

Form **990**

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)

OMB No. 1545-0047

2011

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning and ending

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization THE SHRINERS' HOSPITAL FOR CHILDREN		D Employer identification number 04-2121377
	Doing Business As		E Telephone number (813) 281-0300
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	POST OFFICE BOX 31356		G Gross receipts \$ 602,242,638.
City or town, state or country, and ZIP + 4 TAMPA, FL 33631-3356		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
F Name and address of principal officer: DOUGLAS MAXWELL 2900 ROCKY POINT DRIVE, TAMPA, FL 33607		H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		If "No," attach a list. (see instructions)	
J Website: ▶ HTTP://WWW.SHRINERSHQ.ORG/		H(c) Group exemption number ▶	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1925	M State of legal domicile: MA

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: WE PROVIDE PEDIATRIC SPECIALTY CARE WITHOUT FINANCIAL OBLIGATION TO PATIENTS OR THEIR FAMILIES.		
	2 Check this box <input type="checkbox"/> 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	19
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	19
	5 Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	569
	6 Total number of volunteers (estimate if necessary)	6	1000
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	39,827,375.	42,742,971.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	0.	3,056,204.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	42,638,994.	74,899,338.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,000,324.	223,337.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	83,466,693.	120,921,850.
	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)	0.	0.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	34,806,138.	35,707,985.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.	0.	0.
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	28,483,283.	26,050,145.
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	63,289,421.	61,758,130.
19 Revenue less expenses. Subtract line 18 from line 12	20,177,272.	59,163,720.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	852,520,775.	865,660,518.
	22 Net assets or fund balances. Subtract line 21 from line 20	3,283,579.	32,939,050.
		849,237,196.	832,721,468.

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			
	▶ DOUGLAS MAXWELL, PRESIDENT	Type or print name and title			
Paid Preparer Use Only	Print/Type preparer's name NATHAN SMITH	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN P00543757
	Firm's name ▶ CBIZ KIRKLAND, RUSS, MURPHY & TAPP	Firm's EIN ▶ 27-3605969	Firm's address ▶ 13577 FEATHER SOUND DRIVE, SUITE 400 CLEARWATER, FL 33762	Phone no. (727) 572-1400	

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: SEE SCHEDULE O

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 [X] No

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 36,198,803. including grants of \$) (Revenue \$ 1,921,860.)
TREATMENT OF PEDIATRIC BURN VICTIMS: ADMISSIONS: 582
OUTPATIENT CLINIC VISITS: 5,535
OUTPATIENT CLINIC SURGERIES: 476

4b (Code:) (Expenses \$ 21,365,704. including grants of \$) (Revenue \$ 1,134,344.)
TREATMENT OF ORTHOPEDIC PEDIATRIC PATIENTS: ADMISSIONS: 359
OUTPATIENT CLINIC VISITS: 15,699
OUTPATIENT CLINIC SURGERIES: 240

4c (Code:) (Expenses \$ 4,193,623. including grants of \$) (Revenue \$)
MEDICAL RESEARCH IS PERFORMED AND HAS A STRONG, POSITIVE IMPACT ON THE CARE AND CURE OF CHILDREN WITH ORTHOPAEDIC PROBLEMS, BURN AND SPINAL CORD INJURIES.

4d Other program services (Describe in Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 61,758,130.

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)? <i>If "Yes," complete Schedule A</i>	X	
2	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		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? <i>If "Yes," complete Schedule C, Part II</i>		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? <i>If "Yes," complete Schedule C, Part III</i>		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		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? <i>If "Yes," complete Schedule D, Part II</i>		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		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? <i>If "Yes," complete Schedule D, Part IV</i>		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>		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? <i>If "Yes," complete Schedule D, Part VIII</i>		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? <i>If "Yes," complete Schedule D, Part IX</i>		X
e	Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>		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)? <i>If "Yes," complete Schedule D, Part X</i>		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI, XII, and XIII</i>		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional</i>	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?		X
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		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? <i>If "Yes," complete Schedule G, Part I</i>		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? <i>If "Yes," complete Schedule G, Part II</i>	X	
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	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 any government or organization in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		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? <i>If "Yes," complete Schedule I, Parts I and III</i>		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? <i>If "Yes," complete Schedule J</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25</i>		X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		X
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	X	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		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? <i>If "Yes," complete Schedule R, Part I</i>		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
b Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		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? <i>If "Yes," complete Schedule R, Part VI</i>		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	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

Input box for Schedule O response

Main table with columns for question number, description, sub-questions, and Yes/No columns. Includes rows for Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 1098-C, Form 4947(a)(1), and Form 720.

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

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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?; 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done; 13 Did the organization have a written whistleblower policy?; 14 Did the organization have a written document retention and destruction policy?; 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?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 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?; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MA
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
Own website [] Another's website [X] Upon request [X]
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: SHARON RUSSELL - 813-281-0300 2900 ROCKY POINT DR., TAMPA, FL 33607-1435

