TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

June 30, 2011

Prepared for	St. Agnes Healthcare, Inc. 900 Caton Avenue No. 040 Baltimore, MD 21229-5201
Prepared by	DELOITTE TAX LLP 200 RENAISSANCE CENTER, SUITE 3900 DETROIT, MI 48243
Amount due or refund	Not applicable
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Not applicable
Return must be mailed on or before	Not applicable
Special Instructions	This return has been prepared for electronic filing. If you wish to have it transmitted electronically to the IRS, please sign, date, and return Form 8453-EO to our office. We will then submit the electronic return to the IRS. Do not mail a paper copy of the return to the IRS.

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 black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning JUL 1, 2010 **and ending** JUN 30, 2011

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
ST. AGNES HEALTHCARE, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) 900 CATON AVENUE

Room/suite 040

City or town, state or country, and ZIP + 4 BALTIMORE, MD 21229-5201

D Employer identification number 52-0591657

E Telephone number (410) 368-2491

G Gross receipts $ 426,961,229.

F Name and address of principal officer: BONNIE PHIPPS
SAME AS C ABOVE

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.STAGNES.ORG

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

L Year of formation: 1862

M State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: ST. AGNES HEALTHCARE IS COMMITTED TO SPIRITUALLY-CENTERED HEALTH CARE WHICH IS ROOTED IN THE

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	17
5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	3342
6	Total number of volunteers (estimate if necessary)	6	202
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	4,810,453.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-340,992.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	3,150,286.	2,538,629.
9	Program service revenue (Part VIII, line 2g)	370,493,603.	390,651,963.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	23,425,917.	29,360,028.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,242,726.	4,260,951.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	400,312,532.	426,811,571.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	220,297.	172,827.
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)	185,283,470.	193,953,318.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	55,500.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	163,981,672.	168,869,193.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	349,540,939.	362,995,338.
19	Revenue less expenses. Subtract line 18 from line 12	50,771,593.	63,816,233.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	418,680,261.	484,392,822.
21	Total liabilities (Part X, line 26)	171,668,134.	153,786,674.
22	Net assets or fund balances. Subtract line 21 from line 20	247,012,127.	330,606,148.

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

▶ SCOTT FURNISS, SENIOR VICE PRESIDENT/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
JENNIFER L. GILARDI			☐	

Firm's name ▶ DELOITTE TAX LLP — Firm's EIN ▶

Firm's address ▶ 200 RENAISSANCE CENTER, SUITE 3900
DETROIT, MI 48243

Phone no. (313) 396-3000

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III X

1 Briefly describe the organization's mission:

ST. AGNES HEALTHCARE IS A SPIRITUALLY CENTERED HOSPITAL WHICH IS ROOTED IN THE HEALING MINISTRY OF JESUS. IN THE SPIRIT OF ST. ELIZABETH ANN SETON, AND IN COLLABORATION WITH OTHERS, WE CONTINUALLY REACH OUT TO ALL PERSONS IN OUR COMMUNITY WITH A SPECIAL CONCERN FOR

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 exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts 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 $ 183,032,490. including grants of $ 0.) (Revenue $ 232,827,903.)

ST. AGNES HOSPITAL PROVIDES A SUBSTANTIAL PORTION OF ITS SERVICES TO THE ELDERLY AND POOR. DURING THE FISCAL YEAR ENDING JUNE 30, 2011, APPROXIMATELY 45% OF THE VALUE OF SERVICES RENDERED WAS TO ELDERLY PATIENTS UNDER THE MEDICARE PROGRAM, AND APPROXIMATELY 15% OF THE VALUE OF SERVICES WAS PROVIDED TO PATIENTS WHO WERE DEEMED INDIGENT UNDER STATE, COUNTY, OR HOSPITAL GUIDELINES. IN THE SPIRIT OF PRINCIPLES ADOPTED BY ASCENSION HEALTH, ST. AGNES HOSPITAL HAS TAKEN PROACTIVE STEPS TO ADDRESS THOSE ISSUES THAT WILL AFFECT ACCESSIBILITY, THE FINANCING, AND THE DELIVERY OF HEALTHCARE TO ALL PERSONS, ESPECIALLY THE UNINSURED, UNDERINSURED, AND THE UNDERSERVED. DURING THE FISCAL YEAR ENDING JUNE 30, 2011, THE ESTIMATED UNREIMBURSED COST OF SERVICES PROVIDED TO THE ELDERLY, UNINSURED, AND UNDERINSURED TOTALED

4b (Code:) (Expenses $ 6,820,772. including grants of $ 172,827.) (Revenue $ 713,045.)

COMMUNITY BENEFITS ARE PROGRAMS OR ACTIVITIES THAT PROVIDE TREATMENT AND/OR PROMOTE HEALTH AND HEALING AS A RESPONSE TO IDENTIFIED COMMUNITY NEEDS. IN AN EFFORT TO PROMOTE HEALTHY LIVING, ST. AGNES HAS MADE AVAILABLE WELLNESS PROGRAMS TO THE COMMUNITY. THESE PROGRAMS INCLUDE, BUT ARE NOT LIMITED TO: ADULT, INFANT AND CHILD CPR CLASSES; ASTHMA CURRICULA; BARIATRIC SEMINARS; BASIC LIFE SUPPORT CLASSES; BREAST HEALTH CLINICS AND SEMINARS; FIRST AID CLASSES; JOINT AND PAIN SEMINARS; RUNNING CLINICS; BABYSITTING CLASSES; BLOOD PRESSURE, CHOLESTEROL, AND BLOOD SUGAR SCREENINGS; DIABETES AND HEART DISEASE PREVENTION EDUCATION; INTERNATIONAL EARLY LUNG CARE ACTION PROJECT STUDIES; HEART HEALTH AWARENESS PROGRAMS FOR AFRICAN AMERICAN WOMEN; GASTRO ESOPHAGEAL REFLUX DISEASE SEMINARS; ACTIVITIES IN THE PEDIATRICS

4c (Code:) (Expenses $ 110,943,315. including grants of $ 0.) (Revenue $ 192,209,230.)

ST. AGNES HOSPITAL PROVIDES THE FOLLOWING IN-PATIENT AND OUTPATIENT MEDICAL SERVICES TO THE COMMUNITY: AMBULATORY CARE CENTER SERVICES, CARDIOVASCULAR SERVICES, CANCER TREATMENT SERVICES, EMERGENCY CARE CENTER SERVICES, LABORATORY SERVICES, ORTHOPEDIC SERVICES, PAIN MANAGEMENT, PRIMARY CARE PHYSICIANS, RADIOLOGY SERVICES, REHABILITATION SERVICES, SLEEP STUDIES, STROKE SERVICES, OBSTETRICS, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, WOUND CARE, RESPIRATORY THERAPY, SURGERY, PEDIATRICS, IMAGING CLINIC, BARIATRIC SERVICES, RESPIRATORY THERAPY, WOMEN'S HEALTH SERVICES, DIABETES WELLNESS PROGRAMS, PALLIATIVE CARE SERVICES, AND AN ANTICOAGULATION CLINIC. SOME OF THE SERVICES LISTED OPERATE AT A LOSS IN ORDER TO ENSURE THAT ALL SERVICES ARE AVAILABLE TO MEET COMMUNITY HEALTH CARE NEEDS. DURING THE FISCAL

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

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

4e Total program service expenses ▶ 300,796,577.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete Schedule B, Schedule of Contributors?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach its audited financial statements to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	X	
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b	X	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34	X	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	35	X	
a	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* [X] Yes [ ] No			
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

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

Check if Schedule O contains a response to any question in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	295		
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		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	3342		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file*. (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

Check if Schedule O contains a response to any question in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	18		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	17		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5		X
6	Does the organization have members or stockholders?		6	X	
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?		7a	X	
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?		7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?		8a	X	
b	Each committee with authority to act on behalf of the governing body?		8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*		9		X

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☒ Upon request

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

SCOTT FURNISS - (410) 368-3130

900 CATON AVENUE, BALTIMORE, MD 21229

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

Check if Schedule O contains a response to any question in this Part VII X

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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 PATRICIA ANN BOSSLE, DC BOARD DIRECTOR	1.40	X						0.	0.	0.
SAM SYDNEY BOARD DIRECTOR	2.10	X						0.	0.	0.
MARC BUNTING BOARD DIRECTOR	2.40	X						0.	0.	0.
HECTOR L. TORRES BOARD DIRECTOR	1.50	X						0.	0.	0.
A. GREGORY KELLY, JR. BOARD DIRECTOR	3.00	X						0.	0.	0.
CHARLES G. TILDON, III BOARD DIRECTOR	2.10	X						0.	0.	0.
GARY N. GEISEL BOARD DIRECTOR	2.10	X						0.	0.	0.
BRUCE R. GRINDROD, JR. BOARD DIRECTOR	1.50	X						0.	0.	0.
SISTER ELLEN MARIE HAGAR BOARD DIRECTOR	1.70	X						0.	0.	0.
M. SUE LOVELL BOARD DIRECTOR	1.40	X						0.	0.	0.
JAMES B. SELLINGER BOARD DIRECTOR	2.70	X						0.	0.	0.
RONALD H. SCHACK BOARD DIRECTOR	2.80	X						0.	0.	0.
ALBERT R. COUNSELMAN BOARD DIRECTOR	2.00	X						0.	0.	0.
BARBARA BOZZUTO BOARD CHAIR	4.40	X		X				0.	0.	0.
JOHN E. WHEELER VICE CHAIR	3.70	X		X				0.	0.	0.
BONNIE PHIPPS PRESIDENT	50.00	X		X				1,104,994.	0.	27,244.
ADIL TOTOONCHIE, M.D., MBA SECRETARY	3.10	X		X				0.	0.	0.

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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			
PAUL J. CHEW TREASURER	2.10	X		X				0.	0.	0.
SCOTT FURNISS SENIOR VP/CFO	50.00				X			263,838.	0.	25,222.
ADRIAN LONG EXECUTIVE VP/CMO	50.00				X			430,702.	0.	32,399.
WILLIAM GRESKOVICH VP OPERATIONS & CAPITAL PROJECTS	50.00				X			265,548.	0.	42,785.
YOLANDA COPELAND SENIOR VP PATIENT CARE SERVICES	50.00				X			277,150.	0.	31,518.
GEORGE GRACE MEDICAL DIR. PLASTIC/HAND SURGERY	50.00					X		843,960.	0.	51,498.
HOWARD HESSAN MEDICAL DIRECTOR OTOLARYNGOLOGY	50.00					X		778,208.	0.	43,745.
LAWRENCE SHIN ORTHOPEDIC SURGEON	50.00					X		665,947.	0.	29,987.
VINEY SETYA CHIEF GENERAL SURGERY	50.00					X		561,808.	0.	21,884.
1b Sub-total ▶								5,192,155.	0.	306,282.
c Total from continuation sheets to Part VII, Section A ▶								520,115.	0.	34,229.
d Total (add lines 1b and 1c) ▶								5,712,270.	0.	340,511.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 10

		Yes	No
3 Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization.

(A) Name and business address	(B) Description of services	(C) Compensation
EAGLEEYE RADIOLOGY, INC., 12100 SUNRISE VALLEY DRIVE, RESTON, VA 20191	RADIOLOGY SERVICES	1,168,000.
DRS. HICKEN, CRANLEY & TAYLOR PA CLINICAL 3455 WILKENS AVENUE, BALTIMORE, MD 21229	CONTRACTUAL SERVICES	1,000,519.
MIDATLANTIC CARDIOVASCULAR 1838 GREENE TREE ROAD, BALTIMORE, MD 21208	CARDIOLOGY SERVICES	711,113.
EMCARE, INC., 7032 COLLECTION CENTER DRIVE, CHICAGO, IL 60693	CONTRACTUAL SERVICES	534,376.
ACCESS NURSING SERVICES 411 MANVILLE ROAD, PLEASANTVILLE, NY 10570	NURSING SERVICES	326,932.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 51

SEE PART VII, SECTION A CONTINUATION SHEETS

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

(A) Name and title	(B) Average hours per week	(C) Position (check all that apply)						(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			
ROBERT PALEY CHAIRMAN DIAGNOSTIC IMAGING	50.00					X		520,115.	0.	34,229.
Total to Part VII, Section A, line 1c								520,115.		34,229.

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d	1,815,903.			
	e Government grants (contributions)	1e	722,726.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f				
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		2,538,629.			
Program Service Revenue		Business Code				
	2a PATIENT REVENUE	621990	384,433,913.	379,623,460.	4,810,453.	
	b ANCILLARY JOINT VENT.	900099	4,732,305.	4,732,305.		
	c SYSTEM SUPPORT	900099	780,914.	780,914.		
	d MEDICAL STUDENT	900099	704,831.	704,831.		
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		390,651,963.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		29,360,028.			29,360,028.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross Rents	710,041.				
	b Less: rental expenses	149,658.				
	c Rental income or (loss)	560,383.				
	d Net rental income or (loss)		560,383.			560,383.
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory					
	b Less: cost or other basis and sales expenses					
	c Gain or (loss)					
	d Net gain or (loss)					
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a					
	b Less: direct expenses b					
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities. See Part IV, line 19 a					
	b Less: direct expenses b					
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances a					
	b Less: cost of goods sold b					
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	Business Code				
	11a CAFETERIA REVENUE	900099	1,428,053.			1,428,053.
	b NET ASSETS RELEASED	900099	670,409.			670,409.
	c					
	d All other revenue		1,602,106.			1,602,106.
	e **Total.** Add lines 11a-11d		3,700,568.			
	12 **Total revenue.** See instructions.		426,811,571.	385,841,510.	4,810,453.	33,620,979.

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) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21	156,232.	156,232.		
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	16,595.	16,595.		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,528,595.		2,528,595.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	11,257,102.	9,682,840.	1,574,262.	
7 Other salaries and wages	148,677,368.	126,755,890.	21,921,478.	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	9,828,468.	8,254,083.	1,574,385.	
9 Other employee benefits	10,117,752.	8,497,028.	1,620,724.	
10 Payroll taxes	11,544,033.	9,694,839.	1,849,194.	
11 Fees for services (non-employees):				
a Management				
b Legal	907,968.	89,620.	818,348.	
c Accounting	96,872.		96,872.	
d Lobbying	36,287.		36,287.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other	27,292,637.	18,681,003.	8,611,634.	
12 Advertising and promotion	1,137,338.	53,597.	1,083,741.	
13 Office expenses	67,892,491.	64,635,280.	3,257,211.	
14 Information technology	8,571,483.	8,571,483.		
15 Royalties				
16 Occupancy	1,865,886.	1,200,263.	665,623.	
17 Travel	216,743.	79,660.	137,083.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	242,266.	171,131.	71,135.	
20 Interest	372,542.		372,542.	
21 Payments to affiliates	2,562,467.		2,562,467.	
22 Depreciation, depletion, and amortization	14,799,226.	8,726,233.	6,072,993.	
23 Insurance	2,193,702.	2,740,362.	-546,660.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a BAD DEBTS	16,691,981.	16,691,981.		
b UTILIZATION	7,767,255.	7,767,255.		
c UTILITIES	4,311,880.	4,311,880.		
d RECRUITING COSTS	728,017.	201,389.	526,628.	
e CME	290,726.	286,431.	4,295.	
f All other expenses	10,891,426.	3,531,502.	7,359,924.	
25 **Total functional expenses.** Add lines 1 through 24f	362,995,338.	300,796,577.	62,198,761.	0.
26 **Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		8,274,448.	1	10,174,402.
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net		3,408,039.	3	3,295,641.
	4	Accounts receivable, net		42,184,727.	4	45,978,875.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	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)			6	
	7	Notes and loans receivable, net		580,541.	7	554,544.
	8	Inventories for sale or use		4,148,141.	8	4,775,336.
	9	Prepaid expenses and deferred charges		1,204,806.	9	1,888,963.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 341,726,561.			
	b	Less: accumulated depreciation	10b 129,384,358.	171,293,200.	10c	212,342,203.
	11	Investments - publicly traded securities		2,618,082.	11	3,017,359.
	12	Investments - other securities. See Part IV, line 11			12	
	13	Investments - program-related. See Part IV, line 11		13,312,673.	13	16,044,977.
	14	Intangible assets			14	1,486,920.
	15	Other assets. See Part IV, line 11		171,655,604.	15	184,833,602.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		418,680,261.	16	484,392,822.
Liabilities	17	Accounts payable and accrued expenses		34,712,034.	17	48,101,034.
	18	Grants payable			18	
	19	Deferred revenue		11,710.	19	11,710.
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties		80,586,587.	24	80,006,845.
	25	Other liabilities. Complete Part X of Schedule D		56,357,803.	25	25,667,085.
	26	**Total liabilities.** Add lines 17 through 25		171,668,134.	26	153,786,674.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		235,998,571.	27	319,306,971.
	28	Temporarily restricted net assets		10,889,313.	28	11,168,819.
	29	Permanently restricted net assets		124,243.	29	130,358.
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		247,012,127.	33	330,606,148.
	34	Total liabilities and net assets/fund balances		418,680,261.	34	484,392,822.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	426,811,571.
2	Total expenses (must equal Part IX, column (A), line 25)	2	362,995,338.
3	Revenue less expenses. Subtract line 2 from line 1	3	63,816,233.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	247,012,127.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	19,777,788.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	330,606,148.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII .....

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization	**Employer identification number**
ST. AGNES HEALTHCARE, INC.	52-0591657

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 11, 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.)

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 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.)

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

11 ☐ 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 that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Other

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? **11g(i)**		
(ii)	A family member of a person described in (i) above? **11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col. (i) of your support? Yes	(v) No	(vi) Is the organization in col. (i) organized in the U.S.? Yes	(vi) No	(vii) Amount of support
Total									

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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 IV.)						
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 2010 (line 6, column (f) divided by line 11, column (f)) **14** %

15 Public support percentage from 2009 Schedule A, Part II, line 14 **15** %

16a **33 1/3% support test - 2010.** 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 - 2009.** 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 - 2010.** 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2009.** 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 IV 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 9 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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 IV.)						
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 2010 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2009 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2010** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2009** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2010.** 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 - 2009.** 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 ▶ ☐

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, 990-EZ, or 990-PF.

OMB No. 1545-0047

2010

Name of the organization	Employer identification number
ST. AGNES HEALTHCARE, INC.	52-0591657

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, aggregate contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not aggregate to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year. ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2 of its Form 990, or check the box on line H of its Form 990-EZ, or on line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
ST. AGNES HEALTHCARE, INC.	52-0591657

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	ST. AGNES FOUNDATION 900 CATON AVENUE BALTIMORE, MD 21229	$ 1,815,903.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	AHRQ GRANT 4600 EDMUNDSON ROAD SAINT LOUIS, MO 63134	$ 132,726.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	MARYLAND STATE GRANT 301 W. PRESTON STREET BALTIMORE, MD 21201	$ 560,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4	MARYLAND HOSPITAL ASSOCIATION, INC. 6820 DEERPATH ROAD ELKRIDGE, MD 21075	$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization	Employer identification number
ST. AGNES HEALTHCARE, INC.	52-0591657

Part II Noncash Property (see instructions)

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

Part III **Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations aggregating more than $1,000 for the year.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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.**
▶ **See separate instructions.**

OMB No. 1545-0047

2010

Open to Public Inspection

If the organization answered "Yes," to 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," to 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," to Form 990, Part IV, line 5 (Proxy Tax), or Form 990-EZ, Part V, line 35a (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
ST. AGNES HEALTHCARE, INC.	52-0591657

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.
2 Political expenditures ▶ $
3 Volunteer hours

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-.

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group.

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2007	**(b)** 2008	**(c)** 2009	**(d)** 2010	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2010

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)).

		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		X	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c	Media advertisements?		X	
d	Mailings to members, legislators, or the public?		X	
e	Publications, or published or broadcast statements?		X	
f	Grants to other organizations for lobbying purposes?		X	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i	Other activities? If "Yes," describe in Part IV	X		36,287.
j	Total. Add lines 1c through 1i			36,287.
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
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 carryover 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) if BOTH Part III-A, lines 1 and 2 are answered "No" OR if 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

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; and Part II-B, line 1i. Also, complete this part for any additional information.

PART II-B, LINE 1(I), OTHER LOBBYING ACTIVITIES:

LOBBYING EXPENSES REPRESENT THE DUES PAID TO NATIONAL AND STATE

HOSPITAL ASSOCIATIONS, A PORTION OF WHICH IS SPECIFICALLY ALLOCABLE TO

LOBBYING.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to 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 Tax Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

7 Amount of expenses incurred in monitoring, inspecting, 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 XIV, 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" to 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 XIV, 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) Revenues included in 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 Revenues included in 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 XIV.

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" to 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 XIV and complete the following table:

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

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIV.

Part V Endowment Funds. Complete if the organization answered "Yes" to 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	2,685,977.	2,374,969.	2,926,667.		
b Contributions					
c Net investment earnings, gains, and losses	412,356.	311,008.	-551,698.		
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	3,098,333.	2,685,977.	2,374,969.		

2 Provide the estimated percentage of the year end balance held as:

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ 96.00 %
c Term endowment ▶ 4.00 %

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

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

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

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		488,600.		488,600.
b Buildings		141,545,890.	23,010,916.	118,534,974.
c Leasehold improvements		2,728,008.	1,422,152.	1,305,856.
d Equipment		78,914,707.	53,850,477.	25,064,230.
e Other		118,049,356.	51,100,813.	66,948,543.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				212,342,203.

Schedule D (Form 990) 2010

Part VII Investments - Other Securities. 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)		
(I)		
Total. (Col (b) must equal Form 990, Part X, col (B) line 12.) ▶		

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col (b) must equal Form 990, Part X, col (B) line 13.) ▶		

Part IX Other Assets. See Form 990, Part X, line 15.

	(a) Description	(b) Book value
(1)	INVESTMENT - DEFERRED COMPENSATION	4,702,427.
(2)	INVESTMENT IN EXEC FLEX CAA	151,016.
(3)	CASH SURRENDER VALUE - LIFE	778,728.
(4)	HEALTH SYSTEM DEPOSITORY (HSD)	175,228,322.
(5)	INTEREST IN FOUNDATION NET ASSETS	2,164,778.
(6)	OTHER NON CURRENT ASSET-FICA RECEIVABLE	1,795,501.
(7)	DUE FROM DCNHS-AHRQ GRANT	12,830.
(8)		
(9)		
(10)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15.)* ▶		184,833,602.

Part X Other Liabilities. See Form 990, Part X, line 25.

1.	(a) Description of liability	(b) Amount
(1)	Federal income taxes	
(2)	PENSION	410,113.
(3)	CURRENT PORTION OF L/T DEBT	579,742.
(4)	OTHER CURRENT LIABILITIES	14,108,314.
(5)	OTHER NON-CURRENT LIABILITIES	6,417,976.
(6)	SELF INSURANCE LIABILITY	4,150,940.
(7)		
(8)		
(9)		
(10)		
(11)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25.)* ▶		25,667,085.

2. FIN 48 (ASC 740) Footnote. In Part XIV, 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).

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	
9	Total adjustments (net). Add lines 4 through 8	9	
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

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 on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	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 XIV.)	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 XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

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 XIV.)	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 XIV.)	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 XIV Supplemental Information

Complete this part to 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, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4, ENDOWMENT FUNDS :

WHITEFORD ENDOWMENT - 50% TO BE UTILIZED TO ERECT A WING OR ADDITIONAL

BUILDING, ADDITIONAL 50% MAY BE USED TO SUPPORT HOSPITAL OPERATIONS.

JENKINS ENDOWMENT - THIS ENDOWMENT WAS ESTABLISHED IN 1911, A PORTION OF

THE EARNINGS FROM THE FUND IS RESTRICTED FOR THE CARE OF CANCER PATIENTS.

IN AUGUST 2012, THE TIME RESTRICTIONS WILL HAVE BEEN MET AND ST. AGNES

PLANS TO USE THE REMAINING BALANCE TO FUND THE CAMPUS REVITILIZATION

PROJECT.

Part XIV Supplemental Information *(continued)*

BROWNE ENDOWMENT - ESTABLISHED FOR USE BY CARDIAC UNIT TO AID THE

INDIGENT.

GITTINGS ENDOWMENT - CREATED TO PROVIDE A BED IN THE CHILDREN'S WARD.

PART X, THE ORGANIZATION DOES NOT CONDUCT A SEPARATE AUDIT OF ITS

FINANCIAL STATEMENTS, BUT IS INCLUDED IN THE ASCENSION HEALTH SYSTEM

CONSOLIDATED AUDITED FINANCIAL STATEMENTS. PER THE FINANCIAL STATEMENTS OF

ASCENSION HEALTH, THERE IS NO CURRENT YEAR ASC 740 (FORMERLY KNOWN AS FIN

48 FOOTNOTE.

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" to 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. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open To Public Inspection

Name of the organization
ST. AGNES HEALTHCARE, INC.

Employer identification number
52-0591657

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

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

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

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

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

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
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.

MD

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))
		(event type)	(event type)	(total number)	
Revenue	1 Gross receipts				
	2 Less: Charitable contributions				
	3 Gross income (line 1 minus line 2)				
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses				
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				( )
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

11 Does the organization operate 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 operated in:

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

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

Name ▶

Address ▶

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

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

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

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ $ _____

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

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

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

Part IV **Supplemental Information.** Complete this part to 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 complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

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	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____ %	X	
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria 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, to determine 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"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
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?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)			12,314,893.		12,314,893.	3.56%
b Unreimbursed Medicaid (from Worksheet 3, column a)			8,928,787.	4,626,162.	4,302,625.	1.19%
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			21,243,680.	4,626,162.	16,617,518.	4.75%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,996,448.	46,948.	2,949,500.	.81%
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)			2,563,049.	524,088.	2,038,961.	.56%
h Research (from Worksheet 7)			443,228.	142,009.	301,219.	.08%
i Cash and in-kind contributions to community groups (from Worksheet 8)			818,047.		818,047.	.23%
j **Total.** Other Benefits			6,820,772.	713,045.	6,107,727.	1.68%
k **Total.** Add lines 7d and 7j			28,064,452.	5,339,207.	22,725,245.	6.43%

Part II Community Building Activities

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support			45,527.	30,000.	15,527.	.00%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total			45,527.	30,000.	15,527.	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense (at cost)	2	11,783,985.		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	147,658.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	137,281,270.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	131,768,096.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	5,513,174.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☒ Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(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 %

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

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

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 ST. AGNES HEALTHCARE, INC. 900 CATON AVENUE BALTIMORE, MD 21229	X	X		X		X	X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of Hospital Facility: ST. AGNES HEALTHCARE, INC.

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 ____			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8		
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care to low income individuals?	9		
	If "Yes," indicate the FPG family income limit for eligibility for free care: _____ %			

Part V Facility Information *(continued)* ST. AGNES HEALTHCARE, INC.

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: _____ %			
11	Explained the basis for calculating amounts charged to patients?	11		
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☐ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12		
13	Included measures to publicize the policy within the community served by the hospital facility?	13		
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☐ The policy was posted on the hospital facility's website			
b	☐ The policy was attached to billing invoices			
c	☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☐ The policy was posted in the hospital facility's admissions offices			
e	☐ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☐ The policy was available on request			
g	☐ Other (describe in Part VI)			
Billing and Collections				
14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16		
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☐ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Part V Facility Information *(continued)* ST. AGNES HEALTHCARE, INC.

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	**18**		

If "No," indicate the reasons why (check all that apply):

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility did not have a policy relating to emergency medical care
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- **d** ☐ Other (describe in Part VI)

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):

- **a** ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility
- **b** ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility
- **c** ☐ The hospital facility used the Medicare rate for those services
- **d** ☐ Other (describe in Part VI)

20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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 Part VI.	**20**		
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI.	**21**		

Part V Facility Information *(continued)*

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

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? 8

Name and address	Type of Facility (describe)
1 PLASTIC AND RECONSTRUCTIVE SURGERY 300 FREDERICK ROAD SUITE 200 CATONSVILLE, MD 21228	PLASTIC SURGERY
2 WOMEN'S CENTER IN COLUMBIA 10910 LITTLE PATUXENT PARKWAY STE 100 COLUMBIA, MD 21044	BLOOD DRAWING STATION
3 ST. AGNES MEDICAL CENTER 700 GEIPE ROAD BALTIMORE, MD 21228	BLOOD DRAWING STATION
4 COMMUNITY CENTER OUTREACH AT BALTIMORE 900 CATON AVENUE BALTIMORE, MD 21229	BLOOD DRAWING STATION
5 PINE HEIGHTS PROFESSIONAL BUILDING 1001 PINE HEIGHTS AVENUE SUITE 202 BALTIMORE, MD 21229	BLOOD DRAWING STATION
6 BENSON AVENUE MEDICAL CENTER 3421 BENSON AVENUE BALTIMORE, MD 21227	WOUND CARE CENTER
7 SETON IMAGING CENTER 3449 WILKINS AVENUE BALTIMORE, MD 21229	DIAGNOSTIC IMAGING
8 SURGERY CENTER OF ELLICOTT CITY 10025 GOVERNOR WARFIELD PKWY SUITE 410 COLUMBIA, MD 21044	OUTPATIENT SURGICAL CENTER

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

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

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

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

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

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

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

PART I, LINE 3C: GENERALLY, DISCOUNTED CARE TO LOW INCOME INDIVIDUALS IS PROVIDED ON A SLIDING SCALE FOR THOSE NOT EXCEEDING 300% OF THE FEDERAL POVERTY LEVEL. FOR EMERGENCY DEPARTMENT PATIENTS AND OTHER OUTPATIENTS (ACCOUNT BALANCES UNDER $500.00) MAY BE GRANTED CHARITY EXCLUSIVELY BASED UPON THE USE OF THE AUTOMATED ELIGIBILITY SOFTWARE ONLY. IN THOSE INSTANCES, A SIGNED/COMPLETED APPLICATION WILL NOT BE REQUIRED.

ADDITIONALLY, PATIENTS MAY ALSO BE ELIGIBLE FOR CHARITY CARE IF THEY MEET CRITERIA THAT WOULD DETERMINE THAT THEY ARE EXPERIENCING A FINANCIAL HARDSHIP. FINANCIAL HARDSHIP IS DEFINED AS MEDICAL DEBT FOR MEDICALLY NECESSARY SERVICES INCURRED BY A FAMILY WITH INCOME BELOW 500% OF THE FEDERAL POVERTY LEVEL THAT EXCEEDS 25% OF THE FAMILY INCOME OVER A 12 MONTH PERIOD. MEDICAL DEBT IS OUT OF POCKET EXPENSES, EXCLUDING COPAYMENTS, COINSURANCE AND DEDUCTIBLES FOR MEDICAL COSTS BILLED BY ST. AGNES HEALTHCARE. THE PATIENT AND ANY IMMEDIATE FAMILY MEMBER OF THE PATIENT LIVING IN THE SAME HOUSEHOLD ARE ELIGIBLE.

PART I, LINE 7: THE COSTING METHODOLOGY USED TO COMPLETE LINE 7A

Part VI Supplemental Information

(CHARITY CARE) AND LINE 7B (UNREIMBURSED MEDICAID) IN THE TABLE WAS THE COST TO CHARGE RATIO. THE COST TO CHARGE RATIO WAS CALCULATED IN ACCORDANCE WITH WORKSHEET 2 OF THE INTERNAL REVENUE SERVICE INSTRUCTIONS FOR SCHEDULE H, WHICH SUGGESTS USING THE OPERATING EXPENSES FROM THE FILING ENTITY'S FINANCIAL STATEMENTS, EXCLUDING BAD DEBT AND CERTAIN OTHER ADJUSTMENTS, AND APPLYING THE RESULT TO THE GROSS CHARGES FROM THE FILING ENTITY'S FINANCIAL STATEMENTS. THE RESULTING RATIO IS USED TO CALCULATE CHARITY CARE AT COST AND UNREIMBURSED MEDICAID.

PART I LINE 7 CHARITY CARE AT COST - LINE 7A COLUMN D

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

PT I LINE 7 UNREIMBURSED MEDICAID - COLUMN C,D,E,F

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY DIRECTED OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY

Part VI Supplemental Information

BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO; MEDICAID RECOGNIZES FULL REIMBURSEMENT. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

THE AMOUNTS REPORTED IN PART I,LINE 7B REPRESENT UNREIMBURSED MEDICAID COSTS FOR UNREGULATED HEALTH CARE ACTIVITIES AND THE MEDICAID ASSESSMENT.

PART I LINE 7 COLUMN F

BAD DEBT EXPENSE FROM PART IX, STATEMENT OF FUNCTIONAL EXPENSES, EXCLUDED FROM THE DENOMINATOR USED TO CALCULATE TOTAL CHARITY CARE EXPENSE WAS $16,691,981.

PART III, LINE 4: PART III SECTION A - BAD DEBT EXPENSE LINE 2 & 3

THE BAD DEBT EXPENSE REPORTED AT COST WAS ESTIMATED USING THE BAD DEBT EXPENSE FROM THE CONSOLIDATED ST. AGNES HEALTHCARE FINANCIAL STATEMENTS, APPLYING THE COST TO CHARGE RATIO DEVELOPED USING WORKSHEET 2 FROM THE SCHEDULE H INSTRUCTIONS. THE STATE OF MARYLAND IS AN "ALL PAYOR" STATE REGULATED BY THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) WHERE ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. THEREFORE, SELF PAY DISCOUNTS, ARE LARGELY NOT APPLICABLE FOR REGULATED ACTIVITY AND HAVE NO IMPACT ON BAD DEBT EXPENSE. THE ESTIMATED AMOUNT OF BAD DEBT EXPENSE, AT COST, ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY WAS ESTIMATED BY EXAMINING ALL BAD DEBT WRITE-OFFS AT THE PATIENT ACCOUNT LEVEL DURING THE FISCAL YEAR. THOSE ACCOUNTS THAT HAD AN INSURANCE

Part VI Supplemental Information

CLASSIFICATIONS OF CHARITY, CHARITY PENDING, OR MEDICAID PENDING THAT WAS SUBSEQUENTLY WRITTEN OFF TO BAD DEBT, ARE ASSUMED TO BE PATIENTS THAT WOULD HAVE BEEN ELIGIBLE FOR ASSISTANCE UNDER THE CHARITY CARE POLICY IF SUFFICIENT INFORMATION WOULD HAVE BEEN PROVIDED TO MAKE THAT DETERMINATION. THE SUM OF THOSE ACCOUNTS, MULTIPLIED BY THE COST TO CHARGE RATIO, IS REPORTED IN SECTION A, LINE 3.

PART III LINE 4 SECTION A - BAD DEBT EXPENSE

NET PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED REALIZABLE AMOUNTS FROM PATIENTS, THIRD-PARTY PAYORS, AND OTHERS FOR SERVICES PROVIDED AND INCLUDES ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYORS. REVENUE UNDER CERTAIN THIRD-PARTY PAYOR AGREEMENTS IS SUBJECT TO AUDIT, RETROACTIVE ADJUSTMENTS, AND SIGNIFICANT REGULATORY ACTIONS. PROVISIONS FOR THIRD-PARTY PAYOR SETTLEMENTS AND ADJUSTMENTS ARE ESTIMATED IN THE PERIOD THE RELATED SERVICES ARE PROVIDED AND ADJUSTED IN FUTURE PERIODS AS ADDITIONAL INFORMATION BECOMES AVAILABLE AND AS FINAL SETTLEMENTS ARE DETERMINED. LAWS AND REGULATIONS GOVERNING THE MEDICARE AND MEDICAID PROGRAMS ARE COMPLEX AND SUBJECT TO INTERPRETATION. AS A RESULT, THERE IS AT LEAST A POSSIBILITY THAT RECORDED ESTIMATES WILL CHANGE BY A MATERIAL AMOUNT IN THE NEAR TERM. DURING 2011 AND 2010, APPROXIMATELY 45% AND 44%, RESPECTIVELY, OF NET PATIENT SERVICE REVENUE WAS RECEIVED UNDER THE MEDICARE PROGRAM AND 15% AND 14%, RESPECTIVELY, UNDER VARIOUS STATE MEDICAID PROGRAMS. THE HEALTH MINISTRY GRANTS CREDIT WITHOUT COLLATERAL TO ITS PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY PAYOR ARRANGEMENTS. SIGNIFICANT CONCENTRATIONS OF ACCOUNTS RECEIVABLE AT JUNE 30, 2011 AND 2010 INCLUDE MEDICARE (29% AND 31%, RESPECTIVELY) AND VARIOUS STATES' MEDICAID (22% AND 20%, RESPECTIVELY)

Part VI Supplemental Information

PROGRAMS.

THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF EXPECTED NET COLLECTIONS CONSIDERING ECONOMIC CONDITIONS, HISTORICAL EXPERIENCE, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY, INCLUDING THOSE AMOUNTS NOT COVERED BY INSURANCE. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE AND REASONABLE EFFORTS TO COLLECT FROM THE PATIENT HAVE BEEN EXHAUSTED, THE HEALTH MINISTRY FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST DUE PATIENT BALANCES WITH COLLECTION AGENCIES, SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY ASCENSION HEALTH. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH THE HEALTH MINISTRY'S POLICIES.

PART III, LINE 8: INCLUDED IN LINE 5 AND 6 OF SECTION B ARE MEDICARE ALLOWABLE COSTS AND REIMBURSEMENT REPORTED ON THE HOSPITAL'S MEDICARE COST REPORT. THIS INCLUDES REIMBURSABLE ACUTE HOSPITAL SERVICES. IN ADDITION, THE HOSPITAL HAS ALSO INCLUDED MEDICARE NET REVENUES AND EXPENSES FOR NON-HOSPITAL SERVICES NECESSARY TO SUPPORT HOSPITAL OPERATIONS. THIS INCLUDES PROFESSIONAL RADIOLOGY, ANESTHESIA AND OTHER PHYSICIAN SPECIALTY SERVICES.

THE MEDICARE SURPLUS OF $17,349,080 FOR HOSPITAL SERVICES WAS CALCULATED

Part VI Supplemental Information

BY SUBTRACTING THE MEDICARE COSTS (GROSS MEDICARE REVENUE MULTIPLIED BY THE COST TO CHARGE RATIOS REPORTED ON THE MEDICARE COST REPORT) FROM THE MEDICARE PAYMENTS. NON-HOSPITAL SERVICES SHORTFALL OF $11,835,906 WAS CALCULATED BY MULTIPLYING EACH NON-HOSPITAL SERVICES' MEDICARE PATIENT SHARE BY THE NON-HOSPITAL SERVICES' ANNUAL OPERATING LOSS. MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. THIS UNIQUE PAYMENT SYSTEM IS DESIGNED FOR ALL PAYORS TO SHARE THE COST OF HEALTHCARE EQUALLY, MEANING THE COST SHIFTING TO PRIVATE PAYORS, THAT IS COMMONLY SEEN IN OTHER STATES, IS NOT EXPERIENCED IN MARYLAND. THIS MODEL RESULTS IN A SURPLUS OF PAYMENT OVER EXPENSE.

PART III, LINE 9B: IT IS ST. AGNES HEALTHCARE'S POLICY TO PLACE ACCOUNTS THAT HAVE BEEN WRITTEN OFF TO BAD DEBT WITH A COLLECTION AGENCY FOR ADDITIONAL COLLECTION EFFORT. PATIENTS MAY APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THE REVENUE CYCLE. PATIENTS WHO WORK TO APPLY FOR CHARITY CARE WHOSE ACCOUNT RESIDES AT THE AGENCY WILL BE REFERRED TO THE HOSPITAL BY THE AGENCY. THE AGENCY WILL DELETE THE ACCOUNT AND THE HOSPITAL WILL WORK WITH THE PATIENT TO COMPLETE THE CHARITY CARE APPLICATION PROCESS. EMERGENCY DEPARTMENT PATIENTS AND OTHER OUTPATIENTS (ACCOUNT BALANCES UNDER $500.00) MAY BE GRANTED CHARITY EXCLUSIVELY BASED UPON THE USE OF AN AUTOMATED ELIGIBILITY SOFTWARE. A SIGNED/ COMPLETED APPLICATION WILL NOT BE REQUIRED IN THOSE INSTANCES.

PART VI, LINE 2: ST. AGNES HEALTHCARE PREPARES A COMMUNITY NEEDS

Part VI Supplemental Information

ASSESSMENT EVERY THREE YEARS, WHICH WAS LAST UPDATED IN APRIL 2007. THE HEALTH STATUS OF A COMMUNITY CAN BE MEASURED BY A VARIETY OF METHODS. CONSIDERATIONS CAN INCLUDE BIRTH AND DEATH RATES, LIFE EXPECTANCY, MORBIDITY, HEALTH INSURANCE COVERAGE, HEALTH RESOURCES AVAILABILITY, AND POPULATION DATA. TO THE EXTENT POSSIBLE, ST. AGNES HEALTHCARE SEEKS TO CONSIDER MANY OF THESE FACTORS. ST. AGNES HEALTHCARE'S COMMUNITY NEEDS ASSESSMENT FOCUSES ON HEALTH STATUS INDICATORS THAT HAVE BEEN GROUPED INTO FOUR KEY AREAS: DEMOGRAPHICS, SOCIOECONOMIC STATUS, HEALTH STATUS, AND HEALTH RESOURCE UTILIZATION/PHYSICIAN MANPOWER NEEDS. TO SUPPORT THE ANALYSIS, READILY AVAILABLE DATA WAS GATHERED FROM THE U.S. CENSUS AND MARYLAND DISCHARGE DATABASES FOR INPATIENT AND EMERGENCY SERVICES, AND POPULATION FORECASTS.

THE FIRST HEALTH STATUS INDICATOR GROUPING INVOLVES DEMOGRAPHICS. THE ANALYSIS OF DEMOGRAPHIC DATA INCLUDES A REVIEW OF POPULATION DENSITY, POPULATION AGE LESS THAN OR EQUAL TO FIVE YEARS OLD, POPULATION AGE GREATER THAN OR EQUAL TO SIXTY-FIVE YEARS OLD, FEMALE POPULATION AGES FIFTEEN TO FORTY-FOUR, FEMALE POPULATION GROWTH AGES FIFTEEN TO FORTY-FOUR, POPULATION GROWTH AGE GREATER THAN OR EQUAL TO SEVENTY-FIVE YEARS OLD, AND MINORITY POPULATION.

THE SECOND HEALTH STATUS INDICATOR GROUPING INVOLVES SOCIOECONOMIC STATUS. THE ANALYSIS OF SOCIOECONOMIC DATA INCLUDES A REVIEW OF THE PERCENT OF HOUSEHOLDS IN POVERTY, CHILDREN LIVING IN POVERTY, AVERAGE HOUSEHOLD INCOME, POPULATION OF UNINSURED, POPULATION AGE EIGHTEEN TO TWENTY-FOUR WITH A HIGH SCHOOL DIPLOMA, TOTAL POPULATION WITHOUT A HIGH SCHOOL DIPLOMA, POPULATION WITH DISABILITIES, UNEMPLOYED CIVILIAN LABOR FORCE, LEVEL OF RENTAL HOUSING, AND LEVEL OF VACANT HOUSING.

Part VI Supplemental Information

THE THIRD DATA GROUPING INVOLVES A MORE DETAILED REVIEW OF CERTAIN ADDITIONAL HEALTH STATUS INDICATORS. THE HEALTH STATUS ANALYSIS REVIEWS AMBULATORY SENSITIVE HOSPITALIZATIONS, SUCH AS ASTHMA, CONGESTIVE HEART FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DIABETES, HYPERTENSION, AND PNEUMONIA. THE HEALTH STATUS ANALYSIS ALSO EXAMINES MATERNAL AND INFANT HEALTH, INCLUDING THE LEVEL OF BIRTHS TO TEEN MOMS, THE LEVEL OF LOW BIRTH WEIGHT INFANTS, THE LEVEL OF BIRTH DEFECTS, THE LEVEL OF INFANT MORTALITY, AND THE LEVEL OF BIRTHS WITH INSUFFICIENT PRENATAL CARE. ADDITIONALLY, MAJOR DISEASE PREVALENCE IS ALSO EXAMINED. THIS INCLUDES EXAMINING THE CANCER, CARDIOVASCULAR, AND STROKE DISCHARGES PER ONE THOUSAND POPULATION. MAJOR DISEASE PREVALENCE ALSO INCLUDES EXAMINING LIFESTYLE BEHAVIORS AND INDICATORS, SUCH AS OBESITY, MENTAL HEALTH, SUBSTANCE ABUSE, TOBACCO USE AND HIV.

THE FINAL DATA GROUPING EXAMINES HEALTH RESOURCE UTILIZATION AND THE PHYSICIAN MANPOWER NEED. THIS ANALYSIS REVIEWS ACUTE CARE DISCHARGES, ACUTE CARE INPATIENT DAYS, AND OUTPATIENT EMERGENCY VISITS PER ONE THOUSAND POPULATION. FURTHERMORE, PRIMARY CARE AND SPECIALTY PHYSICIAN NEEDS ARE EVALUATED.

THE ASSESSMENT PROVIDES A COMPARATIVE ANALYSIS OF THE COMMUNITIES THAT COMPRISE ST. AGNES HEALTHCARE'S SERVICE AREA. THE PRIMARY METHODOLOGY UTILIZED IS A RANKING OF THE COMMUNITY SCORES FOR EACH INDICATOR AGAINST THE CENTRAL MARYLAND AVERAGE. AN INDEX IS CREATED WHERE 1.0 IS THE AVERAGE OF CENTRAL MARYLAND. IN THE ANALYSIS, ANY SCORE ABOVE 1.0 IS WORSE THAN AVERAGE AND ANYTHING BELOW 1.0 IS BETTER THAN AVERAGE. COMPOSITE SCORES ARE DEVELOPED FOR EACH OF THE FOUR MAJOR ASSESSMENT AREAS AND THESE ARE

Part VI Supplemental Information

THEN SUMMARIZED TO GENERATE A COMPOSITE OVERALL NEED INDEX. THIS METHODOLOGY IS MODELED AFTER THE APPROACH FORMERLY UTILIZED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR THE STATEWIDE PRIMARY CARE ACCESS PLAN.

PART VI, LINE 3: ST. AGNES HEALTHCARE DISPLAYS SIGNAGE, IN BOTH ENGLISH AND SPANISH IN ALL REGISTRATION AREAS THAT INFORM PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE PROGRAMS AND CONTACT INFORMATION. THE SIGNAGE IS ACCOMPANIED BY BROCHURES THAT EXPLAIN THE VARIOUS FINANCIAL ASSISTANCE PROGRAMS THAT ARE AVAILABLE. THE MARYLAND STATE FINANCIAL ASSISTANCE APPLICATION IS ALSO AVAILABLE. REGISTRATION AREAS ARE ROUTINELY CHECKED TO INSURE THESE MATERIALS ARE PROMINENTLY DISPLAYED. ST. AGNES HEALTHCARE HAS EMPLOYEES WHO ARE RESPONSIBLE FOR SCREENING ADMISSIONS TO IDENTIFY PATIENTS WHO MAY BE ELIGIBLE FOR CHARITY, MEDICAID, OR OTHER STATE PROGRAMS. ONCE THESE PATIENTS ARE IDENTIFIED, ST. AGNES HEALTHCARE EMPLOYEES ASSIST THEM WITH COMPLETING THE ELIGIBILITY PROCESS.

ALL INPATIENTS ARE PROVIDED THE PATIENT BILLING AND FINANCIAL ASSISTANCE INFORMATION SHEET AT THE TIME OF ADMISSION. IT IS ALSO MAILED TO THE PATIENT WITH THE SUMMARY BILL THAT IS SENT AFTER DISCHARGE. THE INFORMATION SHEET IS PROVIDED IN BOTH ENGLISH AND SPANISH AND PROVIDES THE PATIENT WITH INFORMATION REGARDING ST. AGNES HEALTHCARE'S FINANCIAL ASSISTANCE POLICY, HOW TO APPLY FOR FINANCIAL ASSISTANCE AND MEDICAL ASSISTANCE AND THE PATIENT'S RIGHTS AND OBLIGATIONS.

A PUBLIC NOTICE IS ALSO PUBLISHED ANNUALLY IN THE BALTIMORE SUN NEWSPAPER NOTIFYING THE PUBLIC OF THE AVAILABILITY OF UNCOMPENSATED CARE AT ST. AGNES HEALTHCARE.

Part VI Supplemental Information

PART VI, LINE 4: THE AREAS SURROUNDING ST. AGNES HEALTHCARE HAVE A DIVERSE SOCIOECONOMIC COMPOSITION WITH A MIX OF URBAN AND SUBURBAN COMMUNITIES THAT ARE CONSISTENT WITH THE RANGE OF COMMUNITIES FOUND IN ANY LARGE METROPOLITAN REGION. FOR ST. AGNES HEALTHCARE, THE CHALLENGE OF SERVING THESE COMMUNITIES LIES IN MEETING THE DIFFERENT NEEDS ASSOCIATED BETWEEN SOME OF THE POOREST AND MOST AFFLUENT NEIGHBORHOODS IN CENTRAL MARYLAND ALL LOCATED WITHIN A THREE MILE RADIUS OF THE HOSPITAL CAMPUS. A FURTHER CHALLENGE IS THE RAPIDLY CHANGING COMPOSITION OF THE NEIGHBORHOODS LOCATED MOST IMMEDIATE TO ST. AGNES HEALTHCARE, WHICH OVER THE LAST FIVE YEARS, HAVE EXPERIENCED INCREASING URBAN BLIGHT.

ST. AGNES HEALTHCARE'S SERVICE AREA SPANS FIVE MARYLAND COUNTIES INCLUDING BALTIMORE COUNTY, BALTIMORE CITY, ANNE ARUNDEL COUNTY, HOWARD COUNTY, AND CARROLL COUNTY. WITHIN THOSE COUNTIES, ELEVEN COMMUNITIES ARE SERVED REPRESENTING 22 POSTAL ZIP CODES. THOSE COMMUNITIES INCLUDE ARBUTUS, BROOKLYN/LINTHICUM, CATONSVILLE, ELLICOTT CITY, GLEN BURNIE, SOUTH CARROLL, PASADENA, SOUTH BALTIMORE CITY, SOUTHWEST BALTIMORE CITY, WEST BALTIMORE CITY, AND WOODLAWN. THIS STUDY AREA REPRESENTS APPROXIMATELY 81% OF THE DISCHARGES FOR ST. AGNES HEALTHCARE, WITH ARBUTUS AND CATONSVILLE RELYING MOST HEAVILY ON ST. AGNES HEALTHCARE FOR THEIR INPATIENT HEALTH CARE NEEDS. THE DEMOGRAPHICS OF ST. AGNES HEALTHCARE'S SERVICE AREA AVERAGE OUT TO BE THE SAME AS CENTRAL MARYLAND OVERALL. HOWEVER, INDEPENDENTLY EACH INDICATOR VARIES SUBSTANTIALLY FROM CENTRAL MARYLAND. THE SERVICE AREA SHOWS A SIGNIFICANTLY HIGHER THAN AVERAGE POPULATION DENSITY OF 2,345 PER SQUARE MILE, COMPARED TO 1,155 FOR CENTRAL MARYLAND.

CHILDREN UNDER AGE FIVE AND ADULTS SIXTY-FIVE AND OLDER TOTALED 49,793 AND

Part VI Supplemental Information

89,932 RESPECTIVELY, COMPARED TO CENTRAL MARYLAND AVERAGES OF 165,227 AND 314,862 RESPECTIVELY. FEMALES AGES FIFTEEN TO FORTY-FOUR TOTALED 157,576 FOR THE SERVICE AREA WHILE THE CENTRAL MARYLAND AVERAGE WAS 554,037. THE SERVICE AREA IS SIGNIFICANTLY MORE RACIALLY AND ETHNICALLY DIVERSE THAN THE CENTRAL MARYLAND AVERAGES. SPECIFICALLY, COMMUNITIES THAT COMPRISE THE SOUTHWEST CORNER OF BALTIMORE CITY AND BALTIMORE COUNTY CONTAIN POPULATIONS WHERE 90% OF THE POPULATIONS CONSIST OF NONWHITE RACIAL OR ETHNIC GROUPS.

TYPICAL TO THE URBAN ENVIRONMENT, EACH COMMUNITY LOCATED IN BALTIMORE CITY IS PROJECTED TO EXPERIENCE A POPULATION DECLINE, WHILE SUBURBAN AREAS LIKE ELLICOTT CITY, SOUTH CARROLL, AND PASADENA ARE PROJECTED TO HAVE POPULATION GROWTH. THE OVERALL POPULATION GROWTH IS EXPECTED TO EXCEED THE CENTRAL MARYLAND AVERAGE, BUT THE GROWTH RATE OF PERSONS OVER THE AGE OF SEVENTY-FIVE IS EXPECTED TO LAG BEHIND. THE DEMOGRAPHIC ANALYSIS SHOWS THAT WEST BALTIMORE CITY CONTINUES TO EXHIBIT DEMOGRAPHIC CHARACTERISTICS WITH HIGHER NEED, WHILE ARBUTUS AND CATONSVILLE EXHIBIT COMPARITIVELY LOWER NEED CHARACTERISTICS. LOWER SOCIOECONOMIC STATUS IS HIGHLY CORRELATED WITH POOR HEALTH OUTCOMES, DECREASED ACCESS TO HEALTH SERVICES, AND UNHEALTHY LIFESTYLES. OVERALL, THE ST. AGNES HEALTHCARE SERVICE AREA IS MARKED BY A LESS FAVORABLE SOCIOECONOMIC STATUS THAN THAT OF CENTRAL MARYLAND AS A WHOLE. THE INDICES ARE DIVIDED AS URBAN COMMUNITIES ARE LESS FAVORABLE AND SUBURBAN COMMUNITIES ARE MORE FAVORABLE THAN THE CENTRAL MARYLAND AVERAGE. THE PERCENTAGE OF HOUSEHOLDS WITH LOW INCOME WAS 40% FOR THE SERVICE AREA, COMPARED TO 30% FOR THE CENTRAL MARYLAND AVERAGE. THE AVERAGE HOUSEHOLD INCOME IN THE SERVICE AREA WAS LOWEST IN WEST BALTIMORE CITY AT $39,014 AND HIGHEST IN ELLICOTT CITY AT $101,620. THE OVERALL AVERAGE FOR THE SERVICE AREA WAS $68,017 COMPARED TO THE CENTRAL MARYLAND

Part VI Supplemental Information

AVERAGE WHICH WAS $83,587. THE RATE OF UNINSURED PATIENTS WAS CLOSELY TIED TO AVERAGE HOUSEHOLD INCOME WITH WEST BALTIMORE CITY SHOWING THE HIGHEST UNINSURED RATE, 39%, AND ELLICOTT CITY SHOWING THE LOWEST UNINSURED RATE, 6%. OVERALL, THE SERVICE AREA HAD A 20% UNINSURED RATE WHILE THE CENTRAL MARYLAND AVERAGE HAD A 16% RATE.

INCOME AND EDUCATION ATTAINMENT CAN BE CAUSAL FACTORS FOR MANY HEALTH DISPARITIES IN THE COMMUNITY. HIGHER EDUCATION PROVIDES GREATER POTENTIAL FOR HIGHER INCOME, WHICH ENABLES INCREASED ACCESS TO MEDICAL CARE, BETTER HOUSING, ACCESS TO SAFER NEIGHBORHOODS, AND INCREASED LIKELIHOOD OF DEVELOPING HEALTHIER LIFESTYLE BEHAVIORS. THE NEEDS ASSESSMENT DATA SHOWED THAT ST. AGNES HEALTHCARE'S SERVICE AREA UNDERPERFORMED THE CENTRAL MARYLAND AVERAGE IN OTHER SOCIOECONOMIC MEASURES. THIS INCLUDES THE PERCENTAGE OF INDIVIDUALS AGE TWENTY-FIVE AND OLDER WITH LESS THAN A HIGH SCHOOL DIPLOMA, THE UNEMPLOYMENT RATE, THE PERCENTAGE OF RENTED HOUSING, AND THE PERCENTAGE OF VACANT HOUSING.

ST. AGNES HEALTHCARE ALSO PERFORMS A COMMUNITY HEALTH STATUS ASSESSMENT. THIS ASSESSMENT CAPTURES DATA FOR WHITE AND NONWHITE POPULATIONS SEPARATELY, WHICH HIGHLIGHTS THE RACIAL DISPARITIES PRESENT WITHIN EACH COMMUNITY AND THE INFLUENCE ON HEALTH STATUS AND HOSPITALIZATION RATES. ST. AGNES HEALTHCARE EVALUATES AMBULATORY SENSITIVE HOSPITALIZATIONS, WHICH ARE ACUTE CARE HOSPITAL ADMISSIONS THAT POTENTIALLY COULD HAVE BEEN PREVENTED THROUGH BETTER OVERALL PATIENT MANAGEMENT, PRIMARILY THROUGH PRIMARY CARE SYSTEMS. ST. AGNES HEALTHCARE COLLECTED DATA ON SIX DIFFERENT CHRONIC ILLNESSES, WHICH INCLUDE ASTHMA, CONGESTIVE HEART FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DIABETES, HYPERTENSION, AND PNEUMONIA. FOR EACH CHRONIC ILLNESS EXAMINED, ST. AGNES HEALTHCARE'S SERVICE AREA HAD

Part VI Supplemental Information

HIGHER RATES OF ILLNESS, FOR BOTH WHITE AND NONWHITE POPULATIONS, WHEN COMPARED TO THE CENTRAL MARYLAND AVERAGE. IN COMPARING THE RACIAL DISPARITIES, THE RATE OF HOSPITALIZATION IN THE ST. AGNES HEALTHCARE SERVICE AREA PROVES TO BE INFLUENCED BY SOCIOECONOMIC FACTORS MORE SO THAN RACE. IN LESS AFFLUENT COMMUNITIES, THE NONWHITE POPULATION HAD A HIGHER RATE OF HOSPITALIZATION THAN THE WHITE POPULATION OF THE SAME COMMUNITY. HOWEVER, THE INVERSE IS TRUE IN THE AFFLUENT COMMUNITIES WHERE THE NONWHITE POPULATION HAS A LOWER ADMISSION RATE THAN THEIR WHITE COUNTERPARTS.

ST. AGNES HEALTHCARE COMPILES AND ANALYZES MATERNAL AND INFANT HEALTH DATA. ONE OF THE MOST POTENTIALLY VULNERABLE POPULATIONS IN THE SERVICE AREA IS POVERTY-STRICKEN WOMEN AND THEIR CHILDREN, ESPECIALLY THOSE LIVING IN POVERTY. THE SOCIOECONOMIC ANALYSIS REVEALED THAT AN ESTIMATED 40% OF CHILDREN IN THE SERVICE AREA ARE LIVING IN POVERTY, WITH THE URBAN AREAS EXPERIENCING RATES OF GREATER THAN 50%. THE QUALITY OF LIFE AND HEALTH STATUS OF WOMEN HAS FAR REACHING IMPLICATIONS. TEEN PREGNANCY, ACCESS TO ADEQUATE PRENATAL CARE, LOW BIRTH WEIGHT AND BIRTH DEFECTS GENERATE INCREASED DEMANDS FOR FUTURE HEALTH CARE NEEDS AND IMPACT NOT JUST THIS GENERATION, BUT SUBSEQUENT GENERATIONS AS THE CYCLE OF POVERTY IS CONTINUED. THE HEALTH STATUS ASSESSMENT EXAMINED THE PERCENTAGE OF BIRTHS TO TEEN MOMS, PERCENTAGE OF NEWBORNS WITH LOW BIRTH WEIGHTS, THE PERCENTAGE OF BIRTH DEFECTS, INFANT MORTALITY, AND THE PERCENTAGE OF MOTHERS WITH INSUFFICIENT PRENATAL CARE. IN NEARLY EVERY CATEGORY, THE SERVICE AREA HAD MORE INCIDENCES THAN THE CENTRAL MARYLAND AVERAGE. THE PERCENTAGE OF INFANTS WITH LOW BIRTH WEIGHT, FOR WHITE POPULATIONS, AND THE INFANT MORTALITY RATES, WITH NONWHITE POPULATIONS, WERE THE ONLY TWO AREAS THAT HAD SLIGHTLY LESS INCIDENCES THAN THE CENTRAL MARYLAND AVERAGE.

Part VI Supplemental Information

UNLIKE AMBULATORY HOSPITALIZATION, THE NONWHITE POPULATIONS HAVE SUBSTANTIALLY HIGHER RATES OF BIRTHS TO TEEN MOTHERS, INFANTS WITH LOW BIRTH WEIGHT, INFANTS WITH BIRTH DEFECTS, AS WELL AS BIRTHS WITH INSUFFICIENT PRENATAL CARE IN ALL COMMUNITIES WITHIN THE SERVICE AREA.

ST. AGNES HEALTHCARE ALSO ANALYZES MAJOR DISEASE PREVALENCE. TRADITIONALLY, MORTALITY DATA IS UTILIZED TO EVALUATE THE IMPACT OF LEADING CAUSES OF DISEASE AND ILLNESS IN THE COMMUNITY. HOWEVER, VITAL STATISTIC DATA IS NOT READILY AVAILABLE AT THE ZIP CODE LEVEL. THEREFORE, AS A PROXY, THE ASSESSMENT UTILIZED ACUTE CARE DISCHARGE DATA FROM THE LEADING CAUSES OF MORTALITY, INCLUDING CANCER, CARDIOVASCULAR, AND STROKE. THE ANALYSIS REVEALED ONCE AGAIN THAT THE SERVICE AREA EXPERIENCED HIGHER DISEASE PREVALENCE OF CANCER, CARDIOVASCULAR, AND STROKE THAN THE CENTRAL MARYLAND AVERAGE, WITH STROKE BEING THE LEAST FAVORABLE. FURTHERMORE, NONWHITE POPULATIONS SHOWED A GREATER NEED IN EACH OF THE THREE MAJOR DISEASE CATEGORIES THAN WHITE POPULATIONS. ALSO, CONTINUING THE TREND, THE URBAN AREAS OF WEST BALTIMORE, SOUTH BALTIMORE, SOUTHWEST BALTIMORE, AND BROOKLYN HAVE THE LEAST FAVORABLE INDICES FOR THESE MAJOR DISEASES.

FINALLY, THE NEEDS ASSESSMENT ALSO EXAMINES LIFESTYLE BEHAVIOR AS A COMPONENT OF THE OVERALL HEALTH STATUS, WHICH INCLUDES INDICATORS RELATED TO OBESITY, MENTAL HEALTH, HIV, SUBSTANCE ABUSE, AND TOBACCO USE. THIS DATA IS ACCUMULATED BY EXAMINING ICD-9 DIAGNOSIS CODING. SIMILAR TO THE OTHER HEALTH AND WELLNESS MEASURES, THE SERVICE AREA WAS LESS FAVORABLE THAN THE CENTRAL MARYLAND AVERAGE FOR EVERY LIFESTYLE BEHAVIOR INDICATOR.

PART VI, LINE 5: THE INFORMATION PROVIDED AS COMMUNITY SUPPORT, IN

Part VI Supplemental Information

PART II, COMMUNITY BUILDING ACTIVITIES, REPRESENTS FUNDS SPENT FOR DISASTER READINESS AND PUBLIC HEALTH EMERGENCY ACTIVITIES. THESE COSTS, WHICH ARE PARTIALLY FUNDED BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, SUPPORT ACTIVITIES SUCH AS EDUCATION AND PREPAREDNESS TRAINING, DECONTAMINATION EQUIPMENT AND SUPPLIES NEEDED FOR VICTIM'S EASE, COMFORT AND TRACKING DURING DECONTAMINATION.

PART VI, LINE 5: ST. AGNES HEALTHCARE FURTHERS ITS EXEMPT PURPOSE BY PROMOTING THE HEALTH OF THE COMMUNITY IN VARIOUS WAYS. A MAJORITY OF THE ORGANIZATION'S GOVERNING BODY RESIDES IN ST. AGNES HEALTHCARE'S SERVICE AREA AND IS NEITHER COMPOSED OF EMPLOYEES NOR CONTRACTORS OF THE ORGANIZATION. THE GOVERNING BODY HAD EIGHTEEN VOTING MEMBERS, SEVENTEEN OF WHICH WERE INDEPENDENT COMMUNITY MEMBERS. ADDITIONALLY, ST. AGNES HEALTHCARE HAS AN OPEN MEDICAL STAFF AND CREDENTIALS ALL QUALIFIED MEDICAL STAFF, INCLUDING COMMUNITY BASED PROVIDERS. ST. AGNES HEALTHCARE APPLIES SURPLUS FUNDS TO IMPROVE PATIENT CARE IN VARIOUS WAYS. FOR INSTANCE, SURPLUS FUNDS ARE USED TO REINVEST IN THE LATEST EQUIPMENT AND TECHNOLOGIES TO IMPROVE PATIENT SAFETY, COMFORT, AND OUTCOMES. SURPLUS FUNDS ARE ALSO USED TO RENOVATE EXISTING FACILITIES AND CONSTRUCT NEW FACILITIES IN ORDER TO IMPROVE THE HEALTHCARE ENVIRONMENT. AS A MEMBER OF A NATIONAL HEALTH SYSTEM, ASCENSION HEALTH, SURPLUS FUNDS GENERATED BY ST. AGNES HEALTHCARE MAY ALSO BE DIRECTED TO ASCENSION HEALTH TO APPLY TOWARDS STRATEGIC INITIATIVES OR TO BE RE-DISTRIBUTED TO OTHER MEMBER HEALTHCARE PROVIDERS WITHIN ASCENSION HEALTH. THIS ALLOWS ST. AGNES TO NOT ONLY SERVICE THE SURROUNDING COMMUNITY, BUT ALSO HELP FUND THE CARE FOR THE UNDERPRIVILEGED THROUGHOUT MANY PARTS OF THE UNITED STATES.

PART VI, LINE 6: ST. AGNES HEALTHCARE IS A MEMBER OF ASCENSION

Part VI Supplemental Information

HEALTH, A NATIONAL HEALTH CARE SYSTEM. ASCENSION HEALTH IS THE SOLE CORPORATE MEMBER OF ST. AGNES HEALTHCARE. ST. AGNES HEALTHCARE IS THE SOLE CORPORATE MEMBER OF SETON MEDICAL GROUP INC., WHICH PROVIDES PRIMARY CARE, GYNECOLOGY AND OBSTETRICS CARE FOR PATIENTS IN ST. AGNES HEALTHCARE'S SERVICE AREA. ST. AGNES HEALTHCARE IS ALSO THE SOLE CORPORATE MEMBER OF ST. AGNES FOUNDATION, THE PHILANTHROPIC ARM OF ST. AGNES HEALTHCARE.

PART VI, LINE 4, CONTINUED:

ALSO, CONSISTENT WITH THE PREVIOUS MEASURES, THE URBAN AREAS EXPERIENCED THE LEAST FAVORABLE RESULTS. THE LEAST FAVORABLE OVERALL WAS SOUTH BALTIMORE CITY, WHICH WAS FOUND TO HAVE THE HIGHEST UTILIZATION RATES FOR MENTAL HEALTH, HIV, AND EMERGENCY ROOM SUBSTANCE ABUSE VISITS. RACIAL DISPARITIES ARE EVIDENT IN URBAN AREAS, WHERE THE RATE OF ADMISSION FOR THE NONWHITE POPULATION IS SIGNIFICANTLY HIGHER THAN THAT OF THE WHITE POPULATION, ESPECIALLY IN THE CASES OF OBESITY, HIV AND TOBACCO USE. THE MOST FAVORABLE COMPOSITE INDEX SCORES WERE IN SUBURBAN AREAS LIKE ELLICOTT CITY AND SOUTH CARROLL, WHICH WERE NEARLY 100% BELOW THEIR URBAN COMMUNITY COUNTERPARTS.

THE FINAL COMPONENT OF THE COMMUNITY NEEDS ASSESSMENT EXAMINED HEALTH RESOURCE UTILIZATION AND PHYSICIAN MANPOWER NEED. THIS ANALYSIS UTILIZES ACUTE CARE ADMISSION RATES, ACUTE CARE DAYS, AND OUTPATIENT EMERGENCY ROOM VISIT RATES. THE LOGIC UNDERLYING OUR ANALYSIS OF THESE INDICATORS IS THAT COMMUNITIES WITH HIGH UTILIZATION RATES HAVE A GREATER NEED FOR HEALTH CARE RESOURCES. ALL THREE MEASURES SHOWED LESS FAVORABLE RESULTS THAN THE CENTRAL MARYLAND AVERAGE. THE INDEX SCORES WERE 1.12, 1.22,AND 1.22 FOR ADMISSIONS, DAYS, AND EMERGENCY ROOM VISITS, RESPECTIVELY. THE PHYSICIAN MANPOWER NEED INDEX SCORE WAS .89.

Part VI Supplemental Information

THE CENTRAL MARYLAND AVERAGE IS INDEXED AT 1.0, WITH SCORES GREATER THAN 1.0 INDICATING LESS FAVORABLE RESULTS AND SCORES LESS THAN 1.0 INDICATING FAVORABLE RESULTS. THE OVERALL AVERAGE INDEX SCORE FOR HEALTH RESOURCE UTILIZATION AND PHYSICIAN MANPOWER NEED WAS .89.

IN SUMMARY, ALL OF THE COMPONENTS OF THE NEEDS ASSESSMENT WERE SUMMARIZED AND INDEXED RESULTING IN AN OVERALL INDEX SCORE OF 1.09. OVERALL, THE ST. AGNES HEALTHCARE SERVICE AREA HAS HIGHER DEMONSTRATED NEED ACROSS ALL MEASURES WHEN COMPARED TO THE CENTRAL MARYLAND REGION. THE OVERALL NEED IS HIGHLY CORRELATED TO SOCIOECONOMIC STATUS, WITH RACIAL DIVERSITY ALONE HAVING LESS OF AN INFLUENCE ON HEALTH CARE STATUS.

PART VI, LINE 8 SUPPLEMENT INFORMATION: ST. AGNES HEALTHCARE FILES A COMMUNITY BENEFITS REPORT WITH THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), THE REGULATORY AGENCY IN THE STATE OF MARYLAND. THE REPORT IS THEN MADE PUBLIC BY THE HSCRC. ADDITIONALLY, COMMUNITY BENEFIT INFORMATION IS AVAILABLE IN THE ST. AGNES HEALTHCARE ANNUAL REPORT AND THE ST. AGNES HEALTHCARE FACT SHEET. BOTH DOCUMENTS ARE AVAILABLE ON THE HOSPITAL WEBSITE.

PT V PART V LINE 13G: A NOTICE OF CHARITY IS POSTED WITHIN THE BALTIMORE SUN ON AN ANNUAL BASIS.

PT V PART V LINES 19 AND 21: MARYLAND HOSPITAL REGULATED RATES ARE DETERMINED BY THE HSCRC. BY LAW, REGULATED RATES CHARGED TO ALL PAYORS,INCLUDING SELF PAY PATIENTS, ARE THE SAME.

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

Part I General Information on Grants and Assistance

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

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

Part II **Grants and Other Assistance to Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed ..... ▶ [ ]

1 (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
MHEI WHO WILL CARE 6820 DEERPATH ROAD ELKRIDGE, MD 21075	52-0901664	501(C)(3)	50,000.	0.	FMV		NURSING
AMERICAN HEART ASSOCIATION 415 N. CHARLES STREET BALTIMORE, MD 21203	13-5613797	501(C)(3)	11,376.	0.	FMV		HEART WALK
ST. BONIFACE HAITI FOUNDATION 400 MAIN STREET RANDOLPH, MA 02368	04-3067595	501(C)(3)	8,550.	0.	FMV		HAITI RELIEF
GREATER BALTIMORE COMMITTEE 111 SOUTH CALVERT STREET BALTIMORE, MD 21202	52-0645650	501(C)(4)	6,000.	0.	FMV		SPONSORSHIP
ASSOCIATED BLACK CHARITIES 1114 CATHEDRAL STREET BALTIMORE, MD 21201	52-1427774	501(C)(3)	5,525.	0.	FMV		SPONSORSHIP

2 Enter total number of section 501(c)(3) and government organizations ▶ 4.

3 Enter total number of other organizations ▶ 1.

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to 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 non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
NURSING SCHOLARSHIP/WORKSTUDY PROGRAM	4	16,595.	0.	FMV	

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

SCHEDULE I, PART I, LINE 2: DISCRETIONARY GRANTS OR ASSISTANCE TO OTHER ORGANIZATIONS ARE APPROVED BY EITHER THE CHIEF EXECUTIVE OFFICER OR THE CHIEF FINANICAL OFFICER. THE NURSING WORKSTUDY PROGRAM IS AVAILABLE TO NURSING STUDENTS IN THEIR SENIOR YEAR OF SCHOOLING. AVAILABILITY IS LIMITED AND AWARDED ON A FIRST COME FIRST SERVE BASIS.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

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 in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☒ Travel for companions	☐ Payments for business use of personal residence		
	☒ Tax indemnification and gross-up payments	☒ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**	X	
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.			
	☒ Compensation committee	☒ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in 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 from the organization or a related organization?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in 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**		X
b	Any related organization?	**5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in 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**		X
b	Any related organization?	**6b**		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		X
8	Were any amounts reported in 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**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name		(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 reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 BONNIE PHIPPS	(i)	531,006.	210,613.	363,375.	11,025.	16,219.	1,132,238.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 SCOTT FURNISS	(i)	234,831.	28,145.	862.	6,307.	18,915.	289,060.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 ADRIAN LONG	(i)	339,907.	37,317.	53,478.	11,392.	21,007.	463,101.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 WILLIAM GRESKOVICH	(i)	231,856.	30,346.	3,346.	23,018.	19,767.	308,333.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 YOLANDA COPELAND	(i)	220,600.	29,255.	27,295.	10,196.	21,322.	308,668.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 GEORGE GRACE	(i)	718,967.	119,743.	5,250.	27,525.	23,973.	895,458.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 HOWARD HESSAN	(i)	767,616.	8,105.	2,487.	27,525.	16,220.	821,953.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
8 LAWRENCE SHIN	(i)	684,428.	0.	-18,481.	6,125.	23,862.	695,934.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
9 VINEY SETYA	(i)	558,676.	0.	3,132.	11,392.	10,492.	583,692.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
10 ROBERT PALEY	(i)	516,051.	0.	4,064.	11,025.	23,204.	554,344.	21,463.
	(ii)	0.	0.	0.	0.	0.	0.	0.
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A: TRAVEL FOR COMPANIONS IS AVAILABLE FOR SENIOR LEADERSHIP AND MUST BE PRE-APPROVED BY THE CHIEF FINANCIAL OFFICER. IT IS RECORDED AS A TAXABLE FRINGE BENEFIT.

PART I, LINE 1A THE AMOUNT OF PERSONAL USAGE OF CELL PHONES IS GROSSED-UP AND RECORDED AS TAXABLE INCOME FOR INDIVIDUALS IDENTIFIED AS DISQUALIFIED PERSONS. DISQUALIFIED PERSONS INCLUDE THOSE LISTED ON PART VII AS WELL AS ANY OTHER PHYSICIANS WITH SIGNIFICANT ADMISSIONS.

PART I, LINE 1A CLUB DUES ARE AVAILABLE TO SENIOR LEADERSHIP AND ARE SHOWN AS A TAXABLE FRINGE BENEFIT.

AVERAGE HOURS PER WEEK; ALL PERSONS LISTED AT PART VII AND SCHEDULE J AS WORKING 50 HOURS ARE FULL-TIME EMPLOYEES OF THE ORGANIZATION. THE USE OF 50 HOURS ON THIS RETURN IS INTENDED TO DENOTE THAT SUCH PERSONS MAY WORK SIGNIFICANTLY MORE HOURS DURING THE WEEK ON AVERAGE.

ST. AGNES HEALTHCARE IS A MEMBER OF ASCENSION HEALTH. BONNIE PHIPPS, PRESIDENT AND CEO OF ST. AGNES HEALTHCARE, ALSO SERVES IN AN OVERSIGHT ROLE

Part III Supplemental Information

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

TO OTHER ASCENSION HEALTH FACILITIES AS A MINISTRY MARKET LEADER. THE COMPENSATION EARNED AS A MINISTRY MARKET LEADER IS PAID THROUGH ST. AGNES HEALTHCARE, AND THEREFORE, REPORTED ON THIS FORM 990. THE COMPENSATION HAS NOT BEEN ALLOCATED BACK TO THE ENTITIES DERIVING THE BENEFIT.

PART I, LINE 3

THE COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER (CEO) OF ST. AGNES HEALTHCARE IS DETERMINED BY ASCENSION HEALTH, THE PARENT COMPANY OF ST. AGNES HEALTHCARE. ASCENSION HEALTH USES INDEPENDENT COMPENSATION CONSULTANTS, WHO USE COMPENSATION SURVEYS AND STUDIES, TO ESTABLISH THE PAY RANGE FOR THE CEO OF ST. AGNES HEALTHCARE. THE ASCENSION HEALTH EXECUTIVE COMPENSATION COMMITTEE APPROVES THE RECOMMENDED SALARY FOR THE CEO OF ST. AGNES HEALTHCARE. THE ASCENSION HEALTH EXECUTIVE COMPENSATION COMMITTEE PROVIDES THE LOCAL ST. AGNES HEALTHCARE COMPENSATION COMMITTEE THE ANALYSIS PERFORMED BY THE INDEPENDENT CONSULTANT FOR REVIEW AND APPROVAL.

PART I, LINE 4B: ROBERT PALEY, HOWARD HESSAN, GEORGE GRACE AND BILL GRESKOVICH PARTICIPATED IN 457F SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLANS. ROBERT PALEY'S NON-VESTED PLAN VALUE WAS $66,167.46. HOWARD HESSAN'S

Part III Supplemental Information

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

NON-VESTED PLAN VALUE WAS $49,288.99. GEORGE GRACE'S NON-VESTED VALUE WAS $19,906.04. BILL GRESKOVICH'S NON-VESTED VALUE WAS $156,005.18 AT JUNE 30, 2011.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Open To Public Inspection

Name of the organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

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

1 **(a)** Name of disqualified person	**(b)** Description of transaction	**(c)** Corrected? Yes	No

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 ▶ $

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person and purpose	**(b)** Loan to or from the organization? To	From	**(c)** Original principal amount	**(d)** Balance due	**(e)** In default? Yes	No	**(f)** Approved by board or committee? Yes	No	**(g)** Written agreement? Yes	No
Total ▶ $										

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount and type of assistance

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
ALBERT COUNSELMAN	FORMER BOARD MEMBER	43,649.	COMPENSATIO		X

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: ALBERT COUNSELMAN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FORMER BOARD MEMBER/FAMILY MEMBER

(D) DESCRIPTION OF TRANSACTION: COMPENSATION

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
ST. AGNES HEALTHCARE, INC.

Employer identification number
52-0591657

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

HEALING MINISTRY OF JESUS, WITH A SPECIAL CONCERN FOR THOSE WHO ARE POOR AND VULNERABLE. AS A CATHOLIC HEALTHCARE MINISTRY, WE ARE DEDICATED TO THE ART OF HEALING TO IMPROVE THE LIVES OF THOSE THAT WE SERVE.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

THOSE WHO ARE POOR AND VULNERABLE. AS A CATHOLIC HEALTHCARE MINISTRY AND A MEMBER OF ASCENSION HEALTH, WE ARE DEDICATED TO THE ART OF HEALING TO SUSTAIN AND IMPROVE THE LIVES OF THE INDIVIDUALS, FAMILIES AND COMMUNITIES WE SERVE; WE ADVOCATE FOR A JUST SOCIETY.

THROUGH OUR WORDS AND DEEDS, WE MINISTER IN AN ATMOSPHERE OF DEEP RESPECT, LOVE AND COMPASSION.

PATIENTS ARE OUR PASSION. OUR PHYSICIANS, NURSES AND ASSOCIATES ARE OUR PRIDE. HEALING IS OUR JOY. WE ARE WIDELY KNOWN FOR THE WAY OUR PHYSICIANS, NURSES AND ASSOCIATES COMBINE SOPHISTICATED MEDICAL TECHNOLOGY WITH SPIRITUALITY AND COMPASSION. SHOULDER-TO-SHOULDER, WE STAND UNITED IN OUR COMMITMENT TO CARE FOR THOSE IN NEED. WE WILL BE A LEADER IN SERVICE EXCELLENCE.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

$16,617,518, INCLUDING $12,314,893 FOR CHARITY CARE, AND $4,302,625 OF UNREIMBURSED MEDICAID.

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS:

WAITING ROOM OF THE COMMUNITY CARE CLINIC PROMOTING EARLY DEVELOPMENT OF READING SKILLS; ACTIVITIES RELATED TO THE SUCCESSFUL DISCHARGE OF PATIENTS SUCH AS PROVIDING TRANSPORTATION, PRESCRIPTIONS, OXYGEN, DURABLE MEDICAL EQUIPMENT, AND SHORT-TERM STAYS IN NURSING OR REHABILITATION CENTERS; AND PROVIDING GYNECOLOGICAL SERVICES TO UNINSURED, LARGELY SPANISH SPEAKING PERSONS AT THE ESPERANZA CLINIC; AND THE WELL4LIFE PROGRAM, WHICH USES A MULTIDISCIPLINARY APPROACH TO WEIGHT LOSS, EXERCISE, LIFESTYLE AND MINDSET CHANGES, FOCUSED ON BATTLING OBESITY CHALLENGES.

ST. AGNES HEALTHCARE HAS A LONG STANDING TRADITION OF PROVIDING MEDICAL EDUCATION AND TRAINING. ST. AGNES ADMINISTERS A FIVE YEAR, FULLY ACCREDITED, GENERAL SURGERY RESIDENCY PROGRAM CONSISTING OF TWENTY SURGICAL RESIDENTS. THIS ACADEMICALLY ORIENTED, COMMUNITY BASED, UNIVERSITY AFFILIATED RESIDENCY PROGRAM IS THE SECOND OLDEST SURGICAL RESIDENCY PROGRAM IN THE UNITED STATES. THE PROGRAM IS ACTIVE IN BOTH BASIC AND ADVANCED LAPAROSCOPIC SURGERY. RESIDENTS ARE OFFERED A BROAD BASED SURGICAL EXPERIENCE WITH EXPOSURE NOT ONLY TO THE FIELD OF GREATER GENERAL SURGERY, BUT ALSO TO ALL THE SURGICAL SPECIALTIES. THERE IS EXTENSIVE EXPERIENCE AND TRAINING IN MANAGING THE CRITICALLY ILL SURGICAL PATIENT. ADDITIONALLY, THE PROGRAM ALSO CONTAINS ROTATIONS IN BURN MANAGEMENT, TRAUMA, TRANSPLANT AND GASTROINTESTINAL ENDOSCOPY. THE DEPARTMENT OF SURGERY INCLUDES MORE THAN 198 SURGEONS IN 10 SURGICAL SPECIALTIES. THERE ARE TWENTY-SIX FULL-TIME SURGEONS IN THE DEPARTMENT COMPLEMENTED BY ATTENDING SURGEONS WHO ARE DEDICATED TO THE RESIDENCY-TRAINING PROGRAM AND ARE ACTIVELY INVOLVED IN THE TEACHING PROGRAM. MEDICAL STUDENTS HAVE ALSO BEEN A PART OF ST. AGNES' TRAINING

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

PROGRAM FOR MORE THAN SIX DECADES. THE OPPORTUNITY FOR THE RESIDENTS TO TEACH THE STUDENTS CONTRIBUTES SIGNIFICANTLY TO THE PROFESSIONAL DEVELOPMENT OF THE RESIDENT AND PROVIDES A VITAL SERVICE TO THE STUDENT.

ST. AGNES ALSO HAS A MEDICAL RESIDENCY PROGRAM CONSISTING OF FORTY RESIDENTS. THE DYNAMIC INTERACTION BETWEEN THE FACULTY AND THE HOUSE STAFF CREATES A STIMULATING INTELLECTUAL ENVIRONMENT CENTERED ON THE KEY PRINCIPLES OF PATIENT CARE, EDUCATION AND CLINICAL RESEARCH. SIMILAR TO THE SURGICAL RESIDENTS, THE MEDICAL RESIDENTS ARE INVOLVED IN THE TEACHING OF MEDICAL STUDENTS. DUE TO ST. AGNES' AFFILIATION WITH THE UNIVERSITY OF MARYLAND MEDICAL SCHOOL AND JOHNS HOPKINS SCHOOL OF MEDICINE, THE RESIDENTS ARE PRESENTED AN OPPORTUNITY TO ROTATE THROUGH THOSE HOSPITALS, FURTHER ENRICHING THE PATIENT CARE EXPERIENCE. THE RESIDENCY PROGRAM ALLOWS THE RESIDENTS TO BECOME PROFICIENT IN OBTAINING CLINICAL DATA BY PATIENT INTERVIEW, PHYSICAL EXAMINATION, AND INTERPRETATION OF LABORATORY DATA. THE RESIDENTS ALSO BECOME PROFICIENT IN UTILIZING CLINICAL DATA TO PRIORITIZE PROBLEMS AND FORMULATE DIFFERENTIAL DIAGNOSES. THE TRAINING PROGRAM HELPS THE RESIDENTS LEARN TO FORMULATE DIAGNOSTIC AND THERAPEUTIC PLANS DEMONSTRATING AWARENESS OF RISKS, BENEFITS, COSTS, PATIENT PREFERENCES, AND ETHICAL AND PSYCHOSOCIAL ISSUES.

FORM 990, PART III, LINE 4C, PROGRAM SERVICE ACCOMPLISHMENTS:

YEAR ENDING JUNE 30, 2011, OUR HOSPITAL TREATED 19,618 INPATIENT ADULTS AND CHILDREN IN THE COMMUNITY FOR A TOTAL OF 80,500 PATIENT DAYS OF SERVICE. THE HOSPITAL ALSO PROVIDED SERVICES TO 499,369 OUTPATIENTS, INCLUDING 6,432 OUTPATIENT SURGERY PATIENTS, 68,705 EMERGENCY ROOM

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

VISITS, AND 43,823 CLINIC VISITS.

FORM 990, PART VI, SECTION A, LINE 2: CERTAIN PERSONS REPORTED ON PART VII ARE EMPLOYED BY AND/OR SERVE AS OFFICER, DIRECTOR, TRUSTEE, OR KEY EMPLOYEE AT A RELATED TAX EXEMPT ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 6: ST. AGNES HEALTHCARE HAS A SOLE CORPORATE MEMBER, ASCENSION HEALTH.

FORM 990, PART VI, SECTION A, LINE 7A: ST. AGNES HEALTHCARE HAS A SOLE CORPORATE MEMBER, ASCENSION HEALTH, WHO HAS THE ABILITY TO ELECT MEMBERS TO THE GOVERNING BODY OF ST. AGNES HEALTHCARE.

FORM 990, PART VI, SECTION A, LINE 7B: ASCENSION HEALTH HAS DESIGNED A SYSTEM AUTHORITY MATRIX WHICH ASSIGNS AUTHORITY FOR KEY DECISIONS THAT ARE NECESSARY IN THE OPERATION OF THE SYSTEM. SPECIFIC AREAS THAT ARE IDENTIFIED IN THE AUTHORITY MATRIX ARE: NEW ORGANIZATIONS AND MAJOR TRANSACTIONS; GOVERNING DOCUMENTS; APPOINTMENTS/REMOVALS; EVALUATION; DEBT LIMITS; STRATEGIC AND FINANCIAL PLANS; SYSTEM POLICIES AND PROCEDURES. THESE AREAS ARE SUBJECT TO CERTAIN LEVELS OF APPROVAL BY ASCENSION HEALTH PER THE SYSTEM AUTHORITY MATRIX.

FORM 990, PART VI, SECTION B, LINE 11: MANAGEMENT,INCLUDING CERTAIN OFFICERS, WORKS DILIGENTLY TO COMPLETE THE FORM 990 AND ATTACHED SCHEDULES IN A THOROUGH MANNER. MANAGEMENT PRESENTS THE FORM TO THE FINANCE COMMITTEE AND CERTAIN MEMBERS OF THE AUDIT COMMITTEE AND ADDRESSES ANY QUESTIONS THAT ARISE. ONCE THE FINANCE COMMITTEE AND AUDIT COMMITTEE REVIEW IS COMPLETED, THE FORM 990 IS THEN MADE AVAILABLE TO THE FULL BOARD OF DIRECTORS VIA A

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

SECURE WEBSITE. MANAGEMENT TEAM MEMBERS ARE AVAILABLE TO ANSWER ANY BOARD MEMBER QUESTIONS. AFTER THE BOARD OF DIRECTORS REVIEW IS COMPLETE, MANAGEMENT FILES THE FORM 990 WITH THE INTERNAL REVENUE SERVICE.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, A CONFLICTS OF INTEREST DISCLOSURE FORM IS DISTRIBUTED TO BOARD MEMBERS, THE EXECUTIVE TEAM, BOARD COMMITTEES, PURCHASING AGENTS, LEGAL COUNSEL, MEDICAL LEADERSHIP, AND CERTAIN MEMBERS OF MANAGEMENT. OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE REQUIRED TO COMPLETE THE ANNUAL DISCLOSURE. ANY CONFLICTS, OR POTENTIAL CONFLICTS THAT ARE IDENTIFIED ARE EXAMINED BY THE CORPORATE RESPONSIBILITY OFFICER AND APPROPRIATE MEASURES ARE TAKEN.

FORM 990, PART VI, SECTION B, LINE 15: THE COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER (CEO) OF ST. AGNES HEALTHCARE IS DETERMINED BY ASCENSION HEALTH, THE PARENT COMPANY OF ST. AGNES HEALTHCARE. ASCENSION HEALTH USES INDEPENDENT COMPENSATION CONSULTANTS, WHO USE COMPENSATION SURVEYS AND STUDIES, TO ESTABLISH THE PAY RANGE FOR THE CEO OF ST. AGNES HEALTHCARE. THE ASCENSION HEALTH EXECUTIVE COMPENSATION COMMITTEE APPROVES THE RECOMMENDED SALARY FOR THE CEO OF ST. AGNES HEALTHCARE. THE ASCENSION HEALTH EXECUTIVE COMPENSATION COMMITTEE PROVIDES THE LOCAL ST. AGNES HEALTHCARE COMPENSATION COMMITTEE THE ANALYSIS PERFORMED BY THE INDEPENDENT CONSULTANT FOR REVIEW AND APPROVAL.

FORM 990, PAART VI, SECTION B, LINE 15B: THE ANNUAL COMPENSATION REVIEW FOR OFFICER LEVEL STAFF IS PERFORMED BY AN OUTSIDE COMPENSATION CONSULTING FIRM, WHICH SPECIALIZES IN EXECUTIVE COMPENSATION. ON AN ANNUAL BASIS, THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS, SENDS AN ENGAGEMENT LETTER OUTLINING THE POSITIONS REQUIRING COMPENSATION ANALYSIS, AND SEEKS

Name of the organization: ST. AGNES HEALTHCARE, INC.
Employer identification number: 52-0591657

ANALYSIS AND RECOMMENDATIONS. THE CONSULTING FIRM THEN PERFORMS A MARKET ANALYSIS OF COMPENSATION AND BENEFITS FOR THE EXECUTIVES WITH RECOMMENDED SALARY RANGES BY EXECUTIVE POSITION, AND THOSE ARE REVIEWED AND APPROVED BY THE COMPENSATION COMMITTEE. THE SENIOR VP/CHIEF FINANCIAL OFFICER, EXECUTIVE VP/CHIEF MEDICAL OFFICER, VP OPERATIONS & CAPITAL PROJECTS, SENIOR VP PATIENT CARE SERVICES ARE ALL INCLUDED IN THE GROUP OF PERSONS WHOSE COMPENSATION IS REVIEWED BY AN OUTSIDE CONSULTING FIRM.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION WILL PROVIDE ANY DOCUMENTS OPEN TO PUBLIC INSPECTION UPON WRITTEN REQUEST.

HOURS DEVOTED TO A RELATED ORGANIZATION

BOARD MEMBER, BONNIE PHIPPS, AND KEY EMPLOYEES SCOTT FURNISS, YOLANDA COPELAND AND ADRIAN LONG WORK AT ST. AGNES HEALTHCARE AS WELL AS RELATED ORGANIZATIONS, SETON MEDICAL GROUP AND ST. AGNES FOUNDATION. FOR DISCLOSURE PURPOSES, THE AVERAGE HOURS WORKED AT RELATED ORGANIZATIONS IS ESTIMATED BY USING THE NUMBER OF HOURS SERVCED ON BOARD COMMITTEES FOR RELATED ORGANIZATIONS. BONNIE PHIPPS WORKS 3.77 HOURS PER WEEK, ON AVERAGE, SERVING ON COMMITTEES AT SETON MEDICAL GROUP AND ST. AGNES FOUNDATION. SCOTT FURNISS WORKS 2.76 HOURS PER WEEK, ON AVERAGE, SERVING ON COMMITTEES AT SETON MEDICAL GROUP AND ST. AGNES FOUNDATION. YOLANDA COPELAND WORKS 0.92 HOURS PER WEEK, ON AVERAGE, SERVING ON COMMITTEES AT ST. AGNES FOUNDATION. ADRIAN LONG WORKS 1.38 HOURS PER WEEK, ON AVERAGE, SERVING ON COMMITTEES AT SETON MEDICAL GROUP.

FORM 990, PART XI, LINE 5, CHANGES IN NET ASSETS:

TRANSFER TO ASCENSION HEALTH -6,884,840.

Name of the organization: ST. AGNES HEALTHCARE, INC.

Employer identification number: 52-0591657

TRANSFER TO SPONSOR	-548,045.
DEFERRED PENSION COSTS	36,593,482.
STATE GRANT	560,000.
CAPITAL TRANSFER TO SETON MEDICAL GROUP	-6,581,495.
LAB OUTREACH EXPENSES	-4,756,079.
LAB OUTREACH UTILIZATION	-395,366.
DONATED EQUIPMENT	1,504,506.
NET CHANGE IN INTEREST IN FOUNDATION ASSETS	-260,269.
SPECIAL PURPOSE FUNDS UNREALIZED GAINS	421,375.
SPECIAL PURPOSE FUNDS RESTRICTED CONTRIBUTIONS	803,945.
NET ASSETS RELEASED FROM RESTRICTION	-670,408.
SPECIAL PURPOSE FUNDS INVESTMENT INCOME	-9,018.
TOTAL TO FORM 990, PART XI, LINE 5	19,777,788.

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

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2010
Open to Public Inspection

Name of the organization
ST. AGNES HEALTHCARE, INC.

Employer identification number
52-0591657

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

(a) Name, address, and EIN 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" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
ASCENSION HEALTH - 31-1662309 P.O. BOX 45998 ST. LOUIS, MO 63145	NATIONAL HEALTH OFFICE	MISSOURI	501(C)(3)	BOX 11A	N/A		X
SETON MEDICAL GROUP - 39-2064992 900 CATON AVENUE BALTIMORE, MD 21229	PROVIDE HEALTH CARE SERVICES TO THE COMMUNITY	MARYLAND	501(C)(3)	BOX 3-HOSPITAL	ST. AGNES HOSPITAL	X	
ST. AGNES FOUNDATION - 52-1415083 900 CATON AVENUE BALTIMORE, MD 21229	PROVIDES FUNDING TO THE HOSPITAL AND THE COMMUNITY	MARYLAND	501(C)(3)	BOX 11-509(A)3-T	ST. AGNES HOSPITAL	X	
ST. AGNES AUXILIARY - 52-0643673 900 CATON AVENUE BALTIMORE, MD 21229	FUNDRAISING	MARYLAND	501(C)(3)	BOX 9	ST. AGNES HOSPITAL	X	

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
ST. AGNES HEALTH VENTURES, INC. - 52-1733632 900 CATON AVENUE BALTIMORE, MD 21229	HOLDING COMPANY	MD	N/A	C CORP	11,233.	1,119,531.	100.00%

Part V **Transactions With Related Organizations** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, or 36.)

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

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 other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1)	SETON MEDICAL GROUP	B	6,581,495.	FAIR MARKET VALUE
(2)	ST. AGNES FOUNDATION	C	1,815,903.	FAIR MARKET VALUE
(3)	ST. AGNES FOUNDATION	L	522,366.	FAIR MARKET VALUE
(4)	ST. AGNES FOUNDATION	P	595,550.	FAIR MARKET VALUE
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Are all partners section 501(c)(3) organizations? Yes	(d) No	(e) Share of end-of-year assets	(f) Disproportionate allocations? Yes	(f) No	(g) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner? Yes	(h) No

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

Form **8453-EO**

Department of the Treasury
Internal Revenue Service

Exempt Organization Declaration and Signature for Electronic Filing

For calendar year 2010, or tax year beginning JUL 1 , 2010, and ending JUN 30 , 20 11

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

▶ **See instructions.**

OMB No. 1545-1879

2010

Name of exempt organization

ST. AGNES HEALTHCARE, INC.

Employer identification number

52-0591657

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the type of return being filed with Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a** below and the amount on that line of the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than one line in Part I.

1a	**Form 990** check here ▶ [X]	**b**	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	426811571
2a	**Form 990-EZ** check here ▶ [ ]	**b**	**Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	**Form 1120-POL** check here ▶ [ ]	**b**	**Total tax** (Form 1120-POL, line 22)	**3b**	
4a	**Form 990-PF** check here ▶ [ ]	**b**	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	**Form 8868** check here ▶ [ ]	**b**	**Balance due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration of Officer

6 [ ] I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.

[ ] If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2010 electronic return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

Sign Here ▶ _____ Signature of officer | _____ Date | ▶ SENIOR VICE PRESIDENT/CF Title

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-file (MeF) Information for Authorized IRS *e-file* Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only

ERO's signature ▶ | Date | Check if also paid preparer [X] | Check if self-employed [ ] | ERO's SSN or PTIN P00653098

Firm's name (or yours if self-employed), address, and ZIP code ▶ DELOITTE TAX LLP
200 RENAISSANCE CENTER, SUITE 3900
DETROIT 48243

EIN 86-1065772

Phone no. (313) 396-3000

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer Use Only

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

Firm's name ▶ | Firm's EIN ▶

Firm's address ▶ | Phone no.