

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No 1545-0047
2018
Open to Public Inspection

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

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

C Name of organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

% AARON NEUHARTH
Doing business as

Number and street (or P O box if mail is not delivered to street address) Room/suite
1801 LIND AVE SW ATTN TAX DEPT

City or town, state or province, country, and ZIP or foreign postal code
RENTON, WA 980579016

D Employer identification number
95-1643360

E Telephone number
(949) 364-1400

G Gross receipts \$ 724,009,310

F Name and address of principal officer
EILEEN HAUBL
27700 MEDICAL CENTER ROAD
MISSION VIEJO, CA 92691

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

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

H(c) Group exemption number ▶ 0928

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

J Website: ▶ WWW MISSION4HEALTH COM

K Form of organization Corporation Trust Association Other ▶

L Year of formation 1941

M State of legal domicile CA

Part I Summary

1 Briefly describe the organization's mission or most significant activities
AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

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)	11
4 Number of independent voting members of the governing body (Part VI, line 1b)	7
5 Total number of individuals employed in calendar year 2018 (Part V, line 2a)	3,164
6 Total number of volunteers (estimate if necessary)	759
7a Total unrelated business revenue from Part VIII, column (C), line 12	542,981
7b Net unrelated business taxable income from Form 990-T, line 34	117,634

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	8,624,064	20,623,860
9 Program service revenue (Part VIII, line 2g)	318,301,788	695,552,123
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,437,782	5,138,169
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	-168,277	-192,913
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	328,195,357	721,121,239
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,554,389	8,668,104
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)	125,614,940	269,359,338
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 3,389,233		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	177,924,154	341,908,907
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	307,093,483	619,936,349
19 Revenue less expenses Subtract line 18 from line 12	21,101,874	101,184,890
	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	568,706,675	542,602,706
21 Total liabilities (Part X, line 26)	342,918,054	291,380,529
22 Net assets or fund balances Subtract line 21 from line 20	225,788,621	251,222,177

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: _____ Date: 2019-11-15

EILEEN HAUBL CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: _____ Preparer's signature: _____ Date: _____

Check if self-employed PTIN P00023315

Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ _____

Firm's address ▶ 18101 VON KARMAN AVE STE 1700 IRVINE, CA 92612 Phone no (949) 794-2300

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

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 \$ 540,072,247 including grants of \$ 8,668,104) (Revenue \$ 695,552,123)
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 ▶ 540,072,247

Part IV Checklist of Required Schedules

Table with 3 columns: Question Number, Question Text, and Yes/No columns. Rows include questions 1 through 22 regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

		Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23	Yes
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a	No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a	No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b	No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>	26	No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>	27	No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)		
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a	No
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b	No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	No
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29	Yes
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 Compliance

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

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

<p>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</p>	2a	3,164			
<p>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)</p>			2b	Yes	
<p>3a Did the organization have unrelated business gross income of \$1,000 or more during the year?</p>			3a	Yes	
<p>b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O</p>			3b	Yes	
<p>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)?</p>			4a		No
<p>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)</p>					
<p>5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?</p>			5a		No
<p>b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>			5b		No
<p>c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?</p>			5c		
<p>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?</p>			6a		No
<p>b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?</p>			6b		
7 Organizations that may receive deductible contributions under section 170(c).					
<p>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?</p>			7a	Yes	
<p>b If "Yes," did the organization notify the donor of the value of the goods or services provided?</p>			7b	Yes	
<p>c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?</p>			7c		No
<p>d If "Yes," indicate the number of Forms 8282 filed during the year</p>	7d				
<p>e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>			7e		No
<p>f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?</p>			7f		No
<p>g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?</p>			7g		
<p>h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?</p>			7h		
8 Sponsoring organizations maintaining donor advised funds.					
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?</p>			8		
<p>9a Did the sponsoring organization make any taxable distributions under section 4966?</p>			9a		
<p>b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?</p>			9b		
10 Section 501(c)(7) organizations. Enter					
<p>a Initiation fees and capital contributions included on Part VIII, line 12</p>	10a				
<p>b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	10b				
11 Section 501(c)(12) organizations. Enter					
<p>a Gross income from members or shareholders</p>	11a				
<p>b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)</p>	11b				
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?					
<p>b If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	12b				
13 Section 501(c)(29) qualified nonprofit health insurance issuers.					
<p>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</p>			13a		
<p>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</p>	13b				
<p>c Enter the amount of reserves on hand</p>	13c				
<p>14a Did the organization receive any payments for indoor tanning services during the tax year?</p>			14a		No
<p>b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O</p>			14b		
<p>15 Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N</p>			15		No
<p>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</p>			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

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (11); 1b Enter the number of voting members included in line 1a, above, who are independent (7); 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? (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? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (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? (Yes); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (Yes); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (Yes); b Each committee with authority to act on behalf of the governing body? (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 (No)

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b 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?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 11b 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 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (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 (No); b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (Yes); 16b 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? (Yes)

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (CA); 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: AARON NEUHARTH 27700 MEDICAL CENTER ROAD MISSION VIEJO, CA 92691 (949) 364-7767

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a			
	b Membership dues	1b			
	c Fundraising events	1c	1,878,253		
	d Related organizations	1d	2,032,728		
	e Government grants (contributions)	1e	197,271		
	f All other contributions, gifts, grants, and similar amounts not included above	1f	16,515,608		
	g Noncash contributions included in lines 1a - 1f \$ _____		2,376,349		
h Total. Add lines 1a-1f		20,623,860			

Program Service Revenue			Business Code				
	2a NET PATIENT REVENUE		622110	622,155,475	622,155,475	0	0
b CAPITATION REVENUE		621511	44,392,106	44,392,106	0	0	
c MOB RENTAL REVENUE		531120	13,507,547	13,507,547	0	0	
d CHILDRENS' HOSPITAL AT MISSION		622110	5,541,318	5,541,318	0	0	
e NUTRITIONAL SERVICES		722310	3,031,071	3,031,071	0	0	
f All other program service revenue			6,924,606	6,381,625	542,981	0	
g Total. Add lines 2a-2f			695,552,123				

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			5,138,947			5,138,947
	4 Income from investment of tax-exempt bond proceeds			0			
	5 Royalties			0			
	6a Gross rents	(i) Real	(ii) Personal				
	b Less rental expenses						
	c Rental income or (loss)	0	0				
	d Net rental income or (loss)			0			
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
	b Less cost or other basis and sales expenses	2,075,979					
	c Gain or (loss)	2,076,757					
	d Net gain or (loss)	-778		-778			-778
	8a Gross income from fundraising events (not including \$ 1,878,253 of contributions reported on line 1c) See Part IV, line 18	a	458,126				
	b Less direct expenses	b	768,814				
	c Net income or (loss) from fundraising events			-310,688			-310,688
	9a Gross income from gaming activities See Part IV, line 19	a	160,275				
b Less direct expenses	b	42,500					
c Net income or (loss) from gaming activities			117,775			117,775	
10a Gross sales of inventory, less returns and allowances	a	0					
b Less cost of goods sold	b	0					
c Net income or (loss) from sales of inventory			0				
11a Miscellaneous Revenue	Business Code						
b							
c							
d All other revenue							
e Total. Add lines 11a-11d			0				
12 Total revenue. See Instructions			721,121,239	695,009,142	542,981	4,945,256	

Part IX Statement of Functional Expenses

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

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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.				
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	8,601,150	8,601,150		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	66,954	66,954		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0	0		
4 Benefits paid to or for members.	0	0		
5 Compensation of current officers, directors, trustees, and key employees.	2,799,860	1,970,690	829,170	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	120,972	120,972	0	0
7 Other salaries and wages.	209,624,607	198,344,791	9,623,856	1,655,960
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	10,315,394	9,904,924	329,439	81,031
9 Other employee benefits.	31,756,197	28,636,572	2,790,931	328,694
10 Payroll taxes.	14,742,308	13,982,801	625,976	133,531
11 Fees for services (non-employees)				
a Management.	35,857,309	28,443,711	7,413,598	0
b Legal.	1,265,195	0	1,265,195	0
c Accounting.	148,489	1,100	0	147,389
d Lobbying.	40,257	40,257	0	0
e Professional fundraising services. See Part IV, line 17.	0			0
f Investment management fees.	324,951	0	262,951	62,000
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	84,340,939	63,014,997	21,237,954	87,988
12 Advertising and promotion.	1,693,813	0	1,654,463	39,350
13 Office expenses.	18,539,802	18,316,831	180,671	42,300
14 Information technology.	2,032,860	2,032,860	0	0
15 Royalties.	0	0	0	0
16 Occupancy.	37,319,250	19,011,596	18,052,910	254,744
17 Travel.	782,048	441,016	324,754	16,278
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.	0	0	0	0
19 Conferences, conventions, and meetings.	87,567	78,857	1,370	7,340
20 Interest.	8,348,651	6,595,434	1,753,217	0
21 Payments to affiliates.	0	0	0	0
22 Depreciation, depletion, and amortization.	25,070,812	20,302,899	4,760,989	6,924
23 Insurance.	3,974,484	0	3,974,484	0
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	86,277,764	86,234,749	43,015	0
b HOSPITAL FEE PROGRAM	32,453,446	32,453,446	0	0
c LICENSEES / TAXES / DUES	1,003,666	440,290	557,432	5,944
d ALL OTHER EXPENSES	2,347,604	1,035,350	792,494	519,760
e All other expenses.				
25 Total functional expenses. Add lines 1 through 24e.	619,936,349	540,072,247	76,474,869	3,389,233
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).	0			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	0	1	0
	2 Savings and temporary cash investments	7,663,031	2	18,227,623
	3 Pledges and grants receivable, net	5,957,776	3	14,472,863
	4 Accounts receivable, net	70,951,610	4	67,060,446
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	3,334,634	7	2,745,929
	8 Inventories for sale or use	7,364,494	8	8,391,529
	9 Prepaid expenses and deferred charges	8,107,513	9	1,312,763
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 636,713,612		
	b Less accumulated depreciation	10b 300,351,901	350,442,574	10c 336,361,711
	11 Investments—publicly traded securities	83,783,677	11	85,302,167
	12 Investments—other securities See Part IV, line 11	15,415,109	12	2,467,328
	13 Investments—program-related See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
	15 Other assets See Part IV, line 11	15,686,257	15	6,260,347
16 Total assets. Add lines 1 through 15 (must equal line 34)	568,706,675	16	542,602,706	
Liabilities	17 Accounts payable and accrued expenses	100,881,518	17	64,643,281
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	100,943
	20 Tax-exempt bond liabilities	0	20	0
	21 Escrow or custodial account liability Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	0	23	0
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D	242,036,536	25	226,636,305
	26 Total liabilities. Add lines 17 through 25	342,918,054	26	291,380,529
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	123,720,288	27	142,105,482
	28 Temporarily restricted net assets	100,054,237	28	107,299,233
	29 Permanently restricted net assets	2,014,096	29	1,817,462
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	225,788,621	33	251,222,177	
34 Total liabilities and net assets/fund balances	568,706,675	34	542,602,706	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	721,121,239
2	Total expenses (must equal Part IX, column (A), line 25)	2	619,936,349
3	Revenue less expenses Subtract line 2 from line 1	3	101,184,890
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	225,788,621
5	Net unrealized gains (losses) on investments	5	-8,509,564
6	Donated services and use of facilities	6	-1,436,000
7	Investment expenses	7	-262,951
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-65,542,819
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	251,222,177

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990 Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- 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
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

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

Additional Data

Software ID:

Software Version:

EIN: 95-1643360

Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

Form 990 (2018)

Form 990, Part III, Line 4a:

SEE SCHEDULE O

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			
SISTER LINDA BUCK BOARD CHAIR	5 0 0 0	X						0	0	0
SISTER JO-ANN EANNARENO BOARD MEMBER	2 0 2 0	X						0	0	0
ED JORDAN BOARD MEMBER, COMMITTEE CHAIR	4 0 0 0	X						0	0	0
TODD LEMPert MD BOARD MEMBER	2 0 0 0	X						91,530	0	0
MICHAEL MARINO DO SVP, CHIEF MED INFO OFFICER	2 0 50 0	X		X				0	698,684	52,839
RUDY MARQUEZ MD BOARD MEMBER	2 0 0 0	X						0	0	0
JAIME MUNOZ BOARD MEMBER	2 0 0 0	X						0	0	0
STEVEN PAL BOARD VICE - CHAIR	2 0 0 0	X						0	0	0
TAREK SALAWAY CHIEF EXECUTIVE	50 0 2 0	X		X				0	640,285	23,950
PATRICIA WALLACE MD BOARD MEMBER	2 0 0 0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES WICKHAM MD BOARD MEMBER, CHIEF OF STAFF	2 0 0 0	X						41,667	0	0
TARA COWELL VP/ASSOC GENERAL COUNSEL/SEC	2 0 52 0			X				0	399,477	64,180
EILEEN HAUBL CHIEF FINANCIAL OFFICER	50 0 0 0			X				455,820	0	50,856
MARK JABLONSKI CHIEF MISSION INTEGRATION	2 0 50 0			X				0	358,148	45,700
MICHAEL BECK CHIEF ADMIN OFFICER - LB	50 0 0 0				X			344,029	0	64,392
JENNIFER CORD CHIEF NURSING OFFICER	50 0 0 0				X			352,276	0	29,730
WENDY FERRO-GRANT DIRECTOR, SURGICAL SERVICES	50 0 0 0				X			207,309	0	45,755
DEANNE NIEDZIELA DIRECTOR, NURSING	50 0 0 0				X			239,969	0	45,100
TERRENCE WOOTEN VP, INTEGRATED OPERATIONS	50 0 0 0				X			263,201	0	28,711
ANNABELLE BRAUN DIRECTOR, NURSING	50 0 0 0					X		256,803	0	35,726

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			
LAUREN DWINELL EXEC DIR, CHIEF OPS-PAT FLOW	50 0 0 0					X		296,917	0	43,985
TERRI FOX-COVERT DIRECTOR, HUMAN RESOURCES	50 0 0 0					X		301,704	0	51,212
EVELYN SCHLOSSER EXEC DIR, QLTY & PAT SAFETY	50 0 0 0					X		254,912	0	26,332
LINDA SIEGLEN CHIEF MEDICAL OFFICER	50 0 0 0					X		491,693	0	40,808
KENNETH MCFARLAND FORMER OFFICER & TRUSTEE	0 0 0 0						X	0	295,676	0
LINDA JOHNSON FORMER KEY EMPLOYEE	0 0 0 0						X	112,375	0	0

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
 Attach to Form 990 or Form 990-EZ.
 Go to www.irs.gov/Form990 for the latest information.

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number

95-1643360

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6	Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					12	

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

Section C. Computation of Public Support Percentage

14	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2017 Schedule A, Part II, line 14	15	

- 16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶
- b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶
- 17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶
- b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c	Add lines 7a and 7b						
8	Public support. (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9	Amounts from line 6						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c	Add lines 10a and 10b						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests—2018. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

b 33 1/3% support tests—2017. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

		Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?		
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
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>	Yes	No
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

- 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 2018 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 Excess distributions carryover to 2019. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Additional Data

Software ID:

Software Version:

EIN: 95-1643360

Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047
2018
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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 MISSION HOSPITAL REGIONAL MEDICAL CENTER	Employer identification number 95-1643360
--	--

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

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

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

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

Part II-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	0
d Mailings to members, legislators, or the public?		No	0
e Publications, or published or broadcast statements?		No	0
f Grants to other organizations for lobbying purposes?		No	0
g Direct contact with legislators, their staffs, government officials, or a legislative body?		No	0
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	0
i Other activities?	Yes		40,257
j Total Add lines 1c through 1i			40,257
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1I	OTHER ACTIVITIES THE LOBBYING EXPENDITURES REPORTED REPRESENTS THE PORTION OF DUES ALLOCATED TO MISSION HOSPITAL

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements
► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047
2018
Open to Public Inspection

Name of the organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number
95-1643360

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)

Preservation of land for public use (e g , recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

	Held at the End of the Year	
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

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

b Assets included in Form 990, Part X ► \$ _____

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|---|--------|
| 1c Beginning balance | |
| 1d Additions during the year | |
| 1e Distributions during the year | |
| 1f Ending balance | |
- 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	5,547,788	5,163,079	4,520,369	4,693,718	4,573,054
b Contributions	179,437		0	40,365	47,943
c Net investment earnings, gains, and losses	-254,088	414,008	654,184	-73,142	118,728
d Grants or scholarships					0
e Other expenditures for facilities and programs				95,886	0
f Administrative expenses	21,553	29,299	11,474	44,686	46,007
g End of year balance	5,451,584	5,547,788	5,163,079	4,520,369	4,693,718

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 50 000 %
 - b** Permanent endowment ▶ 33 340 %
 - c** Temporarily restricted endowment ▶ 16 660 %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | Yes | No |
|--|--------------------------|--------------------------|
| (i) unrelated organizations | <input type="checkbox"/> | No |
| (ii) related organizations | <input type="checkbox"/> | No |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | <input type="checkbox"/> | <input type="checkbox"/> |
- 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		49,101,906		49,101,906
b Buildings		334,100,317	119,867,937	214,232,380
c Leasehold improvements		23,336,833	16,726,590	6,610,243
d Equipment		208,070,214	157,729,795	50,340,419
e Other		22,104,342	6,027,579	16,076,763
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				336,361,711

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

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

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

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

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
INTERCO WITH HEALTH SYSTEM - BONDS	217,184,118
INTERCOMPANY PAYABLE	1,272,323
THIRD PARTY PAYABLE	4,650,244
OTHER LIABILITIES	3,529,620
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	226,636,305

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: 95-1643360

Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	INTENDED USE OF ENDOWMENT FUNDS THE USE OF THE RESTRICTED ENDOWMENTS ARE SPECIFIED WHEN PUT IN PLACE BY THE DONORS LIKE ALL ENDOWMENTS, ONLY THE DISTRIBUTED EARNED INCOME IS AVAILABLE FOR USE THE UNRESTRICTED INCOME IS USED AT THE DISCRETION OF THE EXECUTIVE LEADERSHIP OF THE HOSPITAL FOR CAPITAL/BUILDING, EQUIPMENT AND PROGRAM NEEDS

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a
 Attach to Form 990 or Form 990-EZ.
 Go to www.irs.gov/Form990 for instructions and the latest information

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number
95-1643360

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

- 1** Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- | | |
|---|---|
| <p>a <input type="checkbox"/> Mail solicitations</p> <p>b <input type="checkbox"/> Internet and email solicitations</p> <p>c <input type="checkbox"/> Phone solicitations</p> <p>d <input type="checkbox"/> In-person solicitations</p> | <p>e <input type="checkbox"/> Solicitation of non-government grants</p> <p>f <input type="checkbox"/> Solicitation of government grants</p> <p>g <input type="checkbox"/> Special fundraising events</p> |
|---|---|
- 2a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? Yes No
- b** If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
Harris Connect INC CHESAPEAKE VA	Telephone OUTREACH		No			
Total				▶		

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

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

Revenue		(a)Event #1	(b) Event #2	(c)Other events	(d)
		<u>GALA</u> (event type)	<u>FASHION SHOW</u> (event type)	<u>5</u> (total number)	Total events (add col (a) through col (c))
1	Gross receipts	1,000,999	420,354	915,026	2,336,379
2	Less Contributions	818,343	295,167	764,743	1,878,253
3	Gross income (line 1 minus line 2)	182,656	125,187	150,283	458,126
Direct Expenses	4 Cash prizes	0	0	0	0
	5 Noncash prizes	0	0	0	0
	6 Rent/facility costs	14,495	4,029	90,719	109,243
	7 Food and beverages	99,074	52,425	75,296	226,795
	8 Entertainment	19,950	10,000	0	29,950
	9 Other direct expenses	198,350	40,707	163,769	402,826
	10	Direct expense summary Add lines 4 through 9 in column (d) ▶			
11	Net income summary Subtract line 10 from line 3, column (d) ▶				-310,688

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

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
		1	Gross revenue		
Direct Expenses	2 Cash prizes			3,500	3,500
	3 Noncash prizes			39,000	39,000
	4 Rent/facility costs			0	0
	5 Other direct expenses			0	0
	6	Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes 100.000 % <input type="checkbox"/> No
7	Direct expense summary Add lines 2 through 5 in column (d) ▶				42,500
8	Net gaming income summary Subtract line 7 from line 1, column (d) ▶				117,775

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

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

b If "No," explain SEE SCHEDULE G, PART IV

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

b If "Yes," explain _____

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

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

13 Indicate the percentage of gaming activity conducted in

a The organization's facility	13a	%
b An outside facility	13b	100 000 %

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

Name ▶ JOHN D MILLER

Address ▶ 27700 MEDICAL CENTER ROAD
MISSION VIEJO, CA 92691

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

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

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

Name ▶ _____

Address ▶ _____

16 Gaming manager information

Name ▶ JOHN D MILLER

Gaming manager compensation ▶ \$ 11,990

Description of services provided ▶ Director/officer

 Director/officer Employee Independent contractor**17** Mandatory distributions

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

b Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ 144,248

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

Return Reference	Explanation
SCHEDULE G, PART III, LINE 9B	GAMING MISSION HOSPITAL IS A NOT-FOR-PROFIT ORGANIZATION AND GAMING IS NOT THE PRIMARY FUNDRAISING ACTIVITY AS A HOSPITAL, THEY ARE NOT REQUIRED TO REGISTER WITH THE CALIFORNIA ATTORNEY GENERAL THERE WERE RAFFLES FOR PRIZE BASKETS AND CASH PRIZES TOTALING \$160,275 90% OF THE PROCEEDS WERE RETAINED AS REQUIRED

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Go to www.irs.gov/Form990EZ for instructions and the latest information.**

OMB No 1545-0047
2018
Open to Public Inspection

Name of the organization
 MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number
 95-1643360

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 <i>free</i> 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 _____ %	3a	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> 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 type="checkbox"/> 400% <input checked="" type="checkbox"/> Other _____ 500 %	3b	Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b If "Yes," did the organization make it available to the public?	6b	Yes	

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			8,543,217		8,543,217	1 370 %
b Medicaid (from Worksheet 3, column a)			93,562,394	110,075,614	0	
c Costs of other means-tested government programs (from Worksheet 3, column b)			0		0	
d Total Financial Assistance and Means-Tested Government Programs			102,105,611	110,075,614	8,543,217	1 370 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,632,952	214,122	3,418,830	0 550 %
f Health professions education (from Worksheet 5)			106,427		106,427	0 020 %
g Subsidized health services (from Worksheet 6)			307,668	2,500	305,168	0 050 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			3,974,364		3,974,364	0 640 %
j Total. Other Benefits			8,021,411	216,622	7,804,789	1 260 %
k Total. Add lines 7d and 7j			110,127,022	110,292,236	16,348,006	2 620 %

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			51,090		51,090	0.010 %
2 Economic development						
3 Community support			37,244		37,244	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members			168,104		168,104	0.030 %
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other			58,850		58,850	0.010 %
10 Total			315,288		315,288	0.060 %

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?		No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	120,266,705
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	147,520,355
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-27,253,650
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 type="checkbox"/> Cost to charge ratio <input checked="" 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 (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 MECC - SEE PART VI	PHYSICIAN OFFICE & CONF ED CT	50 %		50 %
2 MAS - SEE PART VI	OUTPATIENT SURGERY CENTER	36.7 %		63.3 %
3 MVPP - SEE PART VI	MEDICAL OFFICE BUILDING	24.8 %		12.64 %
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										

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)
MISSION HOSPITAL REGIONAL MEDICAL CTR

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		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		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)	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 <u>20 16</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	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		No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>SEE PART V, SECTION C</u>	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
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)**

MISSION HOSPITAL REGIONAL MEDICAL CTR

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>500</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input checked="" type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	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)	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)	Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input 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**

MISSION HOSPITAL REGIONAL MEDICAL CTR

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

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why	21	Yes	
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)

MISSION HOSPITAL REGIONAL MEDICAL CTR

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
23		No
24		No

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 4

Name and address	Type of Facility (describe)
1 MISSION AMBULATORY SURGICENTER LTD 26730 CROWN VALLEY PARKWAY MISSION VIEJO, CA 92691	OUTPATIENT SURGERY CENTER
2 CALIFORNIA SPECIALTY SURGERY CENTER LP 26371 CROWN VALLEY PARKWAY MISSION VIEJO, CA 92691	OUTPATIENT SURGERY CENTER
3 FAMILY RESOURCE CENTER 22481 ASPAN STREET LAKE FOREST, CA 92630	COMMUNITY OUTREACH CENTER
4 CHEC FAMILY RESOURCE CENTER 27412 CALLE ARROYO MISSION VIEJO, CA 92675	COMMUNITY OUTREACH CENTER
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 3C	IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE, FPG IS A KEY FACTOR THE ORGANIZATION ALSO CONSIDERED CERTAIN ASSETS OF A PATIENT IN ADDITION, A PATIENT'S SPECIAL CIRCUMSTANCES WERE ALSO CONSIDERED WHEN DETERMINING ELIGIBILITY, INCLUDING BUT NOT LIMITED TO, DISABILITY AND HOMELESSNESS
SCHEDULE H, PART I, LINE 6A	MISSION HOSPITAL REGIONAL MEDICAL CENTER PREPARES AN ANNUAL REPORT AND IT IS PUBLICLY AVAILABLE AT WWW MISSION4HEALTH COM

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	THE AMOUNTS REPORTED IN THE TABLE WERE DERIVED FROM THE COST ACCOUNTING SYSTEM AND GENERAL LEDGER
SCHEDULE H, PART I, LINE 7, COLUMN (F)	JOINT VENTURE COSTS OF \$3,945,338 WERE INCLUDED IN THE TOTAL EXPENSE AMOUNT USED TO CALCULATE PERCENTAGES IN PART I, LINE 7, COLUMN F SCHEDULE H, PART I, LINE 7G NO COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS WERE INCLUDED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART II	COMMUNITY BUILDING ACTIVITIES FOSTERING A PREPARED AND PRODUCTIVE WORKFORCE IS THE PRIMARY FOCUS OF OUR COMMUNITY BUILDING AT MISSION HOSPITAL WE COMPLETE THIS EFFORT THROUGH CONTINUED COLLABORATION WITH CAPISTRANO UNIFIED SCHOOL DISTRICT ADULT TRANSITION PROGRAM SINCE 2006, MISSION HOSPITAL HOSTS YOUNG ADULTS WITH DISABILITIES EACH FALL TO PROVIDE WORK EXPERIENCE IN A HOSPITAL SETTING THESE STUDENT INTERNS ARE PLACED IN HOSPITAL DEPARTMENTS SUCH AS NUTRITIONAL CARE SERVICES, ENVIRONMENTAL SERVICES AND CENTRAL SUPPLY TO LEARN JOB SKILLS THAT WILL HELP THEM ATTAIN LONG-TERM EMPLOYMENT EITHER AT THE HOSPITAL OR A LOCAL ORGANIZATION MANY OF THESE STUDENTS WOULD BE HIGHLY CHALLENGED TO FIND PERMANENT, ON-GOING WORK BECAUSE OF THEIR DISABILITIES IN 2018, 4 INTERNS RECEIVED MENTORING/JOB COACHING SUPPORT EMERGENCY ASSISTANCE/HOMELESS OUTREACH PROVIDED EMERGENCY ASSISTANCE TO RESIDENTS FACING HOMELESSNESS 55 FAMILIES RECEIVED SUPPORT TO CONTINUE THEIR HOUSING NEEDS COMMUNITY SUPPORT MISSION HOSPITAL CONTINUED ITS IMPLEMENTATION OF SAFE RIDES, A FREE, ANONYMOUS PROGRAM THAT PROVIDES TRANSPORTATION FOR YOUTH WHO HAVE FOUND THEMSELVES WITHOUT A RIDE HOME ON THE WEEKENDS DUE TO DRINKING OR OTHER RISKY BEHAVIORS 186 RIDES WERE PROVIDED TO LOCAL TEENS LEADERSHIP DEVELOPMENT MISSION HOSPITAL HAS PARTNERED WITH THE SISTERS OF ST JOSEPH TO FOSTER LEADERSHIP DEVELOPMENT AS PART OF THEIR ST JOSEPH WORKER PROGRAM THIS PROGRAM SUPPORTS WOMEN FOR A 10 MONTH FORMATION PROGRAM WITH THE SISTERS WHILE THEY WORK WITH LOCAL COMMUNITIES AND DEVELOP PUBLIC HEALTH AND ADVOCACY SKILLS THE FOLLOWING ARE INCLUDED UNDER OTHER COMMUNITY BUILDING EXPENSES FOOD DONATIONS MISSION HOSPITAL PARTNERS WITH NON-PROFIT ORGANIZATIONS TO FEED THE HOMELESS FOOD DONATIONS ARE MADE TO LOCAL CHARITIES AND FAITH COMMUNITIES TO DISTRIBUTE TO HOMELESS RESIDENTS IN SOUTH ORANGE COUNTY
SCHEDULE H, PART III, LINE 2	METHODOLOGY USED TO ESTIMATE BAD DEBT EXPENSE THE ORGANIZATION ANALYZES ITS HISTORICAL EXPERIENCE AND TRENDS TO ESTIMATE THE APPROPRIATE BAD DEBT EXPENSE DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE RECORDED PRIOR TO CALCULATING BAD DEBT EXPENSE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 3	METHODOLOGY OF ESTIMATING BAD DEBT EXPENSE ATTRIBUTABLE TO FAP PATIENTS THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDERINSURED PATIENT POPULATION MAY NOT ENGAGE IN THE TRADITIONAL FINANCIAL ASSISTANCE APPLICATION PROCESS THEREFORE, THE ORGANIZATION ALSO USED AN AUTOMATED PREDICTIVE SCORING TOOL TO IDENTIFY AND QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE FOR ACCOUNTS THAT WERE INITIALLY CLASSIFIED AS BAD DEBT COLLECTION ACTIONS WERE NOT PURSUED ON THESE ACCOUNTS ONCE THEY WERE RECLASSIFIED BECAUSE RECLASSIFIED ACCOUNTS WERE GRANTED 100 PERCENT FINANCIAL ASSISTANCE (FREE CARE) AFTER THE RECLASSIFICATION, THERE WAS NO REMAINING AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER OUR FINANCIAL ASSISTANCE POLICY
SCHEDULE H, PART III, LINE 4	FINANCIAL STATEMENT BAD DEBT EXPENSE FOOTNOTE FOOTNOTE FROM THE PROVIDENCE ST JOSEPH HEALTH COMBINED FINANCIAL STATEMENTS FOR THE YEAR ENDED 12/31/2018 THE HEALTH SYSTEM PROVIDES FOR AN ALLOWANCE AGAINST PATIENT ACCOUNTS RECEIVABLE FOR AMOUNTS THAT COULD BECOME UNCOLLECTIBLE THE HEALTH SYSTEM ESTIMATES THIS ALLOWANCE BASED ON THE AGING OF ACCOUNTS RECEIVABLE, HISTORICAL COLLECTION EXPERIENCE BY PAYOR, AND OTHER RELEVANT FACTORS THERE ARE VARIOUS FACTORS THAT CAN IMPACT THE COLLECTION TRENDS, SUCH AS CHANGES IN THE ECONOMY, WHICH IN TURN HAVE AN IMPACT ON UNEMPLOYMENT RATES AND THE NUMBER OF UNINSURED AND UNDERINSURED PATIENTS, THE INCREASED BURDEN OF COPAYMENTS TO BE MADE BY PATIENTS WITH INSURANCE COVERAGE AND BUSINESS PRACTICES RELATED TO COLLECTION EFFORTS THESE FACTORS CONTINUOUSLY CHANGE AND CAN HAVE AN IMPACT ON COLLECTION TRENDS AND THE ESTIMATION PROCESS USED BY THE HEALTH SYSTEM THE HEALTH SYSTEM RECORDS A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICES ON THE BASIS OF PAST EXPERIENCE, WHICH HAS HISTORICALLY INDICATED THAT MANY PATIENTS ARE UNRESPONSIVE OR ARE OTHERWISE UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE

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Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 8	THE ORGANIZATION DOES NOT REPORT MEDICARE REVENUES AND EXPENSES AS COMMUNITY BENEFIT
SCHEDULE H, PART III, LINE 9B	PATIENT ACCOUNTS WERE NOT FORWARDED TO COLLECTION STATUS WHEN THE PATIENT MADE A GOOD FAITH EFFORT TO RESOLVE OUTSTANDING ACCOUNT BALANCES SUCH EFFORTS INCLUDE APPLYING FOR FINANCIAL ASSISTANCE, NEGOTIATING A PAYMENT PLAN, OR APPLYING FOR MEDICAID COVERAGE PRIOR TO ADVANCING ANY ACCOUNT FOR EXTERNAL COLLECTION, THE ORGANIZATION PERFORMED AN EVALUATION TO IDENTIFY IF THE ACCOUNT QUALIFIED FOR FINANCIAL ASSISTANCE ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR FREE CARE WERE WRITTEN OFF AND COLLECTION EFFORTS WERE NOT PURSUED THE ORGANIZATION'S COLLECTION POLICY ALSO APPLIED TO ACCOUNTS FOR PATIENTS WHO QUALIFIED FOR DISCOUNTED CARE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART IV, COLUMN (A)	NAME OF ENTITY 1 MISSION EDUCATION CONFERENCE CENTER, LLC 2 MISSION AMBULATORY SURGICENTER, LTD, DBA MISSION SURGERY CENTER 3 MISSION VIEJO PHYSICIAN PARTNERS I, LLC
SCHEDULE H, PART VI, LINE 2	NEEDS ASSESMENT AN ANNUAL MARKET ASSESMENT IS COMPLETED FOR OUR LOCAL MARKET THAT PROVIDES INFORMATION ON DEMOGRAPHICS, COUNTY HEALTH RANKINGS, PHYSICIAN LANDSCAPE, ACUTE CARE UTILIZATION RATES, MARKET SHARE, OUTMIGRATION TO OTHER MEDICAL FACILITIES FOR TREATMENT, EMERGENCY DEPARTMENT AND ANCILLARY UTILIZATION, AS WELL AS SERVICE LINE FORECASTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 3</p>	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE THE ORGANIZATION POSTED NOTICES INFORMING THE PUBLIC OF THE FINANCIAL ASSISTANCE PROGRAM NOTICES WERE POSTED IN HIGH VOLUME INPATIENT AND OUTPATIENT SERVICE AREAS NOTICES WERE ALSO POSTED AT LOCATIONS WHERE A PATIENT COULD PAY THEIR BILL NOTICES INCLUDED CONTACT INFORMATION ON HOW A PATIENT COULD OBTAIN MORE INFORMATION ON FINANCIAL ASSISTANCE AS WELL AS WHERE TO APPLY FOR ASSISTANCE THESE NOTICES WERE POSTED IN ENGLISH AND SPANISH AND ANY OTHER LANGUAGES THAT WERE REPRESENTATIVE OF 5% OR GREATER OF PATIENTS IN THE HOSPITAL'S SERVICE AREA ALL PATIENTS WHO DEMONSTRATED LACK OF FINANCIAL COVERAGE BY THIRD PARTY INSURERS WERE OFFERED AN OPPORTUNITY TO COMPLETE THE FINANCIAL ASSISTANCE APPLICATION AND WERE OFFERED INFORMATION, ASSISTANCE, AND REFERRAL AS APPROPRIATE TO GOVERNMENT SPONSORED PROGRAMS FOR WHICH THEY MAY HAVE BEEN ELIGIBLE</p>
<p>SCHEDULE H, PART VI, LINE 4</p>	<p>COMMUNITY INFORMATION MISSION HOSPITAL'S TOTAL HOSPITAL SERVICE AREA (TSA) INCLUDES PORTIONS OF SOUTH ORANGE COUNTY THE TOTAL HOSPITAL SERVICE AREA POPULATION IS 609,266 WITH A MEDIAN HOUSHOLD INCOME OF NEARLY \$100,000 THE TOTAL SERVICE AREA HAS 12.4 PERCENT OF THE POPULATION WITH A HOUSEHOLD INCOME BELOW 200% FPL AND 7.7 PERCENT OF CHILDREN AND 7.1 PERCENT OF OLDER ADULTS LIVE BELOW 100% OF POVERTY LEVEL WHEN LOOKING AT THE PRIMARY SERVICE AREA, 22.3 PERCENT OF THE POPULATION IS UNDER THE AGE OF 18 AND 15.1 PERCENT OF THE POPULATION IS OVER THE AGE OF 65 FUTHERMORE, 13 PERCENT OF THE POPULATIONS HOUSEHOLD INCOME IS BELOW 200% FPL AND 8.5 PERCENT OF CHILDREN AND 6.6 PERCENT OF OLDER ADULTS LIVE BELOW 100% OF FEDERAL POVERTY LEVEL MISSION HOSPITALS TSA IS PRIMARILY CAUCASIAN, REPRESENTING 64.1 PERCENT OF THE TOTAL POPULATION HISPANIC RESIDENTS MAKE UP 20.1 PERCENT AND THE REMAINING 15 PERCENT ARE OTHER ETHNICITIES THE REPRESENTATION OF RACIAL AND ETHNIC DIVERSITY IS THE VIRTUALLY THE SAME IN MISSION HOSPITALS PSA BECAUSE OF THE EXTREME DIVERSITY OF INCOME IN MISSION HOSPITAL'S TSA, ONLY ONE ZIP CODE IS IDENTIFIED AS HAVING HIGH NEEDS SAN JUAN CAPISTRANO, ZIP CODE 92675 HOWEVER, THERE ARE MANY POCKETS OF POVERTY WITHIN THE TSA THAT REMAIN HIDDEN DUE TO THE WIDE VARIANCE OF HOUSEHOLD INCOMES BY ZIP CODE OTHER HOSPITALS IN THE COMMUNITY INCLUDE SADDLEBACK HOSPITAL CAN BE FOUND IN MISSION HOSPITALS SECONDARY SERVICE AREA (SSA) HEALTH PROFESSIONS SHORTAGE AREA MENTAL, DENTAL, OTHER THE FEDERAL HEALTH RESOURCES AND SERVICES ADMINISTRATION DESIGNATES HEALTH PROFESSIONAL SHORTAGE AREAS AS AREAS WITH A SHORTAGE OF PRIMARY MEDICAL CARE, DENTAL CARE, OR MENTAL HEALTH PROVIDERS THEY ARE DESIGNATED ACCORDING TO GEOGRAPHY (I.E., SERVICE AREA), DEMOGRAPHICS (I.E., LOW-INCOME POPULATION), OR INSTITUTIONS (I.E., COMPREHENSIVE HEALTH CENTERS) MISSION HOSPITAL IS NOT LOCATED IN A SHORTAGE AREA MEDICALLY UNDERSERVED AREA/MEDICAL PROFESSIONAL SHORTAGE AREA MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ARE DEFINED BY THE FEDERAL GOVERNMENT TO INCLUDE AREAS OR POPULATION GROUPS THAT DEMONSTRATE A SHORTAGE OF HEALTHCARE SERVICES THIS DESIGNATION PROCESS WAS ORIGINALLY ESTABLISHED TO ASSIST THE GOVERNMENT IN ALLOCATING COMMUNITY HEALTH CENTER GRANT FUNDS TO THE AREAS OF GREATEST NEED MEDICALLY UNDERSERVED AREAS ARE IDENTIFIED BY CALCULATING A COMPOSITE INDEX OF NEED INDICATORS COMPILED AND COMPARED WITH NATIONAL AVERAGES TO DETERMINE AN AREAS LEVEL OF MEDICAL "UNDER SERVICE " MEDICALLY UNDERSERVED POPULATIONS ARE IDENTIFIED BASED ON DOCUMENTATION OF UNUSUAL LOCAL CONDITIONS THAT RESULT IN ACCESS BARRIERS TO MEDICAL SERVICES MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ARE PERMANENTLY SET, AND NO RENEWAL PROCESS IS NECESSARY MISSION HOSPITAL MISSION VIEJO AND MISSION HOSPITAL LAGUNA BEACH ARE NOT LOCATED IN MEDICALLY UNDERSERVED AREAS HOWEVER, COASTAL COMMUNITIES WITHIN THEIR SERVICE AREA, STRETCHING BETWEEN DANA POINT AND SAN CLEMENTE, ARE DESIGNATED AS MEDICALLY UNDERSERVED AREA/MEDICALLY UNDERSERVED POPULATION AREAS, SIGNIFYING THE IMPORTANCE OF MISSION HOSPITAL TO THE COMMUNITY IT SERVES FOR MORE INFORMATION, GO TO THE MISSION HOSPITAL'S FY18 COMMUNITY BENEFIT REPORT POSTED AT WWW.MISSION4HEALTH.COM</p>

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Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH MISSION HOSPITAL PROVIDES VITAL COMMUNITY HEALTH SERVICES AND ADDRESSES THE NEEDS OF THE UNINSURED AND UNDERSINSURED THROUGH ITS FINANCIAL ASSISTANCE PROGRAM PROVIDING FREE AND DISCOUNTED CARE MISSION HOSPITAL IS COMMITTED TO PROMOTING THE HEALTH AND QUALITY OF LIFE IN ITS SURROUNDING COMMUNITY THIS IS DEMONSTRATED THROUGH THE FOLLOWING MECHANISMS 1) A COMMUNITY BENEFIT COMMITTEE THAT HAS COMMUNITY REPRESENTATION AND IS A SUBCOMMITTEE OF THE BOARD OF TRUSTEES 2) OPEN MEDICAL STAFF 3) ROBUST COMMUNITY BENEFIT PROGRAMS THAT ADDRESS COMMUNITY HEALTH NEEDS SEE STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS
SCHEDULE H, PART VI, LINE 6	AFFILIATED HEALTH CARE SYSTEM ON JULY 1, 2016, PROVIDENCE HEALTH & SERVICES (PHS) AND ST JOSEPH HEALTH SYSTEM (SJHS) ENTERED INTO A BUSINESS COMBINATION AGREEMENT BY COMING TOGETHER, PROVIDENCE ST JOSEPH HEALTH SEEKS TO BETTER SERVE ITS COMMUNITIES THROUGH GREATER PATIENT AFFORDABILITY, OUTSTANDING CLINICAL CARE, IMPROVEMENTS TO THE PATIENT EXPERIENCE AND INTRODUCTION OF NEW SERVICES WHERE THEY ARE NEEDED MOST TOGETHER, OUR CAREGIVERS SERVE IN 51 HOSPITALS AND OVER 829 CLINICS ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT CALIFORNIA

Additional Data**Software ID:****Software Version:****EIN:** 95-1643360**Name:** MISSION HOSPITAL REGIONAL MEDICAL CENTER**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities		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
(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											
1	MISSION HOSPITAL REGIONAL MEDICAL CTR 27700 MEDICAL CENTER ROAD MISSION VIEJO, CA 92691 WWW MISSION4HEALTH COM 06000146	X	X					X			

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
<p>SCHEDULE H, PART V, SECTION B, LINE 3E</p>	<p>THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 I NPUT FROM COMMUNITY THE PROCESS OF COLLECTING QUALITATIVE COMMUNITY INPUT TOOK THREE MAIN FORMS BETWEEN JANUARY MAY 2016 COMMUNITY RESIDENT FOCUS GROUPS, A NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP, AND COMMUNITY FORUMS EACH GROUP WAS DESIGNED TO CAPTURE THE COLLECTIVE KNOWLEDGE AND OPINIONS OF PEOPLE WHO LIVE AND WORK IN THE COMMUNITIES SERVED BY MISSIO HOSPITAL WE DEVELOPED A PROTOCOL FOR EACH GROUP TO ENSURE CONSISTENCY ACROSS INDIVIDUAL FOCUS GROUPS, ALTHOUGH THE FACILITATORS HAD SOME DISCRETION ON ASKING FOLLOW-UP QUESTIONS OR PROBES AS THEY SAW FIT INVITATION AND RECRUITMENT PROCEDURES VARIED FOR EACH TYPE OF GROUP APPENDIX OF THE CHNA INCLUDES A FULL REPORT OF THE COMMUNITY INPUT PROCESS AND FINDINGS ALONG WITH DESCRIPTIONS OF THE PARTICIPANTS RESIDENT FOCUS GROUPS FOR COMMUNITY RESIDENT GROUPS, COMMUNITY BENEFIT STAFF, IN COLLABORATION WITH THEIR COMMITTEES AND THE SYSTEM OFFICE, IDENTIFIED GEOGRAPHIC AREAS WHERE DATA SUGGESTED THERE WERE SIGNIFICANT HEALTH, PHYSICAL ENVIRONMENT, AND SOCIOECONOMIC CONCERNS THIS PROCESS ALSO IDENTIFIED THE LANGUAGE NEEDS OF THE COMMUNITY, WHICH DETERMINED THE LANGUAGE IN WHICH EACH FOCUS GROUP WAS CONDUCTED COMMUNITY BENEFIT STAFF THEN PARTNERED WITH COMMUNITY-BASED ORGANIZATIONS THAT SERVE THOSE AREAS TO RECRUIT FOR AND HOST THE FOCUS GROUPS PARTICIPANTS WERE PROMISED A SMALL INCENTIVE FOR THEIR TIME TWO CONSULTANTS STAFFED EACH FOCUS GROUP, SERVING AS FACILITATORS AND NOTE TAKERS THESE CONSULTANTS WERE NOT DIRECTLY AFFILIATED WITH THE MINISTRY TO ENSURE CANDOR FROM THE PARTICIPANTS 55 HISPANIC RESIDENTS PARTICIPATED IN 4 FOCUS GROUPS, WITH OVER 75% REPRESENTING INCOME LEVELS BELOW \$75,000 ANNUALLY THE MAJORITY OF RESIDENTS WERE BETWEEN THE AGES OF 18 64 YEARS OF AGE NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP FOR THE NONPROFIT AND GOVERNMENT STAKEHOLDER FOCUS GROUP, COMMUNITY BENEFIT STAFF DEVELOPED A LIST OF LEADERS FROM ORGANIZATIONS THAT SERVE DIVERSE CONSTITUENCIES WITHIN THE HOSPITALS SERVICE AREA MINISTRY STAFF SOUGHT TO INVITE ORGANIZATIONS WITH WHICH THEY HAD EXISTING RELATIONSHIPS, BUT ALSO USED THE FOCUS GROUP AS AN OPPORTUNITY TO BUILD NEW RELATIONSHIPS WITH STAKEHOLDERS PARTICIPANTS WERE NOT GIVEN A MONETARY INCENTIVE FOR ATTENDANCE AS WITH THE RESIDENT FOCUS GROUPS, THIS GROUP WAS FACILITATED BY OUTSIDE CONSULTANTS WITHOUT A DIRECT LINK TO ST JOSEPH HEALTH RESIDENT COMMUNITY FORUMS RECRUITMENT FOR THE COMMUNITY RESIDENT FORUMS WAS MUCH BROADER TO ENCOURAGE AS MANY PEOPLE AS POSSIBLE TO ATTEND THE SESSION COMMUNITY BENEFIT STAFF PUBLICIZED THE EVENT THROUGH FLYERS AND EMAILS USING THEIR EXISTING OUTREACH NETWORKS, AND ALSO ASKED THEIR PARTNER ORGANIZATIONS TO INVITE AND RECRUIT PARTICIPANTS NO FORMAL INVITATION LIST WAS USED FOR THE FORUMS AND ANYONE WHO WISHED TO ATTEND WAS WELCOME</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
SCHEDULE H, PART V, SECTION B, LINE 3E	D THE FORUMS WERE CONDUCTED BY AN OUTSIDE CONSULTANT IN ENGLISH, WITH SIMULTANEOUS SPANISH LANGUAGE TRANSLATION FOR ANYONE WHO REQUESTED IT THE COMMUNITY FORUMS CONSISTED PRIMARILY OF HISPANIC RESIDENTS WHOSE HOUSEHOLD INCOME WAS LESS THAN \$75,000 ANNUALLY WHILE THE FOCUS GROUPS FOLLOWED A SIMILAR PROTOCOL TO EACH OTHER IN WHICH FIVE TO SIX QUESTIONS WERE ASKED OF THE GROUP, THE FORUMS FOLLOWED A DIFFERENT PROCESS THE LEAD FACILITATOR SHARED THE HEALTH NEEDS THAT HAD EMERGED FROM THE CHNA PROCESS SO FAR AND ASKED THE PARTICIPANTS TO COMMENT ON THEM AND ADD ANY OTHER CONCERNS ONCE THE DISCUSSION WAS COMPLETE, THE PARTICIPANTS ENGAGED IN A CUMULATIVE VOTING PROCESS USING DOTS TO INDICATE THEIR GREATEST CONCERNS THROUGH THIS DESIGN, THE FORUMS SERVED AS SOMETHING OF A "CAPSTONE" TO THE COMMUNITY INPUT PROCESS

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 7A	THE COMMUNITY HEALTH NEEDS ASSESSMENT IS AVAILABLE TO THE PUBLIC USING THE FOLLOWING URL HTTPS //WWW STJHS ORG/OUR-PROGRAMS/COMMUNITY-PARTNERSHIPS/COMMUNITY-BENEFIT/REPORTS-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
SCHEDULE H, PART V, SECTION B, LINE 10A	THE IMPLEMENTATION STRATEGY IS AVAILABLE TO THE PUBLIC USING THE FOLLOWING URL HTTPS //WWW MISSION4HEALTH COM/SUPPORT-SERVICES/COMMUNITY-BENEFIT/

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	<p>IN RESPONSE TO IDENTIFIED UNMET NEEDS IN THE 2016/17 COMMUNITY HEALTH NEEDS ASSESSMENT, MISSION HOSPITAL WILL FOCUS ON THREE INITIATIVES FOR THE BROADER AND UNDERSERVED MEMBERS OF OUR COMMUNITIES 1) MENTAL HEALTH 2) IMMIGRANT SUPPORT & SOLIDARITY 3) ECONOMIC STABILITY MENTAL HEALTH WILL BE ADDRESSED THROUGH BOTH FAMILY RESOURCE CENTERS BY UTILIZING THE PHQ -9 AS A TOOL TO ASSESS PARTICIPANTS DEPRESSION AND WORKING ON LOWERING THE SCORE IT WILL ALSO BE ADDRESSED THROUGH THE EACH MIND MATTERS CAMPAIGN AND BY COLLABORATING WITH SCHOOLS BOTH IMMIGRANT SUPPORT AND SOLIDARITY AND ECONOMIC STABILITY WILL BE ADDRESSED BY CONNECTING PARTICIPANTS TO A VARIETY OF SOCIAL SERVICES WE WILL ALSO ADDRESS ECONOMIC STABILITY BY OFFERING PROGRAMS AT BOTH FAMILY RESOURCE CENTERS NEEDS BEYOND THE HOSPITAL'S SERVICE PROGRAM NO HOSPITAL FACILITY CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY WE ARE COMMITTED TO CONTINUE OUR MISSION THROUGH COMMUNITY BENEFIT PROGRAMS AND BY FUNDING OTHER NON-PROFITS THROUGH OUR CARE FOR THE POOR PROGRAM MANAGED BY THE MISSION HOSPITAL FURTHERMORE, MISSION HOSPITAL WILL ENDORSE LOCAL NON-PROFIT ORGANIZATION PARTNERS TO APPLY FOR FUNDING THROUGH THE ST JOSEPH HEALTH COMMUNITY PARTNERSHIP FUND ORGANIZATIONS THAT RECEIVE FUNDING PROVIDE SPECIFIC SERVICES AND RESOURCES TO MEET THE IDENTIFIED NEEDS OF UNDERSERVED COMMUNITIES THROUGHOUT MISSION HOSPITAL SERVICE AREAS THE FOLLOWING COMMUNITY HEALTH NEEDS IDENTIFIED IN THE MINISTRY CHNA WILL NOT BE ADDRESSED AND AN EXPLANATION IS PROVIDED BELOW ACCESS TO RESOURCES MISSION HOSPITAL WILL CONTINUE TO FINANCIALLY SUPPORT CAMINO HEALTH CENTER TO PROVIDE PRIMARY CARE SERVICES TO THE LOW-INCOME RESIDENTS OF SOUTH ORANGE COUNTY AND DEPENDING ON THEIR EXPERTISE FOR SERVICE PROVISION WE WILL MAINTAIN MANY OF THE PROGRAMS CURRENTLY IN PLACE THROUGH ITS COMMUNITY BENEFIT PROGRAM TO CONTINUE PROVIDING ACCESS TO CARE SUCH AS HEALTH INSURANCE ENROLLMENT, PREVENTIVE SCREENINGS, EDUCATIONAL CLASSES AND MEDICAL TRANSPORTATION SERVICES DENTAL CARE MISSION HOSPITAL DOES NOT DIRECTLY ADDRESS DENTAL NEEDS AS THIS IS OUTSIDE OUR SCOPE OF EXPERTISE, HOWEVER, WE WILL WORK IN COLLABORATION WITH CAMINO HEALTH CENTER DENTAL SERVICES, LINKING CLIENTS OF THE FAMILY RESOURCE CENTERS TO CAMINO SERVICES DIABETES CAMINO HEALTH CENTER IS THE PRIMARY MEDICAL PROVIDER FOR LOW-INCOME RESIDENTS AND HAS IDENTIFIED THIS CONDITION AS ONE OF THEIR 16 AREAS OF CLINICAL FOCUS WE WILL CONTINUE TO WORK COLLABORATIVELY WITH CAMINO TO CONNECT RESIDENTS IN NEED OF MEDICAL SERVICES WITH THEIR CENTER FOOD AND NUTRITION GIVEN OTHER PRIORITIES RAISED DURING OUR MOST RECENT NEEDS ASSESSMENT, THIS ISSUE BECAME A LOWER PRIORITY COMPARED TO OTHERS HOMELESSNESS MISSION HOSPITAL DOES NOT HAVE THE EXPERTISE TO DIRECTLY ADDRESS HOMELESSNESS, HOWEVER WE PARTNER WITH SEVERAL ORGANIZATIONS THAT SERVE THE HOMELESS, INCLUDING FAMILY ASSISTANCE MINISTRY, FRIENDSHIP SHELTER AND THE ILLUMINATION FOUNDATION HOUSING CONCERNS WE</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
SCHEDULE H, PART V, SECTION B, LINE 11	<p>HAVE CONCENTRATED ON AFFORDABLE HOMES FOR MANY YEARS IN SOUTH ORANGE COUNTY RESIDENTS SHARE THAT HOUSING COSTS REMAIN UNAFFORDABLE WITH THE RECENT CHANGES IN REDEVELOPMENT FUNDS AND THE LACK OF LOCAL RESOURCES AND COLLABORATIVE EFFORTS NEEDED TO FOCUS ON THIS ISSUE, THE COMMITTEE FELT OUR MINISTRY RESOURCES COULD BE BETTER UTILIZED IN THE OTHER AREAS IDENTIFIED WE WILL CONTINUE TO WORK WITH AGENCIES WHO PROVIDE HOUSING ASSISTANCE SUCH AS ILLUMINATION FOUNDATION, FRIENDSHIP SHELTER, AND FAMILY ASSISTANCE MINISTRY INSURANCE AND COST OF CARE GIVEN OTHER PRIORITIES RAISED DURING OUR MOST RECENT NEEDS ASSESSMENT, THIS ISSUE BECAME A LOWER PRIORITY COMPARED TO OTHERS LACK OF EDUCATION GIVEN OTHER PRIORITIES RAISED DURING OUR MOST RECENT NEEDS ASSESSMENT, THIS ISSUE BECAME A LOWER PRIORITY COMPARED TO OTHERS LACK OF EXERCISE GIVEN OTHER PRIORITIES RAISED DURING OUR MOST RECENT NEEDS ASSESSMENT, THIS ISSUE BECAME A LOWER PRIORITY COMPARED TO OTHERS LANGUAGE AND CULTURAL BARRIERS MISSION HOSPITAL MAY CONSIDER HOW TO ADDRESS BARRIERS RELATED TO LANGUAGE AND CULTURE IN THE IMMIGRATION AND ECONOMIC STABILITY INITIATIVES OBESITY GIVEN OTHER PRIORITIES RAISED DURING OUR MOST RECENT NEEDS ASSESSMENT, THIS ISSUE BECAME A LOWER PRIORITY COMPARE D TO OTHERS</p>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 13H	OTHER BASIS FOR CALCULATING AMOUNT CHARGED TO PATIENTS THE ORGANIZATION RECOGNIZES THAT A PORTION OF THE UNINSURED OR UNDER-INSURED PATIENT POPULATION MAY NOT ENGAGE IN THE TRADITIONAL FINANCIAL ASSISTANCE APPLICATION PROCESS THEREFORE, THE ORGANIZATION ALSO USES AN AUTOMATED PREDICTIVE SCORING TOOL TO IDENTIFY AND QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE FOR ACCOUNTS THAT ARE INITIALLY CLASSIFIED AS BAD DEBT

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16A	HTTP //WWW MISSION4HEALTH COM/PATIENTS-VISITORS/FOR-PATIENTS/PATIENT-FINAN CIAL-ASSISTANCE ASPX

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16B	HTTP //WWW MISSION4HEALTH COM/PATIENTS-VISITORS/FOR-PATIENTS/PATIENT-FINAN CIAL-ASSISTANCE ASPX

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16C	HTTP //WWW MISSION4HEALTH COM/PATIENTS-VISITORS/FOR-PATIENTS/PATIENT-FINAN CIAL-ASSISTANCE ASPX

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

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Name of the organization MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number 95-1643360

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance...
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

Table with 8 columns: (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. Rows 1-12.

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 17
3 Enter total number of other organizations listed in the line 1 table 2

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
See Additional Data Table					
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
SCHEDULE I, PART I, LINE 2	DESCR OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS MISSION HOSPITAL HAS AN AFFILIATION AGREEMENT WITH CAMINO HEALTH CENTER THAT CALLS FOR THE STEERING COMMITTEE, WHICH INCLUDES AN OFFICER FROM THE HOSPITAL, TO PROVIDE OVERSIGHT OF FUNDS GRANTED TO CAMINO BY THE HOSPITAL THE CARE FOR THE POOR FUNDS GIVEN TO THE ST JOSEPH HEALTH SYSTEM FOUNDATION IS GOVERNED BY THE HEALTH SYSTEM FOUNDATION THE DISBURSEMENT OF THE FUNDS FOLLOWS SPECIFICS SET FORTH BY THE HEALTH SYSTEM POLICY "CARE FOR THE POOR PROGRAM ACCOUNTING " THERE IS NO MONITORING DONE IN THE OTHER GRANTS

Additional Data

Software ID:
Software Version:
EIN: 95-1643360
Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN HEART ASSOCIATION PO BOX 50085 PRESCOTT, CA 863045085	13-5613797	501(c)(3)	10,000				PROGRAM SUPPORT
BOYS AND GIRLS CLUB OF LAGUNA BEACH 1085 LAGUNA CANYON RD LAGUNA BEACH, CA 92651	95-1878822	501(c)(3)	100,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CAMINO HEALTH CENTER 30300 CAMINO CAPISTRANO SAN JUAN CAPISTRANO, CA 92675	33-0574214	501(c)(3)	1,922,727				PROGRAM SUPPORT
CHILD GUIDANCE CENTER 525 CABRILLO PARK DRIVE 300 SAN ANA, CA 92701	95-2546170	501(c)(3)	81,280				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHOC CHILDREN FOUNDATION 1201 WEST LA VETA AVE ORANGE, CA 92868	95-6097416	501(c)(3)	15,000				PROGRAM SUPPORT
COALITION FOR HUMANE IMMIGRATION RIGHTS 2533 W 3RD STREET SUITE 101 LOS ANGELES, CA 90004	95-4421521	501(c)(3)	100,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FRIENDSHIP SHELTER PO BOX 4252 LAGUNA BEACH, CA 92652	33-0218404	501(C)(3)	102,000				PROGRAM SUPPORT
SACRED HEART RETREAT APOSTOLATE 2927 S GREENVILLE STREET SANTA ANA, CA 92704	43-2005333	501(c)(3)	6,500				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LAGUNA ART MUSEUM 307 CLIFF DRIVE LAGUNA BEACH, CA 92651	33-0717157	501(c)(3)	7,500				PROGRAM SUPPORT
LAGUNA BEACH COMMUNITY CLINIC 362 THIRD ST LAGUNA BEACH, CA 92651	95-2637633	501(c)(3)	262,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LEGAL AID SOCIETY OF ORANGE COUNTY 2101 N TUSTIN AVE SAN ANA, CA 92705	95-1994337	501(c)(3)	83,479				PROGRAM SUPPORT
OC HUMAN RELATIONS 1801 E EDINGER AVE SUITE 115 SAN ANTA, CA 92705	33-0438086	501(c)(3)	50,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
RANCHO MISSION VIEJO RODEO PO BOX 9 SAN JUAN CAPISTRANO, CA 92693	33-0954148		10,000				SPONSORSHIPS
ST JOSEPH HEALTH SYSTEM FOUNDATION 1801 LIND AVE SW RENTON, WA 980579016	33-0143024	501(c)(3)	5,742,700				CARE FOR THE POOR

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
THE ILLUMINATION FOUNDATION 2691 RICHTER AVE STE 107 IRVINE, CA 92606	71-1047686	501(c)(3)	14,950				PROGRAM SUPPORT
LAGUNA HILLS HEALTH AND REHABILITATION 24452 HEALTH CENTER DR LAGUNA HILLS, CA 92653	56-2384926		9,757				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ST TIMOTHY CATHOLIC CHURCH 29102 CROWN VALLEY PKWY LAG NIG CA LAGUNA NIGUEL, CA 92677	95-3656905	501(c)(3)		15,075		FOOD DONATION	PROGRAM SUPPORT
MISSION BASILICA SAN JUAN CAPISTRANO 31520 CAM CAPISTRANO CAPISTRANO, CA 92675	95-1904079	501(c)(3)		24,898		FOOD DONATION	PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WELCOME INN 30791 MARBELLA VIS SAN JUAN CAPISTRANO, CA 92675	61-1503624	501(c)(3)		15,789		FOOD DONATION	PROGRAM SUPPORT

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
HELPING HANDS-PAID TO PATIENTS	231	17,367			
TRANSPORTATION ASSISTANCE	21	13,994			
BENEFITS PROVIDED TO COMMUNITY	543	7,382			
COMMUNITY HEALTH INITIATIVE OF OC		250			
KIDS CONNECTED		2,500			

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
WELLNESS AND PREVENTION CENTER		1,000			
VARIOUS NON-CASH DONATIONS	2898		8,088	FMV	TURKEYS
ST TIMOTHY CATHOLIC CHURCH	1	100			
FUNERALS	9	12,506			
ST JOSEPH HOME CARE SERVICES	25	3,767			

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number
95-1643360

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"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account		
<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III		
<input type="checkbox"/> Compensation committee <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations		
<input type="checkbox"/> Written employment contract <input type="checkbox"/> Compensation survey or study <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? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III	4c	No
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? If "Yes," on line 5a or 5b, describe in Part III	5b	No
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? If "Yes," on line 6a or 6b, describe in Part III	6b	No
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	Yes
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	

Part III Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 3	THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER IS PAID BY ITS TAX EXEMPT PARENT, ST JOSEPH HEALTH SYSTEM, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION. SEE SCHEDULE O, PART VI, LINE 15A FOR THE PROCESS USED BY ST JOSEPH HEALTH SYSTEM.

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4A	THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS FOR EITHER PART OR ALL OF THE YEAR KENNETH MCFARLAND - \$295,676 LINDA JOHNSON - \$112,375

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4B	NONQUALIFIED RETIREMENT PLAN ENTITIES WITHIN THE PSJH SYSTEM SPONSOR NON-QUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLANS FOR CERTAIN EXECUTIVES THE PLANS PROVIDE FOR EMPLOYER CONTRIBUTIONS BASED ON A PERCENTAGE OF EXECUTIVE BASE SALARY AND, DEPENDING ON THE PLAN, ARE SUBJECT TO EITHER A THREE YEAR, AGE 59 OR A FIVE YEAR, AGE 65 VESTING SCHEDULE EXECUTIVES PREVIOUSLY PARTICIPATED IN ANOTHER NON-QUALIFIED DEFERRED COMPENSATION PLAN THAT WAS FROZEN EFFECTIVE DECEMBER 2007, AFTER WHICH TIME NO FURTHER CONTRIBUTIONS WERE PERMITTED THIS FROZEN PLAN WILL CEASE TO EXIST ONCE ALL BENEFITS HAVE BEEN DISTRIBUTED IN ACCORDANCE WITH PROVISIONS OF THE PLAN CERTAIN EXECUTIVES PARTICIPATE IN A NON-QUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN PROVIDED BY A RELATED ENTITY

Return Reference	Explanation
SCHEDULE J, PART I, LINE 7	NON-FIXED PAYMENTS A PORTION OF EXECUTIVE SALARIES ARE PLACED AT-RISK AND ARE NOT AWARDED UNLESS SPECIFIC STRATEGIC OBJECTIVE TARGETS ARE MET OR EXCEEDED THE AT-RISK EXECUTIVE PLAN IS DESIGNED TO MOTIVATE AND REWARD EXECUTIVES FOR TEAM PERFORMANCE THAT SUPPORTS THE STRATEGIC GOALS AND SUCCESSFUL PERFORMANCE OF ST JOSEPH HEALTH SYSTEM AT-RISK PAY IS AWARDED TO ASSISTANT VICE PRESIDENTS, VICE PRESIDENTS, SENIOR VICE PRESIDENTS, EXECUTIVE VICE PRESIDENTS, AND THE CHIEF EXECUTIVE OFFICER BASED ON ACHIEVING OR SURPASSING SPECIFIC GOALS THAT ARE PREDETERMINED BY THE BOARD OF TRUSTEES PRIOR TO THE BEGINNING OF THE FISCAL YEAR THE GOALS INCLUDE STRATEGIC OBJECTIVES AS WELL AS FISCAL STEWARDSHIP EACH OF THESE FACTORS IS TAKEN INTO CONSIDERATION WHEN DETERMINING THE PERCENTAGE OF AT-RISK PAY



Additional Data

Software ID:
Software Version:
EIN: 95-1643360
Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
MICHAEL MARINO DO SVP, CHIEF MED INFO OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	522,502	74,228	101,954	19,250	33,589	751,523	0
TAREK SALAWAY CHIEF EXECUTIVE	(i)	0	0	0	0	0	0	0
	(ii)	440,878	193,962	5,445	9,875	14,075	664,235	0
TARA COWELL VP/ASSOC GENERAL COUNSEL/SEC	(i)	0	0	0	0	0	0	0
	(ii)	314,661	43,479	41,337	22,000	42,180	463,657	0
EILEEN HAUBL CHIEF FINANCIAL OFFICER	(i)	344,360	53,274	58,186	23,888	26,968	506,676	0
	(ii)	0	0	0	0	0	0	0
MARK JABLONSKI CHIEF MISSION INTEGRATION	(i)	0	0	0	0	0	0	0
	(ii)	260,438	61,515	36,195	24,750	20,950	403,848	0
MICHAEL BECK CHIEF ADMIN OFFICER - LB	(i)	265,246	42,146	36,637	24,750	39,642	408,421	0
	(ii)	0	0	0	0	0	0	0
JENNIFER CORD CHIEF NURSING OFFICER	(i)	282,920	0	69,356	0	29,730	382,006	0
	(ii)	0	0	0	0	0	0	0
WENDY FERRO-GRANT DIRECTOR, SURGICAL SERVICES	(i)	186,170	17,384	3,755	17,394	28,361	253,064	0
	(ii)	0	0	0	0	0	0	0
DEANNE NIEDZIELA DIRECTOR, NURSING	(i)	199,774	34,362	5,833	18,699	26,401	285,069	0
	(ii)	0	0	0	0	0	0	0
TERRENCE WOOTEN VP, INTEGRATED OPERATIONS	(i)	209,050	31,931	22,220	18,670	10,041	291,912	0
	(ii)	0	0	0	0	0	0	0
ANNABELLE BRAUN DIRECTOR, NURSING	(i)	232,688	21,427	2,688	9,487	26,239	292,529	0
	(ii)	0	0	0	0	0	0	0
LAUREN DWINELL EXEC DIR, CHIEF OPS-PAT FLOW	(i)	253,506	39,967	3,444	7,688	36,297	340,902	0
	(ii)	0	0	0	0	0	0	0
TERRI FOX-COVERT DIRECTOR, HUMAN RESOURCES	(i)	238,491	37,317	25,896	22,008	29,204	352,916	0
	(ii)	0	0	0	0	0	0	0
EVELYN SCHLOSSER EXEC DIR, QLTY & PAT SAFETY	(i)	217,827	33,597	3,488	3,572	22,760	281,244	0
	(ii)	0	0	0	0	0	0	0
LINDA SIEGLEN CHIEF MEDICAL OFFICER	(i)	388,539	60,383	42,771	11,000	29,808	532,501	0
	(ii)	0	0	0	0	0	0	0
LINDA JOHNSON FORMER KEY EMPLOYEE	(i)	0	0	112,375	0	0	112,375	0
	(ii)	0	0	0	0	0	0	0
KENNETH MCFARLAND FORMER OFFICER & TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	0	0	295,676	0	0	295,676	0

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No 1545-0047

2018

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
 ▶ **Attach to Form 990.**
 ▶ **Go to www.irs.gov/Form990 for the latest information.**

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number
95-1643360

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded	X	28	2,075,979	COST / SELLING PRICE
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (GIFTS IN KIND)	X	502	300,370	SEE PART II
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

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

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

Part II Supplemental Information.

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

Return Reference	Explanation
SCHEDULE M, PART I, COLUMN (B)	AMOUNTS IN THIS COLUMN WERE BASED ON THE NUMBER OF CONTRIBUTIONS
SCHEDULE M, PART I, LINE 25	GIFTS IN KIND WITH AN ESTIMATED VALUE OF \$300,370 WERE RECEIVED DURING THE YEAR AND WERE NOT INCLUDED ON THE BOOKS VALUE WAS ESTIMATED FROM DONOR'S APPROXIMATION OF VALUE REVENUE FROM THE SALE OF THESE ITEMS IS INCLUDED IN FUNDRAISING REVENUE ON FORM 990, PART VIII, LINE 8A

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

2018**Open to Public
Inspection**

Department of the Treasury

Name of the organization

MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number

95-1643360

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>PROVIDENCE ST JOSEPH HEALTH SYSTEM ON JULY 1, 2016, PROVIDENCE HEALTH AND SERVICES (PHS) AND ST JOSEPH HEALTH SYSTEM (SJHS) FORMED A NEW ORGANIZATION, PROVIDENCE ST JOSEPH HEALTH, WITH THE GOAL OF IMPROVING THE HEALTH OF THE COMMUNITIES IT SERVES, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE. BY COMING TOGETHER, PROVIDENCE ST JOSEPH HEALTH HAS THE POTENTIAL TO SEEK GREATER AFFORDABILITY, ACHIEVE OUTSTANDING AND RELIABLE CLINICAL CARE, IMPROVE THE PATIENT EXPERIENCE AND INTRODUCE NEW SERVICES WHERE THEY ARE NEEDED MOST TOGETHER, OUR CAREGIVERS SERVE IN 51 HOSPITALS AND 829 CLINICS ACROSS ALASKA, CALIFORNIA, MONTANA, NEW MEXICO, OREGON, TEXAS AND WASHINGTON. THE FOUNDERS OF BOTH ORGANIZATIONS WERE COURAGEOUS WOMEN AHEAD OF THEIR TIME. THE SISTERS OF PROVIDENCE AND THE SISTERS OF ST JOSEPH OF ORANGE BROUGHT HEALTH CARE AND OTHER SOCIAL SERVICES TO THE AMERICAN WEST WHEN IT WAS STILL A RUGGED FRONTIER. NOW, AS WE FACE A DIFFERENT LANDSCAPE, A CHANGING HEALTH CARE ENVIRONMENT, WE DRAW UPON THEIR PIONEERING AND COMPASSIONATE SPIRIT TO PLAN FOR THE NEXT CENTURY OF HEALTH CARE. PROVIDENCE HEALTH & SERVICES IN 1856, MOTHER JOSEPH AND FOUR SISTERS OF PROVIDENCE ESTABLISHED HOSPITALS, SCHOOLS AND ORPHANAGES ACROSS THE NORTHWEST. OVER THE YEARS, OTHER CATHOLIC SISTERS TRANSFERRED SPONSORSHIP OF THEIR MINISTRIES TO PROVIDENCE, INCLUDING THE LITTLE COMPANY OF MARY, DOMINICANS AND CHARITY OF LEAVENWORTH. RECENTLY, SWEDISH HEALTH SERVICES, KADLEC REGIONAL MEDICAL CENTER AND PACIFIC MEDICAL CENTERS HAVE JOINED PROVIDENCE AS SECULAR PARTNERS WITH A COMMON COMMITMENT TO SERVING ALL MEMBERS OF THE COMMUNITY. TODAY, PROVIDENCE SERVES ALASKA, CALIFORNIA, MONTANA, OREGON AND WASHINGTON. ST JOSEPH HEALTH IN 1912, A SMALL GROUP OF SISTERS OF ST JOSEPH LANDED ON THE RUGGED SHORES OF EUREKA, CALIF, TO PROVIDE EDUCATION AND HEALTH CARE. THE MINISTRY LATER ESTABLISHED ROOTS IN ORANGE, CALIF, AND EXPANDED TO SERVE SOUTHERN CALIFORNIA, THE CALIFORNIA HIGH DESERT, NORTHERN CALIFORNIA AND TEXAS. THE HEALTH SYSTEM ESTABLISHED MANY KEY PARTNERSHIPS, INCLUDING A MERGER BETWEEN LUBBOCK METHODIST HOSPITAL SYSTEM AND ST MARY HOSPITAL TO FORM COVENANT HEALTH IN LUBBOCK TEXAS. RECENTLY, AN AFFILIATION WAS ESTABLISHED WITH HOAG HEALTH TO INCREASE ACCESS TO SERVICES IN ORANGE COUNTY, CALIF. REALIZING OUR MISSION. MISSION HOSPITAL REGIONAL MEDICAL CENTER IS PART OF NEWLY FORMED PROVIDENCE ST JOSEPH HEALTH. MISSION HOSPITAL IS AN ACUTE-CARE HOSPITAL FOUNDED IN 1971, LOCATED AT MISSION VIEJO AND LAGUNA BEACH, CALIFORNIA. THE FACILITY HAS 552 LICENSED BEDS AND A STAFF OF MORE THAN 2,600 COMMITTED CARE GIVERS. MAJOR PROGRAMS AND SERVICES INCLUDE CARDIAC CARE, CRITICAL CARE, DIAGNOSTIC IMAGING, EMERGENCY MEDICINE AND OBSTETRICS. PROGRAM SERVICE ACCOMPLISHMENTS: FAMILY RESOURCE CENTERS (FRCS). MISSION HOSPITAL OPERATES TWO FAMILY RESOURCE CENTERS TO PROVIDE ACCESS TO SOCIAL SERVICES FOR COMMUNITY MEMBERS WITH LIMITED RESOURCES. THESE CENTERS ARE LIFELINES FOR MANY PEOPLE IN THE COMMUNITY.</p>

990 Schedule O, Organizational Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>AND SERVE A MUCH-NEEDED LINKAGE TO COMMUNITY PROGRAMS ESTABLISHED IN 1996, THE SOUTH ORANGE COUNTY FAMILY RESOURCE CENTER (SOCFRC) IS LOCATED IN LAKE FOREST, CA. OUR SECOND LOCATION IN SAN JUAN CAPISTRANO OPENED IN 2001. THE TWO FRCS PROVIDE MENTAL HEALTH SERVICES, HEALTH INSURANCE ACCESS, PARENTING SUPPORT & EDUCATION, CHILDREN'S CLASSES, FAMILY ADVOCACY, INFORMATION & RESOURCE SERVICES, PERSONAL EMPOWERMENT PROGRAMS, FINANCIAL COUNSELING, AND LIMITED EMERGENCY ASSISTANCE. IN JANUARY 2017, THE SOUTH ORANGE COUNTY FAMILY RESOURCE CENTER RELOCATED TO A NEW 20,000 SQUARE FOOT BUILDING THAT HOUSES BOTH THE FRC AND A 3RD LOCATION FOR CAMINO HEALTH CENTER, A FEDERALLY QUALIFIED HEALTH CENTER (FQHC). BOTH FRCS HAD A COMBINED 28,036 ENCOUNTERS THAT SERVED 3,354 UNIQUE PERSONS. BOTH CENTERS CONTINUE AS DESIGNATED FRCS WITH THE FAMILIES AND COMMUNITIES TOGETHER (FACT) CONTRACT FROM THE COUNTY OF ORANGE, CHILDREN AND FAMILIES COMMISSION. CAMINO HEALTH CENTER MISSION HOSPITAL CONTRIBUTED \$1,922,727 DOLLARS IN 2018 TO SUPPORT THE EFFORTS OF CAMINO HEALTH CENTER. MISSION HOSPITAL IS THE SOLE CORPORATE SPONSOR FOR THIS FEDERALLY QUALIFIED HEALTH CENTER, PROVIDING AFFORDABLE, QUALITY PRIMARY MEDICAL, BEHAVIORAL HEALTH, DENTAL CARE, SPECIALTY CARE AND WIC NUTRITION SERVICES FOR THE LOW-INCOME POPULATION OF SOUTH ORANGE COUNTY. THE CENTER ACCOMMODATED 50,489 VISITS AT ITS THREE FIXED CLINIC SITE LOCATIONS IN LAKE FOREST, SAN CLEMENTE, AND SAN JUAN CAPISTRANO. IN THE EARLIER PART OF 2017, THREE NEW SPECIALTY CARE SERVICES WERE ADDED IN TO THE HEALTH CENTERS SCOPE OF SERVICES: NEPHROLOGY, NEUROLOGY, AND PULMONOLOGY. CAMINO COMPLETED THE BUILDOUT OF THE NEW 10,000 SQUARE FOOT HEALTH CENTER LOCATION IN LAKE FOREST, COMPLETE WITH 16 EXAM ROOMS, FIVE DENTAL OPERATORIES, AND A WIC SUITE. THIS LOCATION IS CO-LOCATED WITH MISSION HOSPITALS FAMILY RESOURCE CENTER AND CREATES WRAP-AROUND SERVICES FOR COMMUNITY MEMBERS. COMMUNITY GRANTS: RECOGNIZING THAT LOCAL NON-PROFITS CONDUCT WORK THAT COMPLEMENTS MISSION HOSPITAL COMMUNITY BENEFIT PRIORITY AREAS, A COMPETITIVE, INVITATION-ONLY COMMUNITY GRANT PROGRAM WAS IMPLEMENTED TO HELP FURTHER ADDRESS IDENTIFIED NEEDS IN THE COMMUNITY AND CREATE STRONGER PARTNERSHIPS WITH LOCAL PROVIDERS. IN 2018, MISSION HOSPITAL AWARDED OVER \$511,759 IN GRANTS TO SIX (6) AGENCIES THAT SERVE SOUTH ORANGE COUNTY LOW-INCOME RESIDENTS: 1. CHILD GUIDANCE CENTER 2. FRIENDSHIP SHELTER 3. LEGAL AID SOCIETY OF ORANGE COUNTY 4. OC HUMAN RELATIONS 5. BOYS AND GIRLS CLUB OF LAGUNA BEACH 6. COALITION FOR HUMAN IMMIGRATION RIGHTS. THESE AGENCIES WILL BE WORKING IN 2018 TO IMPLEMENT THEIR PROGRAMS TO IMPROVE THE LIVES OF THE VULNERABLE. MENTAL HEALTH INITIATIVE: THROUGH AN INTEGRATED NETWORK OF CARE, MISSION HOSPITAL AIMS TO IMPROVE MENTAL HEALTH SERVICES FOR THE VULNERABLE POPULATION IN SOUTH ORANGE COUNTY THROUGH PREVENTION AND BY ENSURING ACCESS TO APPROPRIATE, QUALITY MENTAL HEALTH SERVICES. MISSION HOSPITAL IS WORKING TO IMPROVE THE MENTAL HEALTH OF THE MO.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	ST VULNERABLE MEMBERS OF SOUTH ORANGE COUNTY IN 2018 MISSION DEDICATED OVER \$845,363 IN RESOURCES FOR THE IMPLEMENTATION OF OUR MENTAL HEALTH INITIATIVE THE STIGMA REDUCTION CAMPAIGN IN PARTNERSHIP WITH CALIFORNIA'S EACH MIND MATTERS MOVEMENT CONTINUED THROUGH 2018 THIS LOCALLY ACTIVATED CAMPAIGN, PROMISE TO TALK, INCLUDED OUTREACH, CLOSE COLLABORATION WITH COMMUNITY PARTNERS, VIDEO PUBLIC SERVICE ANNOUNCEMENTS, BUS ADVERTISING, ENGAGING BILINGUAL LITERATURE AND SOCIAL MEDIA THE CAMPAIGN RESULTED IN 750 PROMISES TO TALK ABOUT MENTAL HEALTH, 4,586 ENCOUNTERS AND 6.8 MILLION IMPRESSIONS THROUGH SOCIAL MEDIA HITS AND COMMUNITY PROMOTIONS AND EVENTS FOR MORE INFORMATION ABOUT MISSION HOSPITAL, PLEASE VISIT MISSION4HEALTH.COM FOR MORE INFORMATION ABOUT PROVIDENCE ST JOSEPH HEALTH, PLEASE VISIT HTTPS://WWW.PSJHEALTH.ORG/ FOR MORE INFORMATION ABOUT ST JOSEPH HEALTH, PLEASE VISIT WWW.STJHS.ORG

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART V, LINE 1A	ST JOSEPH HEALTH SYSTEM (SJHS) PAYS ALL VENDORS FOR MISSION HOSPITAL FROM ITS SHARED SERVICES SJHS ISSUES FORM 1099-MISC UNDER ITS TAX ID NUMBER AND COMPLIES WITH BACKUP WITHHOLDING RULES FOR REPORTABLE PAYMENTS TO VENDORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 6	CLASSES OF MEMBERS OR STOCKHOLDERS ST JOSEPH HEALTH SYSTEM AND COVENANT HEALTH NETWORK, INC ARE THE CORPORATE MEMBERS OF MISSION HOSPITAL REGIONAL MEDICAL CENTER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 7A	CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS MISSION HOSPITAL HAS A TIERED GOVERNANCE IN WHICH THE CORPORATE MEMBERS RESERVE THE RIGHT TO APPOINT TRUSTEES TO THE MISSION HOSPITAL BOARD ALL TRUSTEE APPOINTMENTS THAT COME FROM THE MISSION HOSPITAL BOARD AS NOMINATIONS MUST BE APPROVED BY ST JOSEPH HEALTH SYSTEM, AS THE CORPORATE MEMBER AND THE ST JOSEPH HEALTH MINISTRY, AS THE ORGANIZATIONAL SPONSOR THE TRUSTEES ARE THEN APPROVED AND ELECTED BY THE COVENANT HEALTH NETWORK, INC BOARD

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 7B	CLASSES OF PERSONS, DECISIONS REQUIRING APPROVAL & TYPE OF VOTING RIGHTS THE RESERVED RIGHTS IN OUR TIERED GOVERNANCE STRUCTURE CONTEMPLATE APPROVAL BY THE ST JOSEPH HEALTH SYSTEM MEMBER OF FINANCING, BUDGETS, UNBUDGETED EXPENDITURES OF DEFINED AMOUNTS, STRATEGIC PLAN, APPOINTMENT OF AUDITORS, CREATION OR INVESTMENT IN A LEGALLY RECOGNIZED ENTITY, JOINT VENTURES, EXEMPT PURPOSES, SALE OR DISPOSITION OF REAL PROPERTY, MERGER OR SALE OF SUBSTANTIALLY ALL ASSETS, APPOINTMENT AND REMOVAL OF TRUSTEES, ADOPTION OR AMENDMENT OF ARTICLES OR BYLAWS THE CORPORATE MEMBERS, ST JOSEPH HEALTH SYSTEM AND COVENANT HEALTH NETWORK, RESERVE THE RIGHT TO APPROVE THE PURPOSES, SALE OR DISPOSITION OF REAL PROPERTY, MERGER OR SALE OF SUBSTANTIALLY ALL ASSETS, APPOINTMENT AND REMOVAL OF TRUSTEES, ADOPTION OR AMENDMENT OF ARTICLES OR BYLAWS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 11B	PROCESS TO REVIEW 990 THE FORM 990 WAS PREPARED BASED ON INFORMATION RECEIVED FROM VARIOUS DEPARTMENTS OF THE ORGANIZATION INCLUDING THE FINANCE TEAM, HUMAN RESOURCES, PAYROLL, COMPLIANCE AND THE GENERAL COUNSELS OFFICE THE ORGANIZATION ENGAGED AN OUTSIDE ACCOUNTING FIRM TO PREPARE THE RETURN THE RETURN HAS BEEN REVIEWED BY AN OFFICER OF THE ORGANIZATION A FULL COPY OF THE FORM 990 WAS PROVIDED TO ALL BOARD MEMBERS PRIOR TO FILING WITH THE IRS THE AUDIT COMMITTEE OF THE PARENT ORGANIZATION IS PROVIDED AN ANNUAL UPDATE ON THE TAX REPORTING PROCESS AND KEY DISCLOSURES

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 12C	PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST BOARD MEMBERS, SPONSORS, SENIOR LEADERS AND KEY EMPLOYEES ARE REQUIRED TO DISCLOSE ANY REAL OR POTENTIAL CONFLICT OF INTEREST (COI) IN ACCORDANCE WITH THE PSJH COI POLICY AND IN CONNECTION WITH THAT INDIVIDUAL SATISFYING HIS OR HER FIDUCIARY OBLIGATIONS TO THE ORGANIZATION DISCLOSURES ARE MADE ANNUALLY AND/OR IF AT ANY TIME AN ACTUAL, REAL OR POTENTIAL CONFLICT OF INTEREST ARISES PSJH CHIEF LEGAL OFFICER AND/OR THE PSJH CHIEF RISK OFFICER, REVIEW ALL DISCLOSURES WHERE APPROPRIATE, THE CEO AND/OR THE BOARD CHAIR CONSIDER MATTERS THAT INVOLVE SENIOR LEADERSHIP OR A BOARD MEMBER PSJH CHIEF LEGAL OFFICER AND/OR CHIEF RISK OFFICER REVIEW MATTERS WHERE CONFLICT IS DIFFICULT OR CANNOT BE RESOLVED AND PRESENT RECOMMENDATIONS TO THE APPROPRIATE BOARD COMMITTEE OR THE CEO, FOR DISCUSSION AND RESOLUTION WHEN APPROPRIATE, THE INDIVIDUAL WITH THE REAL/POTENTIAL CONFLICT THAT IS BEING REVIEWED MAY PARTICIPATE IN THE DISCUSSION BUT IS EXCUSED FROM THE MEETING WHEN ACTION IS DECIDED WHERE APPROPRIATE, THE CHIEF RISK OFFICER OR CHIEF LEGAL OFFICER WILL PROVIDE PLAN TO MANAGE CONFLICTS AUDITING AND MONITORING OF THIS PROCESS IS DONE PERIODICALLY ALL DOCUMENTATION OF COI DISCLOSURES IS RETAINED PER ORGANIZATION RETENTION POLICY

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINES 15A & 15B	<p>PROCESS FOR DETERMINING COMPENSATION THE ORGANIZATION'S CHIEF EXECUTIVE OFFICER IS PAID BY ITS TAX EXEMPT PARENT, ST JOSEPH HEALTH SYSTEM, AND IS DISCLOSED AS A PERSON PAID BY A RELATED ORGANIZATION IT IS PROVIDENCE ST JOSEPH HEALTH'S INTENTION TO MAKE FINANCIAL INFORMATION ACCESSIBLE AND TRANSPARENT ALTHOUGH THE FILING OF FORM 990 PROVIDES INSIGHT INTO HOW PROVIDENCE ST JOSEPH HEALTH ACHIEVES ITS MISSION, DELIVERS ITS PROGRAMS AND STEWARDS ITS FINANCES, DECIPHERING THE INFORMATION DIRECTLY FROM FORM 990 CAN BE CHALLENGING THE FOLLOWING PARAGRAPHS PROVIDE FURTHER INFORMATION ABOUT THE PROCESS WE USE TO DETERMINE COMPENSATION FOR TOP MANAGEMENT, OFFICERS AND KEY EMPLOYEES PROVIDENCE ST JOSEPH HEALTH HAS A SINGLE FIDUCIARY BOARD, WITH RESPONSIBILITY FOR FINANCIAL OVERSIGHT ASSOCIATED WITH FULFILLMENT OF THE PROVIDENCE ST JOSEPH HEALTH MISSION, DEVELOPING SYSTEM POLICIES, PROTECTING THE ASSETS ENTRUSTED TO THE ORGANIZATION AND OVERSEEING THE STRATEGIC AND OPERATIONAL AFFAIRS OF PROVIDENCE ST JOSEPH HEALTH'S LEGAL ENTITIES PROVIDENCE ST JOSEPH HEALTH ALSO MAINTAINS A NETWORK OF COMMUNITY ENTITY BOARDS WITH RESPONSIBILITY FOR QUALITY OF CARE OVERSIGHT, COMMUNITY RELATIONS, ADVOCACY AND COMMUNITY NEEDS ASSESSMENTS PROVIDENCE ST JOSEPH HEALTH HAS A CONSISTENT COMPENSATION PHILOSOPHY FOR ALL OF ITS OFFICERS, INCLUDING OUR SENIOR EXECUTIVES SALARIES FOR SENIOR EXECUTIVES ARE REVIEWED BY THE PROVIDENCE ST JOSEPH HEALTH COMMITTEE THE BOARD RETAINS AN INDEPENDENT CONSULTANT EACH YEAR TO REVIEW SALARIES OF THOSE IN THE MOST SIGNIFICANT LEADERSHIP ROLES IN THE ORGANIZATION PART OF THE CONSULTANT'S ROLE IS TO REVIEW AN EXTENSIVE ARRAY OF COMPENSATION SURVEYS OF LARGE, NOT-FOR-PROFIT HEALTH CARE SYSTEMS IN THE UNITED STATES PROVIDENCE ST JOSEPH HEALTH IS ONE OF THE LARGER HEALTH SYSTEMS IN THE COUNTRY, AND AS SUCH, THE BOARD BENCHMARKS EXECUTIVE COMPENSATION AGAINST OTHER LARGE, NOT-FOR-PROFIT HEALTH SYSTEMS WHOSE REVENUE IS SIMILAR TO THAT OF PROVIDENCE ST JOSEPH HEALTH ADDITIONALLY, PROVIDENCE ST JOSEPH HEALTH'S LABOR MARKET CONTINUES TO SPREAD ACROSS HEALTH CARE AND INTO GENERAL INDUSTRY BECAUSE OF THIS, PROVIDENCE ST JOSEPH HEALTH ALSO TAKES INTO CONSIDERATION GENERAL INDUSTRY FOR-PROFIT MARKET DATA, WHERE APPLICABLE BASE SALARIES FOR PROVIDENCE ST JOSEPH HEALTH EXECUTIVES ARE GENERALLY TARGETED TO THE MEDIAN LEVEL OF THE MARKET, AS IDENTIFIED BY THE INDEPENDENT CONSULTANT AND REVIEWED WITH THE EXECUTIVE COMPENSATION COMMITTEE THE PRESIDENT/CEO UTILIZES THE MARKET INFORMATION PROVIDED BY THE CONSULTANT ALONG WITH FORMAL PERFORMANCE EVALUATIONS, TO DETERMINE SALARY RECOMMENDATIONS FOR OTHER SENIOR EXECUTIVES THIS PROCESS INCLUDES A RIGOROUS ANALYSIS OF THOSE RECOMMENDATIONS WITH THE EXECUTIVE COMPENSATION COMMITTEE AS A PART OF THE REVIEW AND APPROVAL PROCESS PERFORMANCE INCENTIVES ALLOW EXECUTIVES TO EARN ADDITIONAL COMPENSATION IF THEY ACHIEVE SPECIFIC ORGANIZATIONAL GOALS FOR FURTHERING PROVIDENCE ST JOSEPH HEALTH OPERATING CO</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINES 15A & 15B	COMMITMENTS AND STRATEGIC OBJECTIVES THE BOARD OF DIRECTORS CONDUCTS A THOROUGH REVIEW PROCESS TO ENSURE PERFORMANCE INCENTIVES ARE ALIGNED WITH APPROPRIATE MARKET PRACTICES THE BOARD'S PROCESS FOR EXECUTIVE COMPENSATION FULLY COMPLIES WITH IRS STANDARDS AND MIRRORS BEST PRACTICES THE PROCESS TO REVIEW COMPENSATION WAS LAST COMPLETED IN MARCH 5, 2019

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 19	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY & FINANCIAL STATEMENTS THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST THE PSJH COMMUNITY BENEFIT REPORTS, FINANCIAL REPORTS, AND PHILANTHROPY REPORTS ARE ALSO AVAILABLE ON THE PSJH INTERNET SITE AUDITED FINANCIAL STATEMENTS ARE ATTACHED TO FORM 990

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	OTHER CHANGES IN NET ASSETS CHANGE IN TEMPORARY RESTRICTED NET ASSETS \$ 7,048,363 GRANTS TO INDIVIDUALS & ORGS AND OTHER \$ 8,693,278 UNRESTRICTED DISTRIBUTIONS & DIVIDENDS \$ 2,892,425 POPULATION HEALTH NET INCOME FOR 990 \$ 3,393,193 FDN CAPITAL CONTRIBUTIONS RESTRICTED FUNDS (\$ 12,544,915) EQUITY TRANSFERS TO SUBSIDIARIES/JOINT VENTURES (\$ 20,702,718) CAPITAL CONTRIBUTION TO HERITAGE (\$ 23,046,649) RECLASS TO PY UNRESTRICTED FUNDS (\$ 31,289,788) MISCELLANEOUS \$ 13,992 ----- TOTAL (\$ 65,542,819)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PURCHASED SERVICES TOTAL FEES 41999059

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PROFESS & MED PHYSICIAN FEES TOTAL FEES 23326496

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION MEDICAL PURCHASED SERVICES TOTAL FEES 9605357

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION BIOMEDICAL PURCHASED SERVICES TOTAL FEES 5477342

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONSULTING FEES TOTAL FEES 3932685

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
MISSION HOSPITAL REGIONAL MEDICAL CENTER

Employer identification number

95-1643360

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

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

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

See Additional Data Table

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

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

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

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) ST JOSEPH HEALTH SYSTEM FOUNDATION	c	2,032,728	ACCRUAL
(2) ST JOSEPH HEALTH SYSTEM FOUNDATION	b	5,742,700	ACCRUAL
(3) ST JOSEPH HERITAGE HEALTHCARE	m	318,173	ACCRUAL
(4) ST JOSEPH HERITAGE HEALTHCARE	b	22,728,476	ACCRUAL
(5) ST JOSEPH HOSPITAL OF ORANGE	m	61,106	ACCRUAL

Part VII Supplemental Information

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

Return Reference	Explanation
SCHEDULE R, PART III	<p>IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS A PARTNERSHIP 20TH STREET SURGERY LLC EIN 73-1735618 ADDRESS 1301 20TH STREET, STE 140, SANTA MONICA, CA 90404 BROADWAY IMAGING, LLC EIN 52-2405971 ADDRESS 500 W BROADWAY MISSOULA, MT 59802 CENTER FOR SPECIALTY SURGERY, LLC EIN 26-3638838 ADDRESS 11782 SW BARNES RD PORTLAND, OR 97225 CLACKAMAS RADIATION ONCOLOGY CENTER, LLC EIN 26-0381897 ADDRESS 4400 NE HALSEY ST , BLDG II, #495 PORTLAND, OR 97213 COASTAL ASC HOLDINGS LLC EIN 81-0986844 ADDRESS ONE HOAG DRIVE, PO BOX 6100, NEWPORT BEACH, CA 92658 COVENANT LONG-TERM CARE, LP EIN 20-5033419 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 CTR FOR MED IMAGING-BRIDGEPORT, LLC EIN 26-0796953 ADDRESS 4400 NE HALSEY, #495 PORTLAND, OR 97213 CTR FOR MED IMAGING-TANASBOURNE, LLC EIN 20-0477972 ADDRESS 4400 NE HALSEY, #495 PORTLAND, OR 97213 FULLERTON SURGICAL CENTER LP EIN 47-0927394 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 GREATER VALLEY MEDICAL BUILDING, L P EIN 95-4570858 ADDRESS 501 S BUENA VISTA ST BURBANK, CA 91505 HCSA PROPERTIES LLC EIN 46-0620892 ADDRESS 1600 M STREET NW AUBURN, WA 98001 HERITAGE INVESTMENT GROUP I, LLC EIN 27-1000061 ADDRESS 500 S MAIN STREET, STE 1000, ORANGE, CA 92868 HOAG ORTHOPEDIC INSTITUTE EIN 61-1588294 ADDRESS 1 HOAG DRIVE, PO BOX 6100, NEWPORT BEACH, CA 92658 HOAG OUTPATIENT CENTERS, LLC EIN 45-3587572 ADDRESS 27271 LAS RAMBLAS #350, MISSION VIEJO, CA 92691 INLAND IMAGING, LLC EIN 91-1855796 ADDRESS 801 S STEVENS ST , SPOKANE, WA 99204 LSC REAL PROPERTY, LLC EIN 47-4646059 ADDRESS 2301 QUAKER AVENUE, LUBBOCK, TX, 79410 METHODIST DIAGNOSTIC IMAGING EIN 75-2343261 ADDRESS 4005 24TH STREET, LUBBOCK, TX 79410 NEWPORT BAY SURGERY CENTER, LLC EIN 56-2518360 ADDRESS 3333 W PACIFIC COAST HWY, #100 NEWPORT BEACH, CA 92663 NEWPORT BEACH ENDOSCOPY CENTER, LLC EIN 77-0368744 ADDRESS 27271 LAS RAMBLAS #350 MISSION VIEJO, CA 92691 NEWPORT IMAGING CENTER EIN 33-0191776 ADDRESS 360 SN MIGUEL, NEWPORT BEACH, CA 92660 NEWPORT SURGICAL PARTNERS, LLC EIN 39-2060266 ADDRESS 27271 LAS RAMBLAS #350 MISSION VIEJO, CA 92691 NORTH BAY ENDOSCOPY CENTER EIN 61-1559876 ADDRESS 1383 N MCDOWELL BLVD, SUITE 110, PETALUMA, CA 94954 OREGON ADVANCED IMAGING, LLC EIN 45-0471748 ADDRESS 881 O'HARE PARKWAY, MEDFORD, OR 97504 OREGON OUTPATIENT SURGERY CENTER EIN 22-3883387 ADDRESS 7300 SW CHILDS ROAD, TIGARD, OR 97224 PET/CT IMAGING AT SWEDISH CANCER INSTITUTE, LLC EIN 20-3132044 ADDRESS 1221 MADISON STREET SEATTLE, WA 98104 PHS INVESTMENT TRANSITION PORTFOLIO EIN 47-2279711 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST 2015 PRIVATE ASSETS PORTFOLIO EIN 47-3393740 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST 2016 PRIVATE ASSETS PORTFOLIO EIN 81-1532735 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST 2016 PRIVATE REAL ESTATE PORTFOLIO EIN 81-2960145 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST BANK LOANS PORTFOLIO EIN 47-2357735 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST COMMODITIES PORTFOLIO EIN 47-2269004 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST HEDGE FUND PORTFOLIO EIN 47-2293255 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST LDI PORTFOLIO EIN 47-2392060 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST LONG TREASURIES PORTFOLIO EIN 47-2385238 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST MLP PORTFOLIO EIN 47-2367538 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST PUBLIC DEBT PORTFOLIO EIN 47-2353569 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST PUBLIC EQUITY PORTFOLIO EIN 47-2283974 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST RELATIVE VALUE PORTFOLIO EIN 47-2314743 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST RISK PARITY PORTFOLIO EIN 47-2336377 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST SHORT TERM INVESTMENT PORTFOLIO EIN 81-2701056 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST TACTICAL TRADING PORTFOLIO EIN 47-2327491 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PHS INVESTMENT TRUST TIPS PORTFOLIO EIN 47-2402609 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PORTLAND MEDICAL IMAGING, LLC EIN 20-1054971 ADDRESS 4400 NE HALSEY, #495 PORTLAND, OR 97213 PROV RADIATION ONCOLOGY DEVELOP ASSN , LLC EIN 26-0682491 ADDRESS 4400 NE HALSEY, #495 PORTLAND, OR 97213 PROVIDENCE CHILDREN'S NEONATAL SERVICES EIN 47-0918549 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PROVIDENCE IMAGING CENTER JOINT VENTURE EIN 92-0118807 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PROVIDENCE PARTNERS FOR HEALTH, LLC EIN 45-4041798 ADDRESS 501 S BUENA VISTA ST BURBANK, CA 91505 PROVIDENCE ST JOSEPH HEALTH LONG TERM PORTFOLIO EIN 82-3190634 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 PROVIDENCE SURGERY CENTER, LLC EIN 84-1401625 ADDRESS 902 N ORANGE ST MISSOULA, MT 59802 PROVIDENCE/SILVERTON REHAB, LLC EIN 48-1287267 ADDRESS 4400 NE HALSEY #425, PORTLAND, OR 97213 PROVIDENCE/USP SANTA CLARITA GP, LLC EIN 20-2829660 ADDRESS 11550 INDIAN HILLS ROAD #160, MISSION HILLS, CA 91345 PROVIDENCE/USP SURGERY CENTERS, LLC EIN 20-0905938 ADDRESS 11550 INDIAN HILLS ROAD #160, MISSION HILLS, CA 91345 SHA, LLC EIN 75-2569094 ADDRESS 12940 NORTH HIGHWAY 183, AUSTIN, TX 78750 SJO ASC HOLDINGS LLC EIN 82-1655501 ADDRESS 1140 W LA VETA AVE ORANGE, CA 92868 ST JOSEPH PHYSICIAN VENTURES I, LLC EIN 45-4521884 ADDRESS 1100 WEST STEWART DRIVE, ORANGE, CA 92868 ST JOSEPH/SATELLITE DIALYSIS CENTERS, LLC EIN 81-4657391 ADDRESS 300 SANTANA ROW, SUITE 300 SAN JOSE, CA 95128 ST JUDE SURGICAL CENTERS, LLC EIN 82-3352570 ADDRESS 1801 LIND AVE SW, ATTN TAX DEPARTMENT, RENTON, WA 98057-9016 SURGERY CENTER AT TANASBOURNE, LLC EIN 20-8187971 ADDRESS 11221 ROE AVE , STE 300, LEAWOOD, KS 66211 TARZANA PEDIATRIC VENTURES LLC EIN 82-1308306 ADDRESS 18321 CLARK ST, TARZANA, CA 91356 THE MADISON SPOKANE INN, LLC EIN 84-1606484 ADDRESS 15 WEST ROCKWOOD BLVD SPOKANE, WA 99204</p>

Schedule Form 2016

Additional Data

Software ID:
Software Version:
EIN: 95-1643360
Name: MISSION HOSPITAL REGIONAL MEDICAL CENTER

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 61-1573313	HEALTHCARE	TX	501(C)(3)	12, I	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-1259908	HEALTHCARE	CA	501(C)(3)	12, III	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-3516417	HEALTHCARE	TX	501(C)(3)	12, I	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2765566	HEALTHCARE	TX	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2897026	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 82-2913146	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2743883	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1082119	UNEMPLOYMENT	WA	501(C)(3)	12, I	PHS WA	Yes	
PO BOX 5128 EVERETT, WA 982065128 94-3264605	TRANS CARE	WA	501(C)(3)	10	NA		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-4322584	SUPPORT	CA	501(C)(3)	7	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 20-1910170	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
2800 SOUTH 192ND ST 104 SEATAC, WA 98188 27-3133200	HEALTHCARE	WA	501(C)(3)	7	SHS	Yes	
1 HOAG DRIVE PO BOX 6100 NEWPORT BEACH, CA 92658 45-3583707	HEALTHCARE	CA	501(C)(3)	12, I	HMHP	Yes	
2081 BUSINESS CTR DR STE 195 IRVINE, CA 92612 45-2982422	SUPPORT	CA	501(C)(3)	7	HHF	Yes	
1 HOAG DRIVE PO BOX 6100 NEWPORT BEACH, CA 92658 33-0676831	HEALTHCARE	CA	501(C)(3)	10	HMHP	Yes	
330 PLACENTIA AVE NEWPORT BEACH, CA 92663 95-3222343	FUNDRAISING	CA	501(C)(3)	7	HMHP	Yes	
1 HOAG DRIVE PO BOX 6100 NEWPORT BEACH, CA 92658 95-1643327	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2133781	HEALTHCARE	TX	501(C)(3)	10	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1307555	HEALTHCARE	WA	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-4260130	HEALTHCARE	WA	501(C)(3)	7	PHSSJHS	Yes	

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						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-2003593	HEALTHCARE	WA	501(C)(3)	7	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-4291515	HEALTHCARE	CA	501(C)(3)	4	PSJHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-6033089	SUPPORT	WA	501(C)(3)	12, III	KRMC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 23-7005501	SUPPORT	WA	501(C)(3)	12, I	KRMC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-0655392	HEALTHCARE	WA	501(C)(3)	3	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0844408	IMAGING SVCS	CA	501(C)(3)	10	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2220963	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1562797	SUPPORT	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-2054035	RESEARCH	WA	501(C)(3)	7	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2428911	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2246348	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2426010	HEALTHCARE	TX	501(C)(3)	3	CHS	Yes	
PO BOX 16069 SEATTLE, WA 98116 20-0799737	SUPPORT	WA	501(C)(3)	12,I	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 56-2290878	HEALTHCARE	WA	501(C)(3)	10	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-3544877	HEALTHCARE	CA	501(C)(3)	7	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 92-0093565	HEALTHCARE	AK	501(C)(3)	12, I	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1940286	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1789266	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0800140	SUPPORT	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0692907	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
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						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 47-3385506	SUPPORT	WA	501(C)(3)	7	NA		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 31-1744654	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1549796	HEALTHCARE	WA	501(C)(3)	12, II	PSJH		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-0231793	HEALTHCARE	MT	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 51-0216587	HEALTHCARE	OR	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 51-0216586	HEALTHCARE	WA	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1303277	HEALTHCARE	WA	501(C)(3)	3	PMWHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 55-0828701	MEDICAID	OR	501(C)(4)	N/A	PHP	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 32-0014330	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1433382	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0863097	HEALTHCARE	OR	501(C)(4)	N/A	PPP	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 51-0216589	HEALTHCARE	CA	501(C)(3)	3	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0921990	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 27-2552749	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-2077378	HEALTHCARE	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 51-0224944	HEALTHCARE	CA	501(C)(3)	7	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-1554288	HEALTHCARE	WA	501(C)(3)	12, I	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0283773	HEALTHCARE	CA	501(C)(3)	12, I	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-3079515	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016	RELIGIOUS ORG	WA	501(C)(3)	1	NA		No

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations							
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						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1188119	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0889144	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 31-1629656	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1861964	HEALTHCARE	WA	501(C)(4)	N/A	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-1231494	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 31-1584166	SUPPORT	WA	501(C)(3)	10	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-1684082	HEALTHCARE	CA	501(C)(3)	3	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-4542216	HEALTHCARE	CA	501(C)(3)	3	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0927320	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-2171539	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-3244854	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-1244422	HEALTHCARE	WA	501(C)(3)	12, III	NA		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-3078543	HEALTHCARE	WA	501(C)(3)	12, I	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-0463482	HEALTHCARE	MT	501(C)(3)	3	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 45-2841492	HEALTHCARE	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1097056	SUPPORT	WA	501(C)(3)	7	PHS W WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-0575982	HEALTHCARE	OR	501(C)(3)	7	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-3264139	HEALTHCARE	CA	501(C)(3)	10	PHS SOCIAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0261016	HEALTHCARE	CA	501(C)(3)	7	PTCH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 93-1003750	HEALTHCARE	OR	501(C)(3)	12, I	PHS OR	Yes	

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						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-1243669	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-2779313	HEALTHCARE	CA	501(C)(3)	7	RMH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-1384665	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-6100079	SUPPORT	CA	501(C)(3)	7	PSJHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-1231005	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 61-1502822	PHYSN COLLAB	WA	501(C)(3)	7	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 26-2612415	SHELL CORP	MT	501(C)(3)	1	PHS WA		No
480 S BATAVIA ORANGE, CA 92868 95-1643383	RELIGIOUS ORG	CA	501(C)(3)	1	NA		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 68-0395200	HEALTHCARE	CA	501(C)(3)	3	SRMH	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 27-1666576	RELIGIOUS ORG	CA	501(C)(3)	1	SSJO		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-4791043	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-3589356	HEALTHCARE	CA	501(C)(3)	12, I	PSJH		No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0143024	HEALTHCARE	CA	501(C)(3)	7	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0185031	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 68-0331084	HEALTHCARE	CA	501(C)(3)	10	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-1156596	HEALTHCARE	CA	501(C)(3)	3	SJHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-1643359	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-1643324	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 94-3176618	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-1914489	HEALTHCARE	CA	501(C)(3)	3	CHN	Yes	

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						Yes	No
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-1653181	HEALTHCARE	TX	501(C)(3)	7	CHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 23-7056976	HEALTHCARE	MT	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-0233495	EDUCATION	MT	501(C)(3)	10	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 27-2305304	HEALTHCARE	WA	501(C)(3)	3	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-0433740	HEALTHCARE	WA	501(C)(3)	3	WHC	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-0983214	HEALTHCARE	WA	501(C)(3)	7	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 27-3139262	HOLDING CO	WA	501(C)(3)	12, I	SHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1180824	SUPPORT	WA	501(C)(3)	7	PHS WA	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1293869	SUPPORT	CA	501(C)(3)	10	PHS SOCAL	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 91-1214491	SUPPORT	OR	501(C)(3)	10	PHS OR	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-0231777	EDUCATION	MT	501(C)(3)	2	PHS	Yes	
1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 45-4171900	SHELL CORP	WA	501(C)(3)	12, II	PHS W WA	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
(1) AMERICAN UNITY GROUP LTD 90 PITTS BAY ROAD PEMBROKE HM08 BD	CAPTIVE INSURANCE	BD	NA	C-CORP					
(1) 1221 MADISON STREET OWNERS ASSOC 747 BROADWAY SEATTLE, WA 98122 20-1954319	OWNERS' ASSOC	WA	NA	C-CORP					
(2) AYIN HEALTH SOLUTIONS INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 83-3037172	HEALTHCARE	DE	NA	C-CORP					
(3) BOURGET HEALTH SERVICES INC PO BOX 2687 SPOKANE, WA 99220 91-1354431	CLIN/MED LAB	WA	NA	C-CORP					
(4) CARON HEALTH CORPORATION 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 81-0486082	MED PHYS SVCS	MT	NA	C-CORP					
(5) DATU HEALTH INC AND SUBSIDIARIES 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-3070062	IT SVCS	DE	NA	C-CORP					
(6) GRACE CLINIC OF LUBBOCK 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 20-3856995	HEALTHCARE	TX	NA	C-CORP					
(7) GRACE CLINIC SERVICES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 20-3857067	HEALTHCARE	TX	NA	C-CORP					
(8) HOAG CLINIC (FKA COASTAL MGM SVS ORG) 1 HOAG DRIVE PO BOX 6100 NEWPORT BEACH, CA 926586100 33-0676831	HEALTHCARE	CA	NA	C-CORP					
(9) HOAG MANAGEMENT SERVICES INC 1 HOAG DRIVE PO BOX 6100 NEWPORT BEACH, CA 926586100 33-0731587	HEALTHCARE	CA	NA	C-CORP					
(10) LUBBOCK METHODIST HOSP PRACTICE MGMT 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2578995	INACTIVE	TX	NA	C-CORP					
(11) LUBBOCK METHODIST HOSPITAL SVCS 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 75-2118585	HEALTHCARE	TX	NA	C-CORP					
(12) LUMEDIC ACQUISITION CO INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 83-3881097	HEALTHCARE	WA	NA	C-CORP					
(13) MISSION VIEJO MEDICAL VENTURES 27800 MEDICAL CENTER RD 354 MISSION VIEJO, CA 92691 33-0212905	HEALTHCARE	CA	MHRMC	C-CORP	11,478	247,482	100 000 %	Yes	
(14) PHN HOLDINGS 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-1814184	STRAT PLAN SVCS	CA	NA	C-CORP					

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
(16) PIONEER INNOVATIONS INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 36-4818191	HEALTH INNOVATNS	WA	NA	C-CORP					
(1) PROVIDENCE ASSURANCE INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 20-8194071	CAPTIVE INSURANCE	AZ	NA	C-CORP					
(2) PROVIDENCE HEALTH CARE VENTURES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 90-0155714	CLIN/MED LAB	WA	NA	C-CORP					
(3) PROVIDENCE HEALTH NETWORK 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 80-0886966	PREPAID HEALTH	CA	NA	C-CORP					
(4) PROVIDENCE HEALTH VENTURES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0122216	INVESTMENT	CA	NA	C-CORP					
(5) ST JOSEPH HEALTH 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-2340232	HOLDING COMPANY	CA	NA	C-CORP					
(6) ST JOSEPH HEALTH SOURCE INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 46-1900168	HEALTHCARE	CA	NA	C-CORP					
(7) ST JOSEPH PROF SVCS ENTERPRSES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 33-0155323	HEALTHCARE	CA	NA	C-CORP					
(8) VINSERRA INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 95-3943315	INVESTMENT	CA	NA	C-CORP					
(9) WESTERN HEALTHCONNECT VENTURES INC 1801 LIND AVE SW ATTN TAX DEPT RENTON, WA 980579016 80-0953654	INVESTMENT	WA	NA	C-CORP					
(10) YAKIMA MEDICAL ARTS INC 611 N PERRY 100 SPOKANE, WA 99202 91-0787963	RENT REAL ESTATE	WA	NA	C-CORP					