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

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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) RALPH SEMB TRUSTEE	5.00	X						0.	0.	0.
(2) W. BRANDT BEDE, M.D. TRUSTEE	5.00	X						0.	0.	0.
(3) CHARLES CLAYPOOL TRUSTEE	5.00	X						0.	0.	0.
(4) GARY DUNWOODY TRUSTEE	5.00	X						0.	0.	0.
(5) RAOUL L. FREVAL TRUSTEE	5.00	X						0.	0.	0.
(6) DOUGLAS MAXWELL PRESIDENT, TRUSTEE	20.00	X		X				0.	18,000.	0.
(7) GEORGE MITCHELL CHAIRMAN OF THE BOARD, TRUSTEE	5.00	X		X				0.	96,800.	0.
(8) GENE BRACEWELL TREASURER, TRUSTEE	5.00	X		X				0.	4,900.	0.
(9) FRANK PREBLE TRUSTEE	5.00	X						0.	0.	0.
(10) RODNEY PINKHAM TRUSTEE	5.00	X						0.	0.	0.
(11) DAVID S. MCKECHNIE TRUSTEE	5.00	X						0.	0.	0.
(12) HAROLD F. JENNINGS, CPA TRUSTEE	5.00	X						0.	0.	0.
(13) MICHAEL G. SEVERE VICE PRESIDENT, TRUSTEE	5.00	X		X				0.	49,000.	0.
(14) DAVID H. BURSTEIN TRUSTEE	5.00	X						0.	0.	0.
(15) KEVIN J. HECHT, ESQ. TRUSTEE	5.00	X						0.	0.	0.
(16) RICHARD E. JOHNSON ASSISTANT TREASURER, TRUSTEE	5.00	X		X				0.	0.	0.
(17) BOBBY B. SIMMONS TRUSTEE	5.00	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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) G. STEPHEN GETMAN, ESQ. TRUSTEE	5.00	X						0.	0.	0.
(19) ALAN W. MADSEN TRUSTEE	5.00	X						0.	1,800.	0.
(20) JACK H. JONES ASSISTANT SECRETARY	35.00			X				0.	158,833.	0.
(21) CHARLES H. WEAVER CLERK	5.00			X				0.	0.	0.
(22) DAVID M. DRVARIC, M.D. CHIEF OF STAFF	40.00					X		412,354.	0.	19,288.
(23) PETER D. MASSO, M.D. ASSISTANT CHIEF OF STAFF	40.00					X		300,880.	0.	22,883.
(24) CLIFFORD D'ESMOND ADMINISTRATOR	40.00					X		212,607.	0.	2,454.
(25) ALAN J. FISCHMAN SR. INVESTIGATOR	40.00					X		181,138.	0.	6,774.
(26) PHILIP W. MACK, M.D. FORMER ORTHOPAEDIC SURGEON	40.00						X	262,293.	0.	5,585.
1b Sub-total								1,369,272.	329,333.	56,984.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								1,369,272.	329,333.	56,984.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **42**

	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	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	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		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. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
MASSACHUSETTS GENERAL HOSPITAL P.O. BOX 350096, BOSTON, MA 02241	OUTSIDE PATIENT CARE	8,068,201.
HEALTH NEW ENGLAND, 1 MONARCH PLACE #1500, SPRINGFIELD, MA 01144	EMPLOYEE BENEFITS	1,627,922.
SPRINGFIELD ANESTHESIA SERVICE 908 ALLEN ST., SPRINGFIELD, MA 01101	ANESTHESIOLOGY SERVICES	1,052,691.
OWENS & MINOR, 9120 LOCKWOOD BLVD, MECHANICSVILLE, VA 23116	MEDICAL SUPPLIES	948,744.
PHILIPS ELECTRONICS 22100 BOTHELL EVERTT HWY, BOTHELL, WA 98041	MEDICAL SUPPLIES	610,561.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **37**

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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	39,797,428.				
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,945,543.				
	g Noncash contributions included in lines 1a-1f: \$		1,226,900.				
	h Total. Add lines 1a-1f		42,742,971.				
	Program Service Revenue	2 a PATIENT SERVICE	Business Code 621110	3,056,204.	3,056,204.		
b							
c							
d							
e							
f All other program service revenue							
g Total. Add lines 2a-2f			3,056,204.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		25,908,370.			25,908,370.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real					
		(ii) Personal					
		b Less: rental expenses					
		c Rental income or (loss)					
	d Net rental income or (loss)						
	7 a Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other					
		b Less: cost or other basis and sales expenses		481,264,694.	44,974.		
		c Gain or (loss)		49,035,942.	-44,974.		
	d Net gain or (loss)		48,990,968.			48,990,968.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a	89,620.				
		b Less: direct expenses	b	11,120.			
c Net income or (loss) from fundraising events			78,500.			78,500.	
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
10 a 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					
11 a MISCELLANEOUS	900099	144,837.			144,837.		
b							
c							
d All other revenue							
e Total. Add lines 11a-11d		144,837.					
12 Total revenue. See instructions.		120,921,850.	3,056,204.	0.	75,122,675.		

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).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	25,918,755.	25,918,755.		
8 Pension plan accruals and contributions (include section 401(k) and section 403(b) employer contributions)	4,958,065.	4,958,065.		
9 Other employee benefits	2,960,611.	2,960,611.		
10 Payroll taxes	1,870,554.	1,870,554.		
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	547,612.	547,612.		
g Other	10,773,024.	10,773,024.		
12 Advertising and promotion	35,412.	35,412.		
13 Office expenses	128,954.	128,954.		
14 Information technology				
15 Royalties				
16 Occupancy	3,483,161.	3,483,161.		
17 Travel	273,909.	273,909.		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	4,374,246.	4,374,246.		
23 Insurance	452,784.	452,784.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	5,270,742.	5,270,742.		
b PATIENT COSTS	486,465.	486,465.		
c DUES AND REGISTRATIONS	149,100.	149,100.		
d POSTAGE	66,239.	66,239.		
e All other expenses	8,497.	8,497.		
25 Total functional expenses. Add lines 1 through 24e	61,758,130.	61,758,130.	0.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

		(A) Beginning of year		(B) End of year	
Assets	1 Cash - non-interest-bearing	490,797.	1	382,551.	
	2 Savings and temporary cash investments		2		
	3 Pledges and grants receivable, net	87,207.	3	0.	
	4 Accounts receivable, net		4		
	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		7		
	8 Inventories for sale or use	887,932.	8	884,084.	
	9 Prepaid expenses and deferred charges	807,719.	9	635,784.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 145,182,720.			
	b Less: accumulated depreciation	10b 65,213,611.	81,161,618.	10c	79,969,109.
	11 Investments - publicly traded securities	769,085,502.	11	783,580,205.	
	12 Investments - other securities. See Part IV, line 11		12		
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11	0.	15	208,785.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	852,520,775.	16	865,660,518.		
Liabilities	17 Accounts payable and accrued expenses	2,946,045.	17	32,411,880.	
	18 Grants payable		18		
	19 Deferred revenue	337,534.	19	527,170.	
	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		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		25		
	26 Total liabilities. Add lines 17 through 25	3,283,579.	26	32,939,050.	
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	849,237,196.	27	832,721,468.	
	28 Temporarily restricted net assets		28		
	29 Permanently restricted net assets		29		
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building, or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
	33 Total net assets or fund balances	849,237,196.	33	832,721,468.	
34 Total liabilities and net assets/fund balances	852,520,775.	34	865,660,518.		

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	120,921,850.
2	Total expenses (must equal Part IX, column (A), line 25)	2	61,758,130.
3	Revenue less expenses. Subtract line 2 from line 1	3	59,163,720.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	849,237,196.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-75,679,448.
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	832,721,468.

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: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
2b	Were the organization's financial statements audited by an independent accountant?	X	
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
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: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> 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?		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.		

Form **990** (2011)

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

2011

Open to Public Inspection

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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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?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2010 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2011. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2010. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2011. 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		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2010. 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		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

(Complete only if you checked the box on line 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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2011 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2010 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2011. 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 - 2010. 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, Form 990-EZ, or Form 990-PF.**

OMB No. 1545-0047

2011

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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, total 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 total 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 Part I, 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).

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2011)

Name of organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
---	--

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/> <hr/>	\$ 39,797,428.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	<hr/> <hr/> <hr/> <hr/>	\$ 1,226,900.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
---	--

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
2	<u>MEDICAL EQUIPMENT</u> <hr/> <hr/> <hr/> <hr/>	\$ 1,226,900.	11/30/11
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
<hr/>	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____

Name of organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total 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.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(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	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

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, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

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

Part II Conservation Easements. Complete if the organization answered "Yes" 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	760,025,402.	698,824,389.	604,354,755.	834,575,000.	
b Contributions					
c Net investment earnings, gains, and losses	29,611,840.	83,046,382.	117,592,699.	-216,021,898.	
d Grants or scholarships					
e Other expenditures for facilities and programs	14,805,920.	21,845,369.	23,123,065.	14,198,347.	
f Administrative expenses					
g End of year balance	774,831,322.	760,025,402.	698,824,389.	604,354,755.	

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

- a Board designated or quasi-endowment 100.00 %
- b Permanent endowment .00 %
- c Temporarily restricted endowment .00 %

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

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

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)		X
3a(ii)	X	
3b	X	

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

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 property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		303,990.		303,990.
b Buildings		107,659,792.	37,044,597.	70,615,195.
c Leasehold improvements		416,959.	374,151.	42,808.
d Equipment		36,466,676.	27,794,863.	8,671,813.
e Other		335,303.		335,303.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				79,969,109.

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

Table with 3 columns: (a) Description of security or category, (b) Book value, (c) Method of valuation. Rows include Financial derivatives, Closely-held equity interests, and Other (A-I).

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

Table with 3 columns: (a) Description of investment type, (b) Book value, (c) Method of valuation. Rows numbered 1 through 10.

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

Table with 2 columns: (a) Description, (b) Book value. Rows numbered 1 through 10.

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

Table with 2 columns: (a) Description of liability, (b) Book value. Row 1 includes Federal income taxes, followed by rows 2 through 11.

Total. (Column (b) must equal Form 990, Part X, col (B) line 25.)

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	120,921,850.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	61,758,130.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	59,163,720.
4	Net unrealized gains (losses) on investments	4	-75,679,448.
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	-75,679,448.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-16,515,728.

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	4,908,482.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	-75,679,448.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	-547,612.
e	Add lines 2a through 2d	2e	-76,227,060.
3	Subtract line 2e from line 1	3	81,135,542.
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	39,786,308.
c	Add lines 4a and 4b	4c	39,786,308.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	120,921,850.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements	1	61,221,638.
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	11,120.
e	Add lines 2a through 2d	2e	11,120.
3	Subtract line 2e from line 1	3	61,210,518.
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	547,612.
c	Add lines 4a and 4b	4c	547,612.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	61,758,130.

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: THE ENDOWMENT FUNDS (INCLUDING UNRESTRICTED FUND

BALANCES) ARE THE PRIMARY SOURCE OF SUPPORT FROM WHICH SHRINERS HOSPITALS

FOR CHILDREN PERFORMS ITS PROGRAM SERVICES TO ACHIEVE ITS PRIMARY EXEMPT

PURPOSE.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

INVESTMENT MANAGEMENT FEES RECLASSIFIED TO EXPENSES -547,612.

Part XIV Supplemental Information (continued)

PART XII, LINE 4B - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSES RECLASSIFIED FROM EXPENSES -11,120.

FUNDING REVENUES RECLASSIFIED FROM OTHER CHANGES IN FUND

BALANCE 39,797,428.

TOTAL TO SCHEDULE D, PART XII, LINE 4B 39,786,308.

PART XIII, LINE 2D - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSES RECLASSIFIED TO NET WITH REVENUES 11,120.

PART XIII, LINE 4B - OTHER ADJUSTMENTS:

INVESTMENT MANAGEMENT FEES RECLASSIFIED FROM REVENUES 547,612.

SCHEDULE G
(Form 990 or 990-EZ)

**Supplemental Information Regarding
Fundraising or Gaming Activities**

OMB No. 1545-0047

2011

**Open To Public
Inspection**

Department of the Treasury
Internal Revenue Service

**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.**

Name of the organization
THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number
04-2121377

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 <input type="checkbox"/> Mail solicitations | e <input type="checkbox"/> Solicitation of non-government grants |
| b <input type="checkbox"/> Internet and email solicitations | f <input type="checkbox"/> Solicitation of government grants |
| c <input type="checkbox"/> Phone solicitations | g <input type="checkbox"/> Special fundraising events |
| d <input type="checkbox"/> In-person solicitations | |

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?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
Total						

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

Part II Fundraising Events. Complete if the organization answered "Yes" 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))
		GOLF TOURNAMENT (event type)	FOOTBALL GAMES (event type)	6 (total number)	
Revenue	1 Gross receipts	15,311.	52,947.	21,362.	89,620.
	2 Less: Charitable contributions				
	3 Gross income (line 1 minus line 2)	15,311.	52,947.	21,362.	89,620.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	1,900.	6,570.	2,650.	11,120.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				(11,120)
	11 Net income summary. Combine line 3, column (d), and line 10				78,500.

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))
		1 Gross revenue			
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> 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)**

Hospitals

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

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. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300</u> %	X	
b Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> 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?		
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 Worksheet 1)			57,564,507.	3,056,204.	54,508,303.	88.26%
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			57,564,507.	3,056,204.	54,508,303.	88.26%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			4,193,623.		4,193,623.	6.79%
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			4,193,623.		4,193,623.	6.79%
k Total. Add lines 7d and 7j			61,758,130.	3,056,204.	58,701,926.	95.05%

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.

Table with 7 columns: (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. Rows include Physical improvements and housing, Economic development, Community support, etc.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?
2 Enter the amount of the organization's bad debt expense
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense.

Table with 3 columns: Yes, No, and a central column for line numbers (1, 2, 3, 5, 6, 7, 9a, 9b). Includes an 'X' in the 'No' column for line 1.

Section B. Medicare

- 5 Enter total revenue received from Medicare (including DSH and IME)
6 Enter Medicare allowable costs of care relating to payments on line 5
7 Subtract line 6 from line 5. This is the surplus (or shortfall)
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?
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

Part IV Management Companies and Joint Ventures (see instructions)

Table with 5 columns: (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, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

Name and address

1 SHRINERS HOSPITAL FOR CHILDREN
51 BLOSSOM STREET
BOSTON, MA 02114-2699

2 SHRINERS HOSPITAL FOR CHILDREN
516 CAREW STREET
SPRINGFIELD, MA 01104

Table with 8 columns: Licensed hospital, General medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other. Rows 1 and 2 contain 'X' marks in the 'Licensed hospital', 'Children's hospital', 'Teaching hospital', and 'Research facility' columns.

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: SHRINERS HOSPITAL FOR CHILDREN

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 tax year 2011)		
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		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> 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		
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		
5 Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> 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 <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> 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		
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?	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>300</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>400</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		
11 Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input type="checkbox"/> Medical indigency		
d <input type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input checked="" type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	X	
13 Included measures to publicize the policy within the community served by the hospital facility?		X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> 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 (FAP) that explained actions the hospital facility may take upon non-payment?		X
15 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

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?		X
If "No," indicate why:			
a	<input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?		X
If "Yes," explain in Part VI.			

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: SHRINERS HOSPITAL FOR CHILDREN

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)		
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		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> 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		
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		
5 Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> 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 <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> 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		
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?	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>300</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: _____ 400 %		
If "No," explain in Part VI the criteria the hospital facility used.		
11 Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input type="checkbox"/> Medical indigency		
d <input type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input checked="" type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	X	
13 Included measures to publicize the policy within the community served by the hospital facility?		X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> 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 (FAP) that explained actions the hospital facility may take upon non-payment?		X
15 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

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?		X
If "No," indicate why:			
a	<input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?		X
If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? _____ 0 _____

Name and address	Type of Facility (describe)

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, 9, 10, 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: SHRINERS HOSPITALS FOR CHILDREN OFFERS SPECIALIZED

MEDICAL SERVICES PERTAINING TO ORTHOPAEDIC CONDITIONS, BURNS, SPINAL CORD

INJURIES AND CLEFT LIP AND PALATE. UPON PATIENT ADMITTANCE FOR ONE OF

THESE CONDITIONS, SHRINERS HOSPITALS FOR CHILDREN REVIEWS THE PATIENT'S

"ABILITY TO PAY" USING FEDERAL POVERTY GUIDELINES SPECIFIED IN SCHEDULE H,

PART I, LINES 3A AND 3B, AND PROVIDES FREE OR DISCOUNTED CARE PURSUANT TO

THESE GUIDELINES. NEVERTHELESS, SHRINERS HOSPITALS FOR CHILDREN WILL

ALWAYS SERVE THESE SPECIALIZED NEEDS FOR ALL OF ITS PATIENTS, REGARDLESS

OF THEIR "ABILITY TO PAY". AS SUCH, SHRINERS HOSPITALS FOR CHILDREN DID

NOT APPLY ANY INCOME-BASED CRITERIA, ASSET TEST, OR OTHER MEANS TEST OR

THRESHOLD FOR PROVIDING FREE CARE TO PATIENTS IN 2011.

PART I, LINE 7: A GENERAL LEDGER ACCOUNTING SYSTEM WAS USED TO

CALCULATE THE AMOUNTS REPORTED IN PART I, LINE 7. THE SYSTEM ADDRESSES

ALL PATIENT SEGMENTS (INPATIENT AND OUTPATIENT). A COST-TO-CHARGE RATIO

IS NOT PART OF THE SYSTEM AND IS NOT APPLICABLE TO SHRINERS HOSPITALS FOR

CHILDREN.

Part VI Supplemental Information

PART III, LINE 4: BAD DEBT EXPENSE IS NOT APPLICABLE TO SHRINERS

HOSPITALS FOR CHILDREN, AND AS SUCH, IS NOT PART OF THE FOOTNOTES IN ITS

FINANCIAL STATEMENTS. SHRINERS HOSPITALS FOR CHILDREN PROVIDES PATIENT

CARE WITHOUT COST TO THE PATIENT. AS SUCH, THERE ARE NO REVENUES AGAINST

WHICH A BAD DEBT COULD ARISE.

PART III, LINE 9B: SHRINERS HOSPITALS FOR CHILDREN PROVIDES PATIENT

CARE WITHOUT COST TO THE PATIENT OR THE PATIENT'S FAMILY. AS SUCH, THERE

IS NO DEBT COLLECTION POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 11H: PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE

BASED UPON THEIR INCOME LEVEL COMPARED TO THE FEDERAL POVERTY GUIDELINES

AND INTERNAL POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 11H: PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE

BASED UPON THEIR INCOME LEVEL COMPARED TO THE FEDERAL POVERTY GUIDELINES

AND INTERNAL POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 19D: THE AMOUNT CHARGED IS CONSISTENT FOR ALL

PAYER CLASSES, PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE BASED ON THEIR

INCOME AND FEDERAL POVERTY GUIDELINES.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 19D: THE AMOUNT CHARGED IS CONSISTENT FOR ALL

Part VI Supplemental Information

PAYER CLASSES, PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE BASED ON THEIR

INCOME LEVEL AND FEDERAL POVERTY GUIDELINES.

PART VI, LINE 2: SHRINERS HOSPITALS FOR CHILDREN PROVIDES PEDIATRIC,

ORTHOPAEDIC, AND BURN CARE AT NO COST TO ITS PATIENTS.

PART VI, LINE 3: SHRINERS HOSPITALS FOR CHILDREN POSTS ITS CHARITY

CARY POLICY IN ADMISSION AREAS, EMERGENCY ROOMS, AND OTHER AREAS OF

FACILITIES WHERE ELIGIBLE PATIENTS ARE LIKELY TO BE PRESENT, AND PROVIDES

A COPY OF ITS POLICY TO PATIENTS AS PART OF THE INTAKE PROCESS AND WITH

DISCHARGE MATERIALS.

PART VI, LINE 4: SHRINERS HOSPITALS FOR CHILDREN (THROUGH THIS ENTITY

AND ITS RELATED ENTITY) SERVE CHILDREN IN NEED OF SPECIALIZED ORTHOPAEDIC

AND BURN CARE ACROSS THE ENTIRE UNITED STATES.

**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

2011

Open to Public Inspection

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

Part I Questions Regarding Compensation

	Yes	No								
<p>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.</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input checked="" type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input checked="" type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input checked="" type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input checked="" type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input checked="" type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p>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</p>	X									
<p>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?</p>	X									
<p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee									
<p>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:</p> <p>a Receive a severance payment or change-of-control payment?</p>		X								
<p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	X									
<p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>		X								
<p>Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.</p>										
<p>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:</p> <p>a The organization?</p>		X								
<p>b Any related organization?</p> <p>If "Yes" to line 5a or 5b, describe in Part III.</p>		X								
<p>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:</p> <p>a The organization?</p>		X								
<p>b Any related organization?</p> <p>If "Yes" to line 6a or 6b, describe in Part III.</p>		X								
<p>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</p>		X								
<p>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</p>		X								
<p>9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>										

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

Schedule J (Form 990) 2011

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) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name		(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 as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JACK H. JONES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	158,833.	0.	0.	0.	0.	158,833.	0.
2 DAVID M. DRVARIC, M.D.	(i)	412,354.	0.	0.	16,500.	2,788.	431,642.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 PETER D. MASSO, M.D.	(i)	300,880.	0.	0.	16,500.	6,383.	323,763.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 CLIFFORD D'ESMOND	(i)	212,607.	0.	0.	0.	2,454.	215,061.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 ALAN J. FISCHMAN	(i)	181,138.	0.	0.	0.	6,774.	187,912.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 PHILIP W. MACK, M.D.	(i)	262,293.	0.	0.	0.	5,585.	267,878.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organizations answered "Yes" on Form
990, Part IV, lines 29 or 30.
▶ Attach to Form 990.**

Name of the organization
THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number
04-2121377

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (<u>MEDICAL EQUIP</u>)	X	1	1,226,900.	COMPARABLE SALES
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

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

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

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

2011

Open to Public
Inspection

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

SHRINERS HOSPITALS FOR CHILDREN IN BOSTON AND SPRINGFIELD OFFER

"CHARITY CARE" AS PART OF AN INTERNATIONAL NETWORK OF PEDIATRIC

HOSPITALS DEDICATED TO PROVIDING EXCELLENT PATIENT CARE, RESEARCH, AND

EDUCATION FOR ORTHOPAEDIC CONDITIONS AND BURNS.

SHRINERS HOSPITALS FOR CHILDREN-BOSTON SPECIALIZES IN PROVIDING

COMPREHENSIVE ACUTE CARE AND RECONSTRUCTIVE AND REHABILITATIVE CARE TO

CHILDREN WHO HAVE BEEN BURNED, INCLUDING ACUTE BURNS, SMOKE INHALATION

INJURY, RECONSTRUCTIVE SURGERY FOR HEALED BURNS, AND OTHRE RELATED

CONDITIONS.

SHRINERS HOSPITALS FOR CHILDREN-SPRINGFIELD SPECIALIZES IN CARING FOR

CHILDREN WITH ORTHOPAEDIC CONDITIONS AND INJURIES SUCH AS SCOLIOSIS,

CLUBFOOT, AND ORTHOPAEDIC CONDITIONS RELATED TO CEREBRAL PALSY AND

SPINAL BIFIDA. FOR MORE INFORMATION, VISIT [HTTP://WWW.SHRINERSHQ.ORG/](http://www.shrinershq.org/)

OR CALL 1-800-241-GIFT.

FORM 990, PART VI, SECTION A, LINE 6: THE ORGANIZATION IS ORGANIZED AS A

NONPROFIT CORPORATION WITH MEMBERS. MEMBERS HAVE THE RIGHT TO ELECT

PERSONS BELONGING TO THE GOVERNING BODY, AND TO APPROVE SIGNIFICANT

DECISIONS OF THE GOVERNING BODY. COMPENSATION IS NOT PROVIDED FOR BEING A

MEMBER.

FORM 990, PART VI, SECTION A, LINE 7A: THE ORGANIZATION HAS APPROXIMATELY

1,400 MEMBERS WHOM ARE APPOINTED FROM THE TOTAL MEMBERSHIP OF SHRINERS

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule O (Form 990 or 990-EZ) (2011)

132211
01-23-12

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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INTERNATIONAL (A RELATED ORGANIZATION). MEMBERS MAY ELECT PERSONS ON THE ORGANIZATION'S GOVERNING BODY, AND MAY APPROVE SIGNIFICANT DECISIONS OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7B: UNDER THE BYLAWS OF THE ORGANIZATION, SIGNIFICANT DECISIONS OF THE GOVERNING BODY REQUIRE APPROVAL BY THE ORGANIZATION'S 1,400 MEMBERS (SUCH AS CHANGES TO THE BYLAWS, OR SIGNIFICANT RESTRUCTURING OR EXTRAORDINARY EVENTS). THE ORGANIZATION'S MEMBERS ALSO MAY ELECT PERSONS TO SERVE ON THE ORGANIZATION'S GOVERNING BODY. THE ORGANIZATION'S MEMBERS DO NOT HAVE CONTROL OVER THE GENERAL OPERATIONS OR FINANCIAL MATTERS OF THE ORGANIZATION. ELECTIONS ARE HELD ANNUALLY BY THE MEMBERS AT VARYING LOCATIONS IN THE U.S.. VOTING IS DECIDED WITH SIMPLE MAJORITY, WHERE EACH MEMBER'S VOTE IS EQUAL WEIGHTED. ELECTED PERSONS SERVE A THREE-YEAR TERM ON THE BOARD OF TRUSTEES, A ONE-YEAR TERM ON THE BOARD OF DIRECTORS, A ONE-YEAR TERM FOR THE ORGANIZATION'S PRESIDENT, AND A ONE-YEAR TERM FOR THE ORGANIZATION'S TREASURER. THE ORGANIZATION'S OFFICERS ARE NOT ELECTED, AND INSTEAD ARE HIRED BY COMMITTEE.

FORM 990, PART VI, SECTION B, LINE 11: A FULL VERSION OF FORM 990 AS FILED WITH THE IRS IS MADE AVAILABLE TO EACH VOTING MEMBER OF THE GOVERNING BODY AND/OR DESIGNATED COMMITTEE RESPONSIBLE FOR PERFORMING A REVIEW PROCESS PRIOR TO FILING.

FORM 990, PART VI, SECTION B, LINE 12C: THE ORGANIZATION HAS A WRITTEN CONFLICT OF INTEREST POLICY AND ALL MEMBERS ARE REQUIRED TO DISCLOSE ANY CONFLICTING INTERESTS OR STATE "NONE" ON THE ANNUAL CONFLICT OF INTEREST

FORM. POTENTIAL CONFLICTS ARE DETERMINED BY THE BOARD OF DIRECTORS. THE

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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PERSON(S) HAVING A POTENTIAL CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN DELIBERATIONS/DECISIONS IN THE TRANSACTION.

FORM 990, PART VI, SECTION B, LINE 15: A SALARY & PERSONNEL COMMITTEE IS INVOLVED WITH ALL COMPENSATION AND APPROVES WAGES FOR MANAGEMENT AND COMPARES THESE SALARIES TO VARIOUS MARKET INDICATORS.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION'S GOVERNING DOCUMENTS (INCLUDING ITS CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS) ARE AVAILABLE TO THE PUBLIC UPON WRITTEN REQUEST.

FORM 990, PART XI, LINE 5, CHANGES IN NET ASSETS:
NET UNREALIZED LOSSES ON INVESTMENTS: -75,679,448.

FORM 990, PART XII, LINE 2C EXPLANATION:
AUDIT COMMITTEE OVERSIGHT PROCESS
THE ORGANIZATION HAS NOT CHANGED (DURING THE CURRENT YEAR) ITS OVERSIGHT PROCESS OR ITS SELECTION PROCESS REGARDING THE COMMITTEE RESPONSIBLE FOR THE OVERSIGHT OF THE AUDIT OF THE FINANCIAL STATEMENTS AND THE SELECTION OF THE INDEPENDENT ACCOUNTANT.

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.**

Name of the organization: **THE SHRINERS' HOSPITAL FOR CHILDREN**
Employer identification number: **04-2121377**

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	No
SHRINERS HOSPITALS FOR CHILDREN EMPLOYEE DISASTER RELIEF FUND - 26-3733381, 2900 ROCKY POINT DRIVE, TAMPA, FL 33607	DISASTER RELIEF	DISTRICT OF COLUMBIA	501(C)(3)	9	NO		X
SHRINERS HOSPITALS FOR CHILDREN - 36-2193608 POST OFFICE BOX 31356 TAMPA, FL 33631-3356	HOSPITAL SYSTEM	COLORADO	501(C)(3)	3	NO		X
SHRINERS INTERNATIONAL - 36-2158164 POST OFFICE BOX 31356 TAMPA, FL 33631-3356	FOUNDED SHRINERS HOSPITALS FOR CHILDREN	IOWA	501(C)(10)	N/A	NO		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) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" 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

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

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

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

	Yes	No
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)		X
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)	X	
f Sale of assets to related organization(s)		X
g Purchase of assets from related organization(s)		X
h Exchange of assets with related organization(s)		X
i Lease of facilities, equipment, or other assets to related organization(s)		X
j Lease of facilities, equipment, or other assets from related organization(s)		X
k Performance of services or membership or fundraising solicitations for related organization(s)		X
l Performance of services or membership or fundraising solicitations by related organization(s)		X
m Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
n Sharing of paid employees with related organization(s)	X	
o Reimbursement paid to related organization(s) for expenses		X
p Reimbursement paid by related organization(s) for expenses		X
q Other transfer of cash or property to related organization(s)		X
r Other transfer of cash or property from related organization(s)		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) SHRINERS HOSPITALS FOR CHILDREN	C	39,797,428.	
(2) SHRINERS HOSPITALS FOR CHILDREN	N	0.	
(3) SHRINERS HOSPITALS FOR CHILDREN	E	29,832,222.	
(4)			
(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) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.?		(f) Share of total income	(g) Share of end-of-year assets	(h) Dispropor- tionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

Multiple horizontal lines for supplemental information.

**IRS e-file Signature Authorization
for an Exempt Organization**

For calendar year 2011, or fiscal year beginning _____, 2011, and ending _____, 20____

2011

Department of the Treasury
Internal Revenue Service

▶ **Do not send to the IRS. Keep for your records.**
▶ **See instructions.**

Name of exempt organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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Name and title of officer
DOUGLAS MAXWELL
PRESIDENT

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

Check the box for the return for which you are using this Form 8879-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 for 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-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue , if any (Form 990, Part VIII, column (A), line 12)	1b <u>120921850</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue , if any (Form 990-EZ, line 9)	2b _____
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b _____
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b _____
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b _____

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2011 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. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an 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. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize CBIZ KIRKLAND, RUSS, MURPHY & TAPP to enter my PIN 21377
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

50465143757
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2011 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163**, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

STATE COPY

TAX RETURN FILING INSTRUCTIONS

MASSACHUSETTS FORM PC

FOR THE YEAR ENDING

DECEMBER 31, 2011

Prepared for	THE SHRINERS' HOSPITAL FOR CHILDREN POST OFFICE BOX 31356 TAMPA, FL 33631-3356
Prepared by	CBIZ KIRKLAND, RUSS, MURPHY & TAPP 13577 FEATHER SOUND DRIVE, SUITE 400 CLEARWATER, FL 33762
Amount due or refund	BALANCE DUE OF \$1,000
Make check payable to	COMMONWEALTH OF MASSACHUSETTS
Mail tax return and check (if applicable) to	NON-PROFIT ORGANIZATIONS/PUBLIC CHARITIES DIV OFFICE OF THE ATTORNEY GENERAL ONE ASHBURTON PLACE BOSTON, MA 02108
Return must be mailed on or before	PLEASE MAIL AS SOON AS POSSIBLE.
Special Instructions	FORM PC MUST BE SIGNED AND DATED BY THE AUTHORIZED INDIVIDUAL(S). ALSO BE SURE THAT ALL THE NECESSARY ATTACHMENTS ARE INCLUDED WITH FORM PC BEFORE FILING. INCLUDE THE ORGANIZATION'S MASSACHUSETTS ATTORNEY GENERAL SIX-DIGIT ACCOUNT NUMBER AND "2011 FORM PC" ON THE REMITTANCE. ALSO INCLUDE THE ORGANIZATION'S FISCAL YEAR END DATE IN THIS FORMAT (12/11).

The Commonwealth of Massachusetts
OFFICE OF THE ATTORNEY GENERAL
NON-PROFIT ORGANIZATIONS/PUBLIC CHARITIES DIVISION
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

Office Use Only: **Fiscal Year**

(617) 727-2200, ext. 2101
www.mass.gov/ago/charities

Form PC

Report for the Fiscal Period: 01/01/11 to 12/31/11

Attorney General's Account #: _____

Federal ID #: 04-2121377

When did the organization first engage in charitable work in Massachusetts? _____

Has the organization applied for or been granted IRS tax exempt status? Yes No

If yes, date of application **OR** date of determination letter: _____

IRS Exemption under 501(c): 03

If exempt under 501(c), are contributions to the organization tax deductible as charitable contributions? Yes No

Check all items attached (if applicable)	
<input type="checkbox"/>	Schedule A-1
<input type="checkbox"/>	Schedule A-2
<input type="checkbox"/>	Schedule RO
<input type="checkbox"/>	Probate Account
<input type="checkbox"/>	Copy of IRS Return
<input type="checkbox"/>	Audited Financial Statements/Review
<input type="checkbox"/>	Filing Fee
<input type="checkbox"/>	Amended Articles/By-Laws

Organization Data

Name: THE SHRINERS' HOSPITAL FOR CHILDREN

Mailing Address: POST OFFICE BOX 31356

City: TAMPA State: FL ZIP: 33631-3356

Phone Number: (813) 281-0300 Fax Number: _____

Email: _____ Website: HTTP://WWW.SHRINERSHQ.O

In the table below, please enter the appropriate codes from the corresponding tables found in the instructions. Enter **up to 2** codes from Table 3 for your organization's main purpose(s)

Category	Code	Category	Code
County (Table 1)		Organization Purpose Code 1	
Type of Organization (Table 2)		Organization Purpose Code 2	

Please check box if final return prior to dissolution:

Office Use Only: **Payment Received**

All questions must be completed in their entirety whether or not similar questions are answered in an attached federal form. See instructions and definition section for guidance.

1. On what date was the organization created? _____
2. Where was the organization created? _____
3. What is the form of organization? (check one)

Corporation <input type="checkbox"/>	Testamentary Trust <input type="checkbox"/>
Unincorporated Association <input type="checkbox"/>	Inter Vivos Trust <input type="checkbox"/>

Other (please describe): _____

4. Was your organization related to any other organization(s) during the reporting year (see definition of "Related Organization")? If yes, please complete the Schedule RO on pages 13 and 14. Yes No

5. Enter your summary of financial data:

	Financial Data	Amounts
A.	Contributions, gifts, grants, and similar amounts received	42,742,971.
B.	Gross support and revenue	71,930,882.
C.	Program services and similar amounts paid out	61,758,130.
D.	Fundraising expenses	0.
E.	Management and general expenses	0.
F.	Payments to affiliates	0.
G.	Total expenses	61,758,130.
H.	Net assets or fund balances at the end of the year	832,721,468.

6. List the total compensation you provided to your five highest paid employees:

	Name/Title	Hrs/Week	Salary and Other Income	Benefit Plans	Other Compensation
1.	DAVID M. DRVARIC, M.D. CHIEF OF STAFF	40.00	0.	0.	0.
2.	PETER D. MASSO, M.D. ASSISTANT CHIEF OF STAFF	40.00	0.	0.	0.
3.	PHILIP W. MACK, M.D. FORMER ORTHOPAEDIC SURGEON	40.00	0.	0.	0.
4.	CLIFFORD D'ESMOND ADMINISTRATOR	40.00	0.	0.	0.
5.	ALAN J. FISCHMAN SR. INVESTIGATOR	40.00	0.	0.	0.

7. Was any compensation provided to any of the individuals listed in question 6 above which was not quantified in your response to 6? If yes, please provide explanation (attach separate sheet). Yes No

8. List the name, amount of compensation paid, and the nature of services rendered by each of the organization's five highest paid consultants providing professional services (e.g. attorneys, architects, accountants, management companies, investment advisors, professional solicitors, professional fundraising counsel).

	Name/Title	Amount of Compensation	Type(s) of Service
1.	MASSACHUSETTS GENERAL HOSPITAL	8,068,201.	OUTSIDE PATIENT CARE
2.	HEALTH NEW ENGLAND	1,627,922.	EMPLOYEE BENEFITS
3.	SPRINGFIELD ANESTHESIA SERVICE	1,052,691.	ANESTHESIOLOGY SERVICES
4.	OWENS & MINOR	948,744.	MEDICAL SUPPLIES
5.	PHILIPS ELECTRONICS	610,561.	MEDICAL SUPPLIES

9. Bank(s) in which the organization's funds are deposited (include bank addresses and phone numbers):

Bank	Address	Phone Number

10. What is the organization's accounting method? Cash Accrual

Other (specify): _____

11. If organization's mailing address is a P.O. Box, list the organization's full street address:

Address: _____

City: _____ State: _____ ZIP Code: _____

12. Contact Person Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

13. During the fiscal year reported here, did your organization solicit contributions or have funds solicited on its behalf? Yes No
14. At any time during the fiscal year following the year reported here, will your organization, or others acting on its behalf, solicit contributions? Yes No

If you answered yes to Question 13 or 14, you must complete Schedule A-1 and/or Schedule A-2 unless you are exempt from the solicitation certificate requirement.

15. If you are claiming an exemption from the solicitation certificate requirement, please indicate by checking the box to the right to identify which exemption applies to your organization.

a religious organization	<input type="checkbox"/>
an organization which: (a) does not raise more than \$5,000 during a calendar year OR does not receive contributions from more than ten persons during a calendar year; AND (b) carries out all of its activities, including fundraising, through unpaid volunteers. <i>(The conditions at both (a) and (b) must be met for your organization to qualify for this exemption.)</i>	<input type="checkbox"