE |
| PART I, LINES 4A-B | THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS IN CALENDAR 2019. THESE AMOUNTS ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: CHRISTOPHER DALDEZ - \$878,134 KATHLEEN LUCZYK - \$83,638 COLUMN F OF SCHEDULE J, PART II INCLUDES THE PORTION OF THIS AMOUNT THAT WAS REPORTED AS DEFERRED COMPENSATION IN PRIOR YEARS. IN ADDITION, COLUMN C OF SCHEDULE J, PART II INCLUDES THE FOLLOWING SEVERANCE AMOUNTS, WHICH WERE UNPAID AS OF 12/31/19: KATHLEEN LUCZYK - \$48,422 (PAID IN 2020) THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP) IN 2019. THE PLAN PROVIDES RETIREMENT BENEFITS TO CERTAIN TRINITY HEALTH EXECUTIVES SUBJECT TO MEETING SPECIFIED VESTING AND EMPLOYMENT DATE REQUIREMENTS. BENEFITS FOR PARTICIPANTS VESTED IN A PLAN WERE PAID OUT IN 2019, AND BENEFITS FOR PARTICIPANTS NOT YET VESTED IN A PLAN WERE ACCRUED IN 2019. THE FOLLOWING PAYOUTS FOR 2019 FOR THE PLAN ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: DAVID BITTNER - \$70,305 BENJAMIN CARTER - \$250,889 JOHN RODIS - \$180,900 THE FOLLOWING ACCRUALS FOR 2019 ARE INCLUDED IN COLUMN C OF SCHEDULE J, PART II: ROBERT ANTHONY - \$63,815 REGINALD EADIE - \$244,449 JENNIFER SCHNEIDER - \$14,758 THE FOLLOWING ARE PARTICIPANTS IN A TRINITY HEALTH RESTORATION PLAN. THE RESTORATION PLAN PROVIDES RETIREMENT BENEFITS FOR CERTAIN TRINITY HEALTH SYSTEM OFFICE EXECUTIVES WITH EARNINGS ABOVE THE IRS PAY CAP FOR QUALIFIED PLANS (\$280,000 IN 2019). THE FOLLOWING PAYOUTS FOR 2019 FOR THIS PLAN ARE INCLUDED IN COLUMN B(III) OF SCHEDULE J, PART II: THOMAS BURKE - \$815 KIMBERLEE RICHARD - \$1,188 JENNIFER SCHNEIDER - \$2,789 |

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|--|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1BENJAMIN CARTER DIRECTOR; TRINITY HEALTH EVP & COO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 988,630 | 465,109 | 283,201 | 12,600 | 56,699 | 1,806,239 | 0 |
| 1REGINALD EADIE MD DIRECTOR; TH OF NE PRESIDENT/CEO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 993,155 | 377,491 | 19,083 | 257,049 | 37,042 | 1,683,820 | 0 |
| 2JOHN RODIS MD PRESIDENT THROUGH 5/20 | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 787,867 | 310,860 | 212,738 | 12,600 | 53,118 | 1,377,183 | 0 |
| 3CHRISTOPHER DADLEZ FORMER OFFICER | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 0 | 0 | 885,406 | 0 | 22,817 | 908,223 | 878,134 |
| 4DAVID BITTNER TREASURER THROUGH 12/19; TRINITY SVP | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 468,496 | 97,721 | 81,222 | 12,600 | 32,249 | 692,288 | 0 |
| 5ROBERT ANTHONY SECRETARY; TH OF NE GENERAL COUNSEL | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 415,540 | 82,117 | 10,639 | 76,415 | 29,263 | 613,974 | 0 |
| 6PHILLIP ROLAND CMO AS OF 11/19; PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 490,096 | 0 | 44,943 | 16,800 | 34,179 | 586,018 | 0 |
| 7MICHAEL GREY MD FORMER KEY EMP; CHAIR OF MED | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 497,651 | 0 | 44,854 | 12,600 | 3,616 | 558,721 | 0 |
| 8PETER EAMRANOND CHIEF MEDICAL OFFICER THROUGH 11/19 | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 397,640 | 46,693 | 28,771 | 12,600 | 22,654 | 508,358 | 0 |
| 9JENNIFER SCHNEIDER TREAS AS OF 1/20; SVP & REG CFO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 316,296 | 51,398 | 5,525 | 31,558 | 30,946 | 435,723 | 0 |
| 10KATHLEEN LUCZYK REGIONAL DIR LAB SERVICES | (i) | 135,394 | 54,505 | 111,076 | 61,655 | 25,883 | 388,513 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 11THOMAS BURKE VP OPS THRU 5/20; PRES AT 5/20 | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 283,523 | 48,924 | 2,133 | 16,800 | 23,891 | 375,271 | 0 |
| 12LINDA SHANLEY FORMER KE; REGIONAL CIO CLIENT SVCS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 318,867 | 24,904 | 2,136 | 12,578 | 3,500 | 361,985 | 0 |
| 13KIMBERLEE RICHARD CHIEF NURSING OFFICER | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 276,072 | 46,393 | 4,650 | 12,600 | 8,231 | 347,946 | 0 |
| 14RICHARD BRODY PHYSICIAN | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 273,472 | 0 | 12,063 | 12,600 | 32,690 | 330,825 | 0 |
| 15JEFFREY SCHLOSSER REGIONAL DIR OCCUP HLTH AND SAFETY | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 270,997 | 0 | 9,895 | 12,600 | 27,338 | 320,830 | 0 |
| 16JAMES HARRIS FMR OFFICER; TH OF NE DIR OF REIM | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 193,963 | 26,152 | 15,866 | 18,346 | 26,238 | 280,565 | 0 |

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 instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

Employer identification number
06-0646813

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 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 the organization managers or disqualified persons during the year under section 4958. ▶ \$

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

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

Total ▶ \$

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|-------------------------------|---|--------------------------|------------------------|---------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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) NICHOLAS M GREY | FAMILY MEMBER OF MICHAEL GREY, FORMER KEY EMPLOYEE | 35,950 | EMPLOYMENT ARRANGEMENT | | No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Part V Supplemental Information

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

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2019**Open to Public
Inspection****Employer identification number**

06-0646813

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION A, LINE 6 | THE SOLE MEMBER OF SAINT FRANCIS HOSPITAL AND MEDICAL CENTER (SAINT FRANCIS HOSPITAL) IS TRINITY HEALTH OF NEW ENGLAND CORPORATION (TRINITY HEALTH OF NEW ENGLAND). SEE LINE 7 FOR ADDITIONAL INFORMATION. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7A | TRINITY HEALTH OF NEW ENGLAND IS THE SOLE MEMBER OF SAINT FRANCIS HOSPITAL. TRINITY HEALTH OF NEW ENGLAND HAS THE RIGHT TO APPOINT ALL PERSONS TO THE BOARD OF DIRECTORS OF SAINT FRANCIS HOSPITAL. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7B | AS SOLE MEMBER, TRINITY HEALTH OF NEW ENGLAND MUST APPROVE CERTAIN DECISIONS OF THE GOVERNING BODY, INCLUDING THE STRATEGIC PLAN, ANNUAL CAPITAL PLAN, AND ANNUAL OPERATING BUDGET. TRINITY HEALTH OF NEW ENGLAND MUST ALSO APPROVE SIGNIFICANT CHANGES SUCH AS A MERGER, DISSOLUTION, SALE OF ASSETS IN EXCESS OF CERTAIN LIMITS, AND MODIFICATIONS TO GOVERNING DOCUMENTS. AS THE PARENT OF THE NATIONAL TRINITY HEALTH SYSTEM, CERTAIN POWERS ARE RESERVED TO TRINITY HEALTH CORPORATION. THESE INCLUDE THE AUTHORITY TO ADOPT OR MODIFY THE ORGANIZATION'S GOVERNING DOCUMENTS, TO APPROVE MAJOR CHANGES SUCH AS A MERGER OR DISSOLUTION, AND TO APPROVE SIGNIFICANT FINANCE MATTERS IN EXCESS OF CERTAIN LIMITS ESTABLISHED BY TRINITY HEALTH CORPORATION. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 11B | THE AUDIT AND COMPLIANCE COMMITTEE OF TRINITY HEALTH OF NEW ENGLAND HAS THE RESPONSIBILITY FOR OVERSEEING THE REVIEW OF THE FORM 990 INCLUDING ENSURING APPROPRIATE DIRECTORS AND/OR MANAGEMENT PERSONNEL HAVE REVIEWED AND ANY ISSUES ARE COMMUNICATED TO THIS COMMITTEE PRIOR TO FILING. EACH MEMBER OF THE BOARD RECEIVES A COPY OF THE RETURN IN ITS FINAL FORM ONCE IT IS FILED WITH THE INTERNAL REVENUE SERVICE. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>SAINT FRANCIS HOSPITAL HAS ADOPTED TRINITY HEALTH'S GOVERNANCE POLICY NO. 1, WHICH SETS FORTH THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND PROCESSES. IT APPLIES TO ALL "INTERESTED PERSONS" OF SAINT FRANCIS HOSPITAL, WHICH INCLUDES DIRECTORS, PRINCIPAL OFFICERS, KEY EMPLOYEES, AND MEMBERS OF COMMITTEES WITH BOARD-DELEGATED POWERS. INTERESTED PERSONS ARE EXPECTED TO DISCHARGE THEIR DUTIES IN A MANNER THE PERSON REASONABLY BELIEVES TO BE IN THE BEST INTERESTS OF SAINT FRANCIS HOSPITAL AND TO AVOID SITUATIONS INVOLVING A CONFLICT OF INTEREST. ON AN ANNUAL BASIS, INTERESTED PERSONS ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE STATEMENT AND TO AFFIRM THEIR RECEIPT OF THE CONFLICT OF INTEREST POLICY, COMPLIANCE WITH ITS REQUIREMENTS, AND AGREE TO NOTIFY THE ORGANIZATION OF CHANGES IMPACTING THEIR ANNUAL DISCLOSURE IN ACCORDANCE WITH THE POLICY. THE ANNUAL DISCLOSURES ARE PROVIDED TO INTERNAL LEGAL COUNSEL AND THE INTEGRITY AND COMPLIANCE OFFICER, FROM WHICH LEGAL COUNSEL PREPARES A REPORT FOR THE BOARD CHAIR AND CEO. A SUMMARY OF POTENTIAL CONFLICTS IS REVIEWED WITH THE BOARD OF DIRECTORS OF SAINT FRANCIS HOSPITAL (OR A DELEGATED COMMITTEE OF THE BOARD) ON A YEARLY BASIS. INTERESTED PERSONS ARE REQUIRED TO MAKE FULL DISCLOSURE TO SAINT FRANCIS HOSPITAL OF ANY FINANCIAL OR BUSINESS INTERESTS THAT MIGHT RESULT IN OR HAVE THE APPEARANCE OF A CONFLICT OF INTEREST. THE BOARD OF DIRECTORS OF SAINT FRANCIS HOSPITAL (OR A DELEGATED COMMITTEE OF THE BOARD) IS RESPONSIBLE FOR THE REVIEW OF TRANSACTIONS TO DETERMINE WHETHER AN ACTUAL CONFLICT OF INTEREST EXISTS. IN THE EVENT OF AN ACTUAL CONFLICT, THE BOARD (OR A DELEGATED COMMITTEE OF THE BOARD) WILL EITHER AVOID THE CONFLICT OR APPROPRIATELY SCRUTINIZE THE TRANSACTION TO ENSURE IT IS IN THE BEST INTERESTS OF SAINT FRANCIS HOSPITAL. INTERESTED PERSONS ARE REQUIRED TO RECUSE THEMSELVES FROM DISCUSSION AND VOTING ON MATTERS INVOLVING A CONFLICT OF INTEREST. THE POLICY FURTHER ADDRESSES THE PROPER DOCUMENTATION OF THE PROCEEDINGS AND POTENTIAL DISCIPLINARY AND CORRECTIVE ACTION FOR VIOLATIONS OF THE POLICY. THE POLICY IS AVAILABLE TO THE PUBLIC UPON REQUEST.</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 15 | <p>QUESTIONS 15A AND 15B ARE ANSWERED "NO" BECAUSE THE COMPENSATION FOR CERTAIN OFFICERS AND KEY MANAGEMENT OFFICIALS OF SAINT FRANCIS HOSPITAL IS ESTABLISHED AND PAID BY TRINITY HEALTH, A RELATED ORGANIZATION. IN ESTABLISHING THE PRESIDENT AND CFO COMPENSATION, TRINITY HEALTH FOLLOWS A PROCESS AND POLICY THAT IS INTENDED TO MIRROR THE IRC SECTION 4958 GUIDELINES FOR OBTAINING A "REBUTTABLE PRESUMPTION OF REASONABLENESS" WITH REGARD TO COMPENSATION AND BENEFITS. AS PART OF THAT PROCESS, THE COMPENSATION AND BENEFITS OF THE PRESIDENT AND CFO OF SAINT FRANCIS HOSPITAL ARE REVIEWED AT LEAST ANNUALLY BY THE TRINITY HEALTH BOARD OR THE TRINITY HEALTH HUMAN RESOURCES AND COMPENSATION COMMITTEE (HRCC) OF THE BOARD, AUTHORIZED TO ACT ON BEHALF OF THE BOARD WITH RESPECT TO CERTAIN COMPENSATION MATTERS. AS PART OF ITS REVIEW PROCESS, THE HRCC RETAINS AN INDEPENDENT FIRM EXPERIENCED IN COMPENSATION AND BENEFIT MATTERS FOR NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS TO ADVISE IT IN THE DETERMINATIONS IT MAKES ON THE REASONABLENESS OF PROPOSED COMPENSATION AND BENEFITS ARRANGEMENTS. FOR OTHER EXECUTIVES WHO ARE NOT PART OF THE REBUTTABLE PRESUMPTION PROCESS, TRINITY HEALTH USES A MARKET ANALYSIS TO DETERMINE THE APPROPRIATENESS OF THE EXECUTIVE'S COMPENSATION</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION C, LINE 19 | SAINT FRANCIS HOSPITAL IS A SUBSIDIARY ORGANIZATION IN THE TRINITY HEALTH SYSTEM. TRINITY HEALTH MAKES CERTAIN OF ITS KEY DOCUMENTS AVAILABLE TO THE PUBLIC ON ITS WEBSITE, WWW.TRINITY-HEALTH.ORG, IN THE "ABOUT US" SECTION. IN THIS SECTION, THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS ARE PUBLICLY AVAILABLE. IN ADDITION, SAINT FRANCIS HOSPITAL INCLUDES A COPY OF ITS MOST RECENTLY FILED SCHEDULE H ON BOTH ITS OWN WEBSITE AND TRINITY HEALTH'S WEBSITE. SAINT FRANCIS HOSPITAL'S GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|--|
| FORM 990, PART IX, LINE 11G | CONTRACT LABOR: PROGRAM SERVICE EXPENSES 3,630,783. MANAGEMENT AND GENERAL EXPENSES 53,612 . FUNDRAISING EXPENSES 0. TOTAL EXPENSES 3,684,395. PHYSICIAN FEES: PROGRAM SERVICE EXPENSES 73,659,061. MANAGEMENT AND GENERAL EXPENSES 0. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 73,659,061. CONSULTING SERVICES: PROGRAM SERVICE EXPENSES 0. MANAGEMENT AND GENERAL EXPENSES 123,848. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 123,848. MISCELLANEOUS PURCHASED SERVICES: PROGRAM SERVICE EXPENSES 9,685,540. MANAGEMENT AND GENERAL EXPENSES 3,649,630. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 13,335,170. MEDICAL SERVICES: PROGRAM SERVICE EXPENSES 2,546,983. MANAGEMENT AND GENERAL EXPENSES 0. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 2,546,983 . OUTSIDE SERVICES: PROGRAM SERVICE EXPENSES 3,532,503. MANAGEMENT AND GENERAL EXPENSES 883,126. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 4,415,629. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|----------------------------------|---|
| FORM 990, PART XI, LINE 9: | EQUITY TRANSFERS FROM AFFILIATES 4,242,651. CHANGE IN DEFERRED RETIREMENT COST -10,447,507. OTHER TRANSACTIONS -28,839. ASSET IMPAIRMENT -370,622. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-----------------------------------|--|
| FORM 990, PART XII, LINE 2: | SAINT FRANCIS HOSPITAL'S FINANCIAL STATEMENTS WERE INCLUDED IN THE FY20 CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH OF NEW ENGLAND AND TRINITY HEALTH, WHICH WERE BOTH AUDITED BY AN INDEPENDENT PUBLIC ACCOUNTING FIRM. |

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

2019

Open to Public Inspection

Name of the organization
SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

Employer identification number

06-0646813

| 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) COLLABORATIVE LABORATORY SERVICES 114 WOODLAND STREET HARTFORD, CT 06105 06-1520109 | LAB SERVICES | CT | 20,333,700 | 10,784,290 | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER |
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| Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year. | | | | | | | |
|--|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| See Additional Data Table | | | | | | | |
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
| | | | | | | Yes | No |
| | | | | | | | |
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Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

See Additional Data Table

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

See Additional Data Table

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

a Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity

b Gift, grant, or capital contribution to related organization(s)

c Gift, grant, or capital contribution from related organization(s)

d Loans or loan guarantees to or for related organization(s)

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

j Lease of facilities, equipment, or other assets to related organization(s)

k Lease of facilities, equipment, or other assets from related organization(s)

l Performance of services or membership or fundraising solicitations for related organization(s)

m Performance of services or membership or fundraising solicitations by related organization(s)

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

r Other transfer of cash or property to related organization(s)

s Other transfer of cash or property from related organization(s)

Yes

No

1a

No

1b

Yes

1c

Yes

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

Yes

1l

Yes

1m

Yes

1n

No

1o

Yes

1p

Yes

1q

Yes

1r

Yes

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.

See Additional Data Table

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|-------------------------------------|----------------------------------|------------------------|--|
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Schedule R (Form 990) 2019

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

[illegible]

Part VII **Supplemental Information**

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

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

Additional Data

Software ID:
Software Version:
EIN: 06-0646813
Name: SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c) 3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|--|--|--|-------------------------------|--|--|--|----|
| | | | | | | Yes | No |
| 245 STATE ST SE GRAND RAPIDS, MI 49503 27-2491974 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH- MICHIGAN | Yes | |
| 33920 US HIGHWAY 19 NORTH SUITE 269 PALM HARBOR, FL 34684 58-1492325 | GRANT MAKING | FL | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-1450170 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 42-1500277 | HEALTH CARE AND HOSPITAL SERVICES | IA | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 255 NORTH WELCH AVENUE PRIMGHAR, IA 51245 26-2973307 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | BAUM HARMON MERCY HOSPITAL | Yes | |
| 2212 BURDETT AVE TROY, NY 12180 14-1651563 | TITLE HOLDING COMPANY | NY | 501(C)(2) | N/A | LTC (EDDY) INC | Yes | |
| 905 WATSON STREET PITTSBURGH, PA 15219 25-1436685 | HOMELESS SHELTER | PA | 501(C)(3) | LINE 7 | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |
| 40 AUTUMN DRIVE SLINGERLANDS, NY 12159 14-1717028 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 04-2182395 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 10 | THE MERCY HOSPITAL INC | Yes | |
| 421 WEST COLUMBIA STREET COHOES, NY 12047 14-1701597 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 5315 ELLIOTT DR 102 YPSILANTI, MI 48197 38-2507173 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH- MICHIGAN | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 | GOVERNANCE AND MANAGEMENT OF TRINITY HEALTH SYSTEM | VT | 501(C)(3) | LINE 1 | N/A | | No |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 34-2032340 | HEALTH CARE AND HOSPITAL SERVICES | OH | 501(C)(3) | LINE 3 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 250 MERCY DRIVE DUBUQUE, IA 52001 26-2227941 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 1111 3RD STREET SW DYERSVILLE, IA 52040 20-5383271 | FOUNDATION | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2515999 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 433 RIVER ST SUITE 3000 TROY, NY 12180 14-1818568 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 3 | LTC (EDDY) INC | Yes | |
| 333 BUTTERNUT DRIVE DEWITT, NY 13214 46-1051881 | PACE PROGRAM | NY | 501(C)(3) | LINE 12B, II | ST JOSEPH'S HEALTH INC | Yes | |
| 10 BLACKSMITH DRIVE MALTA, NY 12020 14-1795732 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 10 | HOME AIDE SERVICE OF EASTERN NEW YORK INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 04-2501711 | LONG TERM CARE | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|-----------------------------------|--|----------------------------|---|--|---|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | | | | Yes | No |
| PO BOX 2500 WILMINGTON, DE 19805 22-3008680 | LONG TERM CARE (INACTIVE) | DE | 501(C)(3) | LINE 10 | ST FRANCIS HOSPITAL INC | Yes | |
| 1200 EARHART RD ANN ARBOR, MI 48105 20-8072723 | FOUNDATION | MI | 501(C)(3) | LINE 12A, I | GLACIER HILLS INC | Yes | |
| 1200 EARHART RD ANN ARBOR, MI 48105 38-1891500 | SENIOR LIVING COMMUNITY | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1 GLEN EDDY DRIVE NISKAYUNA, NY 12309 14-1794150 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 42-1253527 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 5401 LAKE OCONEE PARKWAY GREENSBORO, GA 30642 26-1720984 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 701 W NORTH AVE MELROSE PARK, IL 60160 36-3332852 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | Yes | |
| 701 WEST NORTH AVENUE MELROSE PARK, IL 60160 74-3260011 | FOUNDATION | IL | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
| 701 W NORTH AVE MELROSE PARK, IL 60160 36-2379649 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | Yes | |
| 30 COMMUNITY WAY EAST GREENBUSH, NY 12061 80-0102840 | SENIOR LIVING COMMUNITY | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 83-0416893 | MANAGEMENT | CT | 501(C)(3) | LINE 12A, I | N/A | | No |
| 2920 TIBBITS AVE TROY, NY 12180 14-1725101 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48152 52-1945054 | LONG TERM CARE | MD | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910 20-8428450 | FOUNDATION | MD | 501(C)(3) | LINE 7 | HOLY CROSS HEALTH INC | Yes | |
| 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910 52-0738041 | HEALTH CARE AND HOSPITAL SERVICES | MD | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 59-0791028 | HEALTH CARE AND HOSPITAL SERVICES | FL | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 46-5421068 | HEALTH CARE SERVICES | FL | 501(C)(3) | LINE 10 | HOLY CROSS HOSPITAL INC | Yes | |
| 4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 81-2531495 | HEALTH CARE SERVICES | FL | 501(C)(3) | LINE 10 | HOLY CROSS HOSPITAL INC | Yes | |
| 4725 NORTH FEDERAL HIGHWAY FT LAUDERDALE, FL 33308 83-2256461 | HEALTH CARE SERVICES | FL | 501(C)(3) | LINE 10 | HOLY CROSS HOSPITAL INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 81-0723591 | HOME HEALTH SERVICES | CT | 501(C)(3) | LINE 10 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|---|--|----------------------------|---|--|---|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | | | | Yes | No |
| 433 RIVER ST SUITE 3000 TROY, NY 12180 14-1514867 | HOME HEALTH SERVICES | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 232 SECOND STREET SE MASON CITY, IA 50401 42-1173708 | HOSPICE SERVICES | IA | 501(C)(3) | LINE 10 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 4300 HAMILTON BLVD SIOUX CITY, IA 51104 38-3320710 | HOSPICE SERVICES | IA | 501(C)(3) | LINE 12A, I | N/A | | No |
| 24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3316559 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 47-5676956 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2519529 | HEALTH CARE SERVICES (INACTIVE) | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2571699 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 2475 MCCLELLAN AVENUE PENNSAUKEN, NJ 08109 26-1854750 | PACE PROGRAM | NJ | 501(C)(3) | LINE 3 | TRINITY HEALTH PACE | Yes | |
| 7TH AND CLAYTON STREETS WILMINGTON, DE 19805 45-2569214 | PACE PROGRAM | DE | 501(C)(3) | LINE 10 | ST FRANCIS HOSPITAL INC | Yes | |
| 7500 K JOHNSON BOULEVARD BORDENTOWN, NJ 08505 22-2797282 | PACE PROGRAM | NJ | 501(C)(3) | LINE 10 | ST FRANCIS MEDICAL CENTER TRENTON NJ | Yes | |
| 4900 RAEFORD ROAD FAYETTEVILLE, NC 28304 27-2159847 | PACE PROGRAM | NC | 501(C)(3) | LINE 3 | TRINITY HEALTH PACE | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 26-2976184 | PACE PROGRAM | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 905 W NORTH AVE MELROSE PARK, IL 60160 47-4147171 | TRANSPORTATION SERVICES | IL | 501(C)(3) | LINE 10 | LOYOLA UNIVERSITY MEDICAL CENTER | Yes | |
| 2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-3342448 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 2160 SOUTH FIRST AVENUE MAYWOOD, IL 60153 36-4015560 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | LOYOLA UNIVERSITY HEALTH SYSTEM | Yes | |
| 2212 BURDETT AVE TROY, NY 12180 22-2564710 | MANAGEMENT SERVICES FOR LONG TERM CARE | NY | 501(C)(3) | LINE 12B, II | ST PETER'S HEALTH PARTNERS | Yes | |
| 801 5TH STREET SIOUX CITY, IA 51101 38-3320705 | HOME HEALTH SERVICES (INACTIVE) | IA | 501(C)(3) | LINE 12A, I | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 91-1940902 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | PA | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |
| 275 STEELE ROAD WEST HARTFORD, CT 06117 06-1058086 | SENIOR LIVING COMMUNITY | CT | 501(C)(3) | LINE 10 | MERCY COMMUNITY HEALTH INC | Yes | |
| 3333 FIFTH AVENUE PITTSBURGH, PA 15213 94-3436142 | GRANT MAKING | PA | 501(C)(3) | LINE 12B, II | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|---|--|----------------------------|---|---|---|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | | | | Yes | No |
| 600 NORTHERN BLVD ALBANY, NY 12204 14-1338457 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 424 DECATUR STREET ATLANTA, GA 30312 58-1448522 | FOUNDATION | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-1352191 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 2021 ALBANY AVENUE WEST HARTFORD, CT 06117 06-1492707 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | CT | 501(C)(3) | LINE 12B, II | TRINITY CONTINUING CARE SERVICES | Yes | |
| 1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-2325059 | HOME HEALTH SERVICES | PA | 501(C)(3) | LINE 10 | MERCY HOME HEALTH SERVICES | Yes | |
| 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227350 | FOUNDATION | IL | 501(C)(3) | LINE 7 | MERCY HEALTH SYSTEM OF CHICAGO | Yes | |
| 888 TERRACE STREET MUSKEGON, MI 49440 38-3321856 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2829864 | FOUNDATION | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 1449 NW 128TH ST BLDG 5 CLIVE, IA 50325 42-1478417 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | DE | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
| 1500 E SHERMAN BLVD MUSKEGON, MI 49444 38-2589966 | HEALTH CARE AND HOSPITAL SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH-MICHIGAN | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 22-2483605 | MEDICAID MANAGED CARE PLAN | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 1000 4TH STREET SW MASON CITY, IA 50401 31-1373080 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3163327 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IL | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 1410 N 4TH ST CLINTON, IA 52732 42-1316126 | FOUNDATION | IA | 501(C)(3) | LINE 7 | MERCY MEDICAL CENTER - CLINTON INC | Yes | |
| 1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-1352099 | HOME HEALTH SERVICES | PA | 501(C)(3) | LINE 10 | MERCY HOME HEALTH SERVICES | Yes | |
| 1001 BALTIMORE PIKE SUITE 310 SPRINGFIELD, PA 19064 23-2325058 | MANAGEMENT SERVICES FOR HOME HEALTH | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-2170152 | HEALTH CARE AND HOSPITAL SERVICES | IL | 501(C)(3) | LINE 3 | MERCY HEALTH SYSTEM OF CHICAGO | Yes | |
| 318 RIVER RIDGE DR NW SUITE 100 WALKER, MI 49544 20-3357131 | FOUNDATION | MI | 501(C)(3) | LINE 12A, I | TRINITY HEALTH-MICHIGAN | Yes | |
| 1200 REEDSDALE STREET PITTSBURGH, PA 15233 25-1604115 | COMMUNITY OUTREACH | PA | 501(C)(3) | LINE 10 | PITTSBURGH MERCY HEALTH SYSTEM INC | Yes | |
| PO BOX 7957 MOBILE, AL 36670 27-3163002 | PACE PROGRAM | AL | 501(C)(3) | LINE 3 | TRINITY HEALTH PACE | Yes | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|---|--|----------------------------|---|---|---|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | | | | Yes | No |
| 200 HILLSIDE CIRCLE WEST SPRINGFIELD, MA 01089 45-3086711 | PACE PROGRAM | MA | 501(C)(3) | LINE 3 | TRINITY HEALTH PACE | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2627944 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 1410 NORTH 4TH ST CLINTON, IA 52732 42-1336618 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 801 5TH STREET SIOUX CITY, IA 51102 14-1880022 | FOUNDATION | IA | 501(C)(3) | LINE 7 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 1000 4TH STREET SW MASON CITY, IA 50401 42-1229151 | FOUNDATION | IA | 501(C)(3) | LINE 7 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| PO BOX 7957 MOBILE, AL 36670 63-6002215 | PACE PROGRAM | AL | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 45-4884805 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 46-1187365 | MANAGEMENT SERVICES FOR PHYSICIAN SERVICE ORGANIZATIONS | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 424 DECATUR STREET ATLANTA, GA 30312 58-1366508 | COMMUNITY OUTREACH | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| 424 DECATUR STREET ATLANTA, GA 30312 27-2046353 | TITLE HOLDING COMPANY | GA | 501(C)(3) | LINE 12B, II | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 38-2719605 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 26-4033168 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-1396763 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 37595 SEVEN MILE ROAD LIVONIA, MI 48152 38-3181557 | BUILDING MANAGEMENT SERVICES | DE | 501(C)(3) | LINE 12A, I | N/A | | No |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1308555 | COLLEGE OF NURSING | OH | 501(C)(3) | LINE 2 | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 25-1912781 | HEALTH INSURANCE | OH | 501(C)(4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 83-1422704 | MEDICARE HMO | ID | 501(C)(4) | N/A | MOUNT CARMEL HEALTH PLAN INC | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 83-3278543 | MEDICARE HMO | NY | 501(C)(4) | N/A | MOUNT CARMEL HEALTH PLAN INC | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1471229 | MEDICARE HMO | OH | 501(C)(4) | N/A | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1439334 | HEALTH CARE AND HOSPITAL SERVICES | OH | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|---|--|----------------------------|---|---|---|----|
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| | | | | | | Yes | No |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1113966 | FOUNDATION | OH | 501(C)(3) | LINE 12A, I | MOUNT CARMEL HEALTH SYSTEM | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 22-2584082 | FOUNDATION | CT | 501(C)(3) | LINE 12C, III-FI | N/A | | No |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-1422973 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 7 HIGHTOWER STREET WATERVILLE, ME 04901 01-0274998 | LONG TERM CARE | ME | 501(C)(3) | LINE 3 | MERCY COMMUNITY HEALTH INC | Yes | |
| 565 W WESTERN AVENUE MUSKEGON, MI 49440 91-1932918 | COMMUNITY OUTREACH | MI | 501(C)(3) | LINE 7 | MERCY HEALTH PARTNERS | Yes | |
| 2701 HOLME AVENUE PHILADELPHIA, PA 19152 23-2300951 | FOUNDATION | PA | 501(C)(3) | LINE 12A, I | NAZARETH HOSPITAL | Yes | |
| 2601 HOLME AVENUE PHILADELPHIA, PA 19152 23-2794121 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 20-3261266 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2497355 | HEALTH CARE SERVICES (INACTIVE) | PA | 501(C)(3) | LINE 3 | MERCY PHYSICIAN NETWORK | Yes | |
| 601 EAST 2ND STREET OAKLAND, NE 68045 20-8072234 | HEALTH CARE AND HOSPITAL SERVICES | NE | 501(C)(3) | LINE 3 | MERCY HEALTH SERVICES-IOWA CORP | Yes | |
| 601 E 2ND STREET OAKLAND, NE 68045 31-1678345 | FOUNDATION | NE | 501(C)(3) | LINE 12A, I | OAKLAND MERCY HOSPITAL | Yes | |
| 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1654603 | COOPERATIVE HEALTH CARE DELIVERY SYSTEM | OH | 501(C)(3) | LINE 12A, I | N/A | | No |
| 2 MERCYCARE LANE GUILDERLAND, NY 12084 14-1743506 | LONG TERM CARE | NY | 501(C)(3) | LINE 3 | ST PETER'S HOSPITAL | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 45-4208896 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 3333 5TH AVENUE PITTSBURGH, PA 15213 25-1464211 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 2058 S STATE STREET ANN ARBOR, MI 48104 20-2020239 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH-MICHIGAN | Yes | |
| 965 FORK STREET MUSKEGON, MI 49442 38-2638284 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 10 | MERCY HEALTH PARTNERS | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 81-1807730 | HEALTH CARE SERVICES | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 27-1763712 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 1303 EAST HERNDON AVE FRESNO, CA 93720 94-1437713 | HEALTH CARE AND HOSPITAL SERVICES | CA | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |

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| | | | | | | Yes | No |
| 1303 EAST HERNDON AVE FRESNO, CA 93720 94-2839324 | HEALTH CARE SERVICES | CA | 501(C)(3) | LINE 12A, I | SAINT AGNES MEDICAL CENTER | Yes | |
| 1055 NORTH CURTIS RD BOISE, ID 83706 94-3028978 | HEALTH CARE SYSTEM SUPPORT | ID | 501(C)(3) | LINE 12A, I | SAINT ALPHONSUS REGIONAL MEDICAL CENTER INC | Yes | |
| 3325 POCAHONTAS ROAD BAKER CITY, OR 97814 94-3164869 | FOUNDATION | OR | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER - BAKER CITY | Yes | |
| 351 SW 9TH STREET ONTARIO, OR 97914 20-2683560 | FOUNDATION | OR | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER-ONTARIO | Yes | |
| 1055 N CURTIS ROAD BOISE, ID 83706 27-1929502 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | ID | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 351 SW 9TH STREET ONTARIO, OR 97914 94-3059469 | VOLUNTEER SERVICE AUXILIARY | OR | 501(C)(3) | LINE 10 | SAINT ALPHONSUS MEDICAL CENTER-ONTARIO | Yes | |
| 3325 POCAHONTAS ROAD BAKER CITY, OR 97814 27-1790052 | HEALTH CARE AND HOSPITAL SERVICES | OR | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 4300 E FLAMINGO AVENUE NAMPA, ID 83687 26-1737256 | FOUNDATION | ID | 501(C)(3) | LINE 7 | SAINT ALPHONSUS MEDICAL CENTER-NAMPA | Yes | |
| 4300 E FLAMINGO AVENUE NAMPA, ID 83687 82-0200896 | HEALTH CARE AND HOSPITAL SERVICES | ID | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 351 SW 9TH STREET ONTARIO, OR 97914 27-1789847 | HEALTH CARE AND HOSPITAL SERVICES | OR | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 1055 NORTH CURTIS RD BOISE, ID 83706 82-0200895 | HEALTH CARE AND HOSPITAL SERVICES | ID | 501(C)(3) | LINE 3 | SAINT ALPHONSUS HEALTH SYSTEM INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 45-1994612 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 12B, II | TRINITY HEALTH OF NEW ENGLAND PNO INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-0646813 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | | No |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-1008255 | FOUNDATION | CT | 501(C)(3) | LINE 7 | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 47-3129127 | PACE PROGRAM | IN | 501(C)(3) | LINE 10 | TRINITY HEALTH PACE | Yes | |
| PO BOX 670 PLYMOUTH, IN 46563 35-1142669 | HEALTH CARE AND HOSPITAL SERVICES | IN | 501(C)(3) | LINE 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 35-0868157 | HEALTH CARE AND HOSPITAL SERVICES | IN | 501(C)(3) | LINE 3 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 1915 LAKE AVENUE PLYMOUTH, IN 46563 35-6043563 | VOLUNTEER SERVICE AUXILIARY | IN | 501(C)(3) | LINE 12A, I | SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH CAMPUS INC | Yes | |
| 5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 35-1568821 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 424 DECATUR STREET ATLANTA, GA 30312 58-1744848 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | GA | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |

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| | | | | | | Yes | No |
| 424 DECATUR STREET ATLANTA, GA 30312 58-1752700 | HEALTH CARE SERVICES | GA | 501(C)(3) | LINE 7 | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 31-1040468 | SENIOR LIVING COMMUNITY | IN | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES - INDIANA INC | Yes | |
| 1430 MONROE NW STE 120 GRAND RAPIDS, MI 49505 38-3320700 | HOME HEALTH SERVICES | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| 200 JEFFERSON ST SE GRAND RAPIDS, MI 49503 38-1779602 | FOUNDATION | MI | 501(C)(3) | LINE 7 | TRINITY HEALTH-MICHIGAN | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 22-2528400 | FOUNDATION | CT | 501(C)(3) | LINE 7 | SAINT MARY'S HOSPITAL INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-0646844 | HEALTH CARE AND HOSPITAL SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 2215 BURDETT AVE TROY, NY 12180 14-1710225 | CHILD CARE SERVICES | NY | 501(C)(3) | LINE 10 | ST PETER'S HEALTH PARTNERS | Yes | |
| 2215 BURDETT AVE TROY, NY 12180 14-1338544 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1938 CURRY ROAD SCHENECTADY, NY 12303 14-1708754 | PACE PROGRAM | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| ONE ABELE BLVD CLIFTON PARK, NY 12065 14-1756230 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| PO BOX 3349 SIOUX CITY, IA 51102 42-1185707 | MEDICAL TRANSPORTATION SERVICES | IA | 501(C)(3) | LINE 12A, I | N/A | | No |
| 114 WOODLAND STREET HARTFORD, CT 06105 22-2541103 | LONG TERM CARE | MA | 501(C)(3) | LINE 3 | THE MERCY HOSPITAL INC | Yes | |
| 424 DECATUR STREET ATLANTA, GA 30312 47-2299757 | HEALTH CARE SYSTEM SUPPORT | GA | 501(C)(3) | LINE 12B, II | SAINT JOSEPH'S HEALTH SYSTEM INC | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2840137 | PACE PROGRAM | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| PO BOX 2500 WILMINGTON, DE 19805 51-0374158 | FOUNDATION | DE | 501(C)(3) | LINE 12A, I | ST FRANCIS HOSPITAL INC | Yes | |
| PO BOX 2500 WILMINGTON, DE 19805 51-0064326 | HEALTH CARE AND HOSPITAL SERVICES | DE | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 601 HAMILTON AVENUE TRENTON, NJ 08629 83-2199054 | HEALTH CARE SERVICES | NJ | 501(C)(3) | LINE 3 | ST FRANCIS MEDICAL CENTER TRENTON NJ | Yes | |
| 601 HAMILTON AVENUE TRENTON, NJ 08629 52-1025476 | FOUNDATION | NJ | 501(C)(3) | LINE 7 | ST FRANCIS MEDICAL CENTER TRENTON NJ | Yes | |
| 601 HAMILTON AVENUE TRENTON, NJ 08629 22-3431049 | HEALTH CARE AND HOSPITAL SERVICES | NJ | 501(C)(3) | LINE 3 | MAXIS HEALTH SYSTEM | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 22-3127184 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT (INACTIVE) | NY | 501(C)(3) | LINE 12A, I | TRINITY HEALTH CORPORATION | Yes | |

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| | | | | | | Yes | No |
| 775 S MAIN ST CHELSEA, MI 48118 82-4757260 | HEALTH CARE AND HOSPITAL SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH-MICHIGAN | Yes | |
| 100 GOSSMAN DRIVE SOUTHERN PINES, NC 28387 56-0694200 | LONG TERM CARE | NC | 501(C)(3) | LINE 3 | TRINITY CONTINUING CARE SERVICES | Yes | |
| 206 PROSPECT AVENUE SYRACUSE, NY 13203 20-2497520 | COLLEGE OF NURSING | NY | 501(C)(3) | LINE 2 | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 23-7219294 | BUILDING MANAGEMENT SERVICES | NY | 501(C)(3) | LINE 12B, II | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 47-4754987 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 15-0532254 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 22-2149775 | FOUNDATION | NY | 501(C)(3) | LINE 12B, II | ST JOSEPH'S HEALTH INC | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 27-3899821 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 16-1516863 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 12A, I | ST JOSEPH'S HOSPITAL HEALTH CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 46-1827502 | TITLE HOLDING COMPANY | PA | 501(C)(2) | N/A | ST MARY MEDICAL CENTER | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 46-5354512 | HEALTH CARE SERVICES | PA | 501(C)(3) | LINE 10 | ST MARY MEDICAL CENTER | Yes | |
| 2021 ALBANY AVENUE WEST HARTFORD, CT 06117 06-0646843 | LONG TERM CARE | CT | 501(C)(3) | LINE 3 | MERCY COMMUNITY HEALTH INC | Yes | |
| 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-1913910 | HEALTH CARE AND HOSPITAL SERVICES | PA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF THE MID-ATLANTIC REGION | Yes | |
| 1230 BAXTER STREET ATHENS, GA 30606 58-2544232 | FOUNDATION | GA | 501(C)(3) | LINE 12A, I | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET ATHENS, GA 30606 81-1660088 | FOUNDATION | GA | 501(C)(3) | LINE 12A, I | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET ATHENS, GA 30606 58-0566223 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 1230 BAXTER STREET ATHENS, GA 30606 02-0576648 | SENIOR LIVING COMMUNITY | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 1230 BAXTER STREET ATHENS, GA 30606 26-1858563 | HEALTH CARE SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 367 CLEAR CREEK PARKWAY LAVONIA, GA 30553 47-3752176 | HEALTH CARE AND HOSPITAL SERVICES | GA | 501(C)(3) | LINE 3 | ST MARY'S HEALTH CARE SYSTEM INC | Yes | |
| 315 SOUTH MANNING BLVD ALBANY, NY 12208 45-3570715 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | NY | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |

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| | | | | | | Yes | No |
| 315 SOUTH MANNING BLVD ALBANY, NY 12208 46-1177336 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 315 SOUTH MANNING BLVD ALBANY, NY 12208 14-1348692 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 310 SOUTH MANNING BLVD ALBANY, NY 12208 22-2262982 | FOUNDATION | NY | 501(C)(3) | LINE 7 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1270 BELMONT AVENUE SCHENECTADY, NY 12308 14-1338386 | HEALTH CARE AND HOSPITAL SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 1270 BELMONT AVE SCHENECTADY, NY 12308 22-2505127 | FOUNDATION | NY | 501(C)(3) | LINE 7 | SUNNYVIEW HOSPITAL AND REHABILITATION CENTER | Yes | |
| 301 PROSPECT AVENUE SYRACUSE, NY 13203 20-3018640 | VOLUNTEER SERVICE AUXILIARY | NY | 501(C)(3) | LINE 10 | ST JOSEPH'S HOSPITAL HEALTH CENTER FOUNDATION INC | Yes | |
| 2215 BURDETT AVE TROY, NY 12180 27-2153849 | HEALTH CARE SERVICES | NY | 501(C)(3) | LINE 3 | SAMARITAN HOSPITAL | Yes | |
| 445 NEW KARNER RD ALBANY, NY 12205 22-2692940 | FOUNDATION | NY | 501(C)(3) | LINE 7 | THE COMMUNITY HOSPICE INC | Yes | |
| 445 NEW KARNER RD ALBANY, NY 12205 14-1608921 | HOSPICE SERVICES | NY | 501(C)(3) | LINE 3 | ST PETER'S HEALTH PARTNERS | Yes | |
| 707 EAST CEDAR STREET STE 175 SOUTH BEND, IN 46617 35-1654543 | FOUNDATION | IN | 501(C)(3) | LINE 7 | SAINT JOSEPH REGIONAL MEDICAL CENTER INC | Yes | |
| 2256 BURDETT AVE TROY, NY 12180 22-2570478 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 421 WEST COLUMBIA ST COHOES, NY 12047 14-1793885 | LONG TERM CARE | NY | 501(C)(3) | LINE 10 | LTC (EDDY) INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 04-3398280 | HEALTH CARE AND HOSPITAL SERVICES | MA | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 310 SOUTH MANNING BLVD ALBANY, NY 12208 22-2743478 | FOUNDATION | NY | 501(C)(3) | LINE 7 | ST PETER'S HEALTH PARTNERS | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-0660403 | VOLUNTEER SERVICE AUXILIARY | CT | 501(C)(3) | LINE 12B, II | N/A | | No |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-3320699 | HOSPICE SERVICES (INACTIVE) | MI | 501(C)(3) | LINE 10 | TRINITY HOME HEALTH SERVICES | Yes | |
| 309 GRAND RIVER PORT HURON, MI 48060 38-2485700 | HEALTH CARE SERVICES | MI | 501(C)(3) | LINE 12A, I | N/A | | No |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 38-2559656 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 93-0907047 | LONG TERM CARE | IN | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 82-4005577 | LONG TERM CARE | MI | 501(C)(3) | LINE 10 | TRINITY CONTINUING CARE SERVICES | Yes | |

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| | | | | | | Yes | No |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-2113393 | HEALTH CARE AND HOSPITAL SERVICES | MI | 501(C)(3) | LINE 3 | TRINITY HEALTH CORPORATION | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 35-1443425 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | IN | 501(C)(3) | LINE 12B, II | CATHOLIC HEALTH MINISTRIES | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 47-5244984 | PACE PROGRAM | PA | 501(C)(3) | LINE 10 | TRINITY HEALTH PACE | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-1491191 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | CT | 501(C)(3) | LINE 12C, III-FI | TRINITY HEALTH CORPORATION | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 83-3546613 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 10 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| 114 WOODLAND STREET HARTFORD, CT 06105 06-1450168 | HEALTH CARE SERVICES | CT | 501(C)(3) | LINE 3 | TRINITY HEALTH OF NEW ENGLAND CORP INC | Yes | |
| ONE WEST ELM STREET SUITE 100 CONSHOHOCKEN, PA 19428 23-2212638 | HEALTH CARE SYSTEM MANAGEMENT AND SUPPORT | PA | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 47-3073124 | PACE PROGRAM | MI | 501(C)(3) | LINE 12B, II | TRINITY HEALTH CORPORATION | Yes | |
| 20555 VICTOR PARKWAY LIVONIA, MI 48152 20-8151733 | RETIREE MEDICAL AND RETIREE LIFE INSURANCE | MI | 501(C)(9) | N/A | TRINITY HEALTH CORPORATION | Yes | |
| PO BOX 9184 FARMINGTON HILLS, MI 48333 38-2621935 | MANAGEMENT SERVICES FOR HOME HEALTH SYSTEM | MI | 501(C)(3) | LINE 10 | TRINITY HEALTH CORPORATION | Yes | |
| 301 HACKETT BLVD ALBANY, NY 12208 14-1438749 | LONG TERM CARE | NY | 501(C)(3) | LINE 3 | ST PETER'S HOSPITAL | Yes | |

| Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership | | | | | | | | | | | | |
|---|-------------------------|---|--|---|---------------------------------|--|--|----|--|--|----|--------------------------------|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of- year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065) | (j) General or Managing Partner? | | (k) Percentage ownership |
| | | | | | | | Yes | No | | Yes | No | |
| WOODLAND PARTNERS REAL ESTATE LLC 129 WOODLAND STREET HARTFORD, CT 06105 83-3371094 | REAL ESTATE | CT | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER | EXCLUDED | | 13,131,034 | | No | | | No | 55.000 % |

| Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust | | | | | | | | | |
|--|------------------------------|---|-------------------------------------|--|---------------------------------|---|--------------------------------|--|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of- year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
| | | | | | | | | Yes | No |
| CALIFORNIA HEALTHCARE MANAGEMENT PARTNERS INC 1303 E HERNDON AVE FRESNO, CA 93720 82-0961647 | MANAGEMENT SERVICES | CA | N/A | C | | | | Yes | |
| CATHERINE HORAN BUILDING CORPORATION 114 WOODLAND STREET HARTFORD, CT 06105 04-2938160 | BUILDING MANAGEMENT | MA | N/A | C | | | | Yes | |
| CENTRAL VALLEY HEALTH PLAN INC 1303 E HERNDON AVE FRESNO, CA 93720 61-1846844 | HEALTH INSURANCE | CA | N/A | C | | | | Yes | |
| DIVERSIFIED COMMUNITY SERVICES INC 114 WOODLAND STREET HARTFORD, CT 06105 04-3128890 | MEDICAL SERVICES | MA | N/A | C | | | | Yes | |
| FHS SERVICES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 27-2995699 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN ASSOCIATES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 20-2991688 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN HEALTH SUPPORT INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1236354 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| FRANCISCAN MANAGEMENT SERVICES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1351193 | MANAGEMENT SERVICES | NY | N/A | C | | | | Yes | |
| FRANKLIN MEDICAL GROUP PC 114 WOODLAND STREET HARTFORD, CT 06105 06-1470493 | PHYSICIAN OFFICE | CT | N/A | C | | | | Yes | |
| GOTTLIEB MANAGEMENT SERVICES INC 701 W NORTH AVE MELROSE PARK, IL 60160 36-3330529 | MANAGEMENT SERVICES | IL | N/A | C | | | | Yes | |
| HACKLEY HEALTH VENTURES INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-2589959 | OTHER MEDICAL SERVICES | MI | N/A | C | | | | Yes | |
| HACKLEY PROFESSIONAL PHARMACY INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-2447870 | PHARMACY | MI | N/A | C | | | | Yes | |
| HEALTH CARE MANAGEMENT ADMINISTRATORS INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1450960 | HEALTH CARE MANAGEMENT | NY | N/A | C | | | | Yes | |
| HURON ARBOR CORPORATION 5301 EAST HURON RIVER DR ANN ARBOR, MI 48106 38-2475644 | PROVIDES OFFICE RENTAL SPACE | MI | N/A | C | | | | Yes | |
| IHA AFFILIATION CORPORATION 24 FRANK LLOYD WRIGHT DR LOBBY J ANN ARBOR, MI 48106 38-3188895 | MEDICAL MANAGEMENT | MI | N/A | C | | | | Yes | |

| Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust | | | | | | | | | |
|---|---|---|--|--|---------------------------------|---------------------------------------|--------------------------------|--|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
| | | | | | | | | Yes | No |
| LANGHORNE SERVICES II INC 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 26-3795549 | GENERAL PARTNER OF LMOB PARTNERS, II | PA | N/A | C | | | | Yes | |
| LANGHORNE SERVICES INC 1201 LANGHORNE-NEWTOWN ROAD LANGHORNE, PA 19047 23-2625981 | GENERAL PARTNER OF LMOB PARTNERS | PA | N/A | C | | | | Yes | |
| MACNEAL HEALTH PROVIDERS INC 750 PASQUINELLI DRIVE SUITE 216 WESTMONT, IL 60059 36-3361297 | MEDICAL SERVICES | IL | N/A | C | | | | Yes | |
| MARYLAND CARE GROUP INC 1500 FOREST GLEN RD SILVER SPRING, MD 20910 52-1815313 | HEALTH CARE HOLDING | MD | N/A | C | | | | Yes | |
| MCMC EASTWICK INC C/O MHS ONE WEST ELM STREET STE 100 CONSHOHOCKEN, PA 19428 23-2184261 | MEDICAL OFFICE BUILDINGS | PA | N/A | C | | | | Yes | |
| MEDNOW INC 4300 E FLAMINGO AVE NAMPA, ID 83687 82-0389927 | MEDICAL SERVICES | ID | N/A | C | | | | Yes | |
| MERCY INPATIENT MEDICAL ASSOCIATES INC 114 WOODLAND STREET HARTFORD, CT 06105 04-3029929 | MEDICAL SERVICES | MA | N/A | C | | | | Yes | |
| MERCY MEDICAL SERVICES 801 5TH STREET SIOUX CITY, IA 51101 42-1283849 | PRIMARY CARE PHYSICIANS | IA | N/A | C | | | | Yes | |
| MERCY SERVICES CORPORATION 2525 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 36-3227348 | DORMANT | IL | N/A | C | | | | Yes | |
| MOUNT CARMEL HEALTH PROVIDERS INC 6150 EAST BROAD STREET COLUMBUS, OH 43213 31-1382442 | MEDICAL SERVICES | OH | N/A | C | | | | Yes | |
| NURSING NETWORK INC 4725 NORTH FEDERAL HIGHWAY FORT LAUDERDALE, FL 33308 59-1145192 | MEDICAL SERVICES | FL | N/A | C | | | | Yes | |
| PROVIDENCE HOMECARE INC 114 WOODLAND STREET HARTFORD, CT 06105 04-3317426 | HEALTH CARE SERVICES | MA | N/A | C | | | | Yes | |
| SAINT ALPHONSUS HEALTH ALLIANCE INC 1055 NORTH CURTIS ROAD BOISE, ID 83706 82-0524649 | ACCOUNTABLE CARE ORGANIZATION | ID | N/A | C | | | | Yes | |
| SAINT ALPHONSUS PHYSICIANS PA 1055 NORTH CURTIS ROAD BOISE, ID 83706 33-1078261 | HEALTH CARE SERVICES (INACTIVE) | ID | N/A | C | | | | Yes | |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP PC 114 WOODLAND STREET HARTFORD, CT 06105 06-1384686 | MEDICAL SERVICES | CT | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER INC | C | -691,806 | 3,227,723 | 100.000 % | Yes | |

| Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust | | | | | | | | | |
|--|-----------------------------------|---|--|--|---------------------------------|---------------------------------------|--------------------------------|--|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
| | | | | | | | | Yes | No |
| SAINT FRANCIS CARE MEDICAL GROUP PC 114 WOODLAND STREET HARTFORD, CT 06105 06-1432373 | MEDICAL SERVICES | CT | SAINT FRANCIS HOSPITAL AND MEDICAL CENTER INC | C | -16,575 | 1,164,212 | 100.000 % | Yes | |
| SAMARITAN MEDICAL OFFICE BUILDING INC 2212 BURDETT AVENUE TROY, NY 12180 14-1607244 | REAL ESTATE | NY | N/A | C | | | | Yes | |
| SJM PROPERTIES INC 20555 VICTOR PARKWAY LIVONIA, MI 48152 16-1294991 | PROPERTY HOLDINGS | NY | N/A | C | | | | Yes | |
| SJPE PRACTICE MANAGEMENT SERVICES INC 301 PROSPECT AVE SYRACUSE, NY 13203 45-4164964 | MANAGEMENT SERVICES | NY | N/A | C | | | | Yes | |
| SJPMC HOLDINGS INC 5215 HOLY CROSS PARKWAY MISHAWAKA, IN 46545 47-4763735 | PROPERTY HOLDINGS | IN | N/A | C | | | | Yes | |
| ST ELIZABETH HEALTH SUPPORT SERVICES INC 333 BUTTERNUT DRIVE SUITE 100 DEWITT, NY 13214 16-1540486 | MEDICAL SERVICES | NY | N/A | C | | | | Yes | |
| SYSTEM COORDINATED SERVICES INC 114 WOODLAND STREET HARTFORD, CT 06105 04-2938161 | LAB SERVICES | MA | N/A | C | | | | Yes | |
| THRE SERVICES LLC 20555 VICTOR PARKWAY LIVONIA, MI 48152 45-2603654 | REAL ESTATE BROKERAGE SERVICES | MI | N/A | C | | | | Yes | |
| TRINITY ASSURANCE LTD PO BOX 1159 GRAND CAYMAN GRAND CAYMAN CJ 98-0453602 | SELF-INSURANCE | CJ | N/A | C | | | | Yes | |
| TRINITY HEALTH ACO INC 20555 VICTOR PARKWAY LIVONIA, MI 48152 47-3794666 | ACCOUNTABLE CARE ORGANIZATION | DE | N/A | C | | | | Yes | |
| TRINITY HEALTH EMPLOYEE BENEFIT TRUST 20555 VICTOR PARKWAY LIVONIA, MI 48152 38-3410377 | GRANTOR TRUST | MI | N/A | T | | | | Yes | |
| TRINITY SENIOR SERVICES MANAGEMENT INC PO BOX 9184 FARMINGTON HILLS, MI 48333 37-1572595 | SENIOR SERVICES | PA | N/A | C | | | | Yes | |
| WORKPLACE HEALTH OF GRAND HAVEN INC 1820 44TH STREET SE KENTWOOD, MI 49508 38-3112035 | OCCUPATIONAL HEALTH | MI | N/A | C | | | | Yes | |

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|---|---------------------------------|------------------------|--|
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | P | 530,979,186 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | Q | 3,392,055 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | J | 232,604 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | O | 62,058,763 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | R | 843,025,963 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND CORPORATION INC | S | 84,425,366 | PER BOOKS |
| ASYLUM HILL FAMILY MEDICINE CENTER INC | J | 405,166 | PER BOOKS |
| ASYLUM HILL FAMILY MEDICINE CENTER INC | R | 300,000 | PER BOOKS |
| ASYLUM HILL FAMILY MEDICINE CENTER INC | S | 3,000,000 | PER BOOKS |
| ASYLUM HILL FAMILY MEDICINE CENTER INC | Q | 242,163 | PER BOOKS |
| ASYLUM HILL FAMILY MEDICINE CENTER INC | P | 365,781 | PER BOOKS |
| JOHNSON MEMORIAL HOSPITAL INC | Q | 1,156,219 | PER BOOKS |
| JOHNSON MEMORIAL HOSPITAL INC | R | 1,686,812 | PER BOOKS |
| JOHNSON MEMORIAL HOSPITAL INC | P | 1,150,592 | PER BOOKS |
| JOHNSON MEMORIAL HOSPITAL INC | S | 6,107,763 | PER BOOKS |
| MOUNT SINAI REHABILITATION HOSPITAL INC | Q | 1,899,386 | PER BOOKS |
| MOUNT SINAI REHABILITATION HOSPITAL INC | P | 209,813 | PER BOOKS |
| MOUNT SINAI REHABILITATION HOSPITAL INC | J | 91,032 | PER BOOKS |
| MOUNT SINAI REHABILITATION HOSPITAL INC | O | 1,898,298 | PER BOOKS |
| MOUNT SINAI REHABILITATION HOSPITAL INC | S | 29,461,266 | PER BOOKS |
| SAINT FRANCIS EMERGENCY MEDICAL GROUP INC | P | 2,714,114 | PER BOOKS |
| SAINT FRANCIS EMERGENCY MEDICAL GROUP INC | R | 278,785 | PER BOOKS |
| SAINT FRANCIS EMERGENCY MEDICAL GROUP INC | S | 10,757,412 | PER BOOKS |
| SAINT FRANCIS EMERGENCY MEDICAL GROUP INC | P | 97,863 | PER BOOKS |
| SAINT FRANCIS EMERGENCY MEDICAL GROUP INC | Q | 351,018 | PER BOOKS |

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|---|---------------------------------|------------------------|--|
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER FOUNDATION INC | S | 610,377 | PER BOOKS |
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER FOUNDATION INC | Q | 146,853 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | O | 39,533,212 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | J | 2,320,828 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | R | 405,487 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | S | 61,289,039 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | P | 9,967,147 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND PROVIDER NETWORK ORGANIZATION INC | Q | 3,493,376 | PER BOOKS |
| MEDWORKS LLC | O | 56,087 | PER BOOKS |
| MEDWORKS LLC | S | 152,223 | PER BOOKS |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP LLC | J | 142,573 | PER BOOKS |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP LLC | P | 2,504,546 | PER BOOKS |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP LLC | S | 3,000,000 | PER BOOKS |
| SAINT FRANCIS BEHAVIORAL HEALTH GROUP LLC | Q | 65,270 | PER BOOKS |
| SAINT FRANCIS CARE MEDICAL GROUP PC | Q | 106,096 | PER BOOKS |
| SAINT FRANCIS CARE MEDICAL GROUP PC | S | 5,250,000 | PER BOOKS |
| SAINT FRANCIS CARE MEDICAL GROUP PC | P | 807,870 | PER BOOKS |
| SAINT MARY'S HOSPITAL INC | O | 52,000 | PER BOOKS |
| SAINT MARY'S HOSPITAL INC | Q | 4,382,000 | PER BOOKS |
| SAINT MARY'S HOSPITAL INC | P | 4,449,000 | PER BOOKS |
| SAINT MARY'S HOSPITAL INC | R | 7,166,000 | PER BOOKS |
| WOODLAND PARTNERS REAL ESTATE LLC | Q | 577,065 | PER BOOKS |
| TRINITY HEALTH OF NEW ENGLAND EMERGENCY MEDICAL SERVICES INC | Q | 4,412,425 | PER BOOKS |
| TRINITY HEALTH CORPORATION | B | 15,667,720 | PER BOOKS |
| TRINITY HEALTH CORPORATION | M | 87,402,699 | PER BOOKS |

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|--|--|-------------------------------|---|
| TRINITY HEALTH CORPORATION | L | 293,739 | PER BOOKS |
| TRINITY HEALTH CORPORATION | Q | 7,907,957 | PER BOOKS |
| TRINITY HEALTH CORPORATION | P | 43,336,136 | PER BOOKS |
| TRINITY HEALTH CORPORATION | S | 53,140 | PER BOOKS |
| THE MERCY HOSPITAL INC | O | 137,008 | PER BOOKS |
| THE MERCY HOSPITAL INC | P | 2,182,139 | PER BOOKS |
| THE MERCY HOSPITAL INC | Q | 93,577 | PER BOOKS |
| THE MERCY HOSPITAL INC | S | 6,589,468 | PER BOOKS |
| SAINT FRANCIS HOSPITAL AND MEDICAL CENTER FOUNDATION INC | C | 5,197,066 | PER BOOKS |
| WOODLAND PARTNERS REAL ESTATE LLC | B | 5,505,205 | PER TAX RETURN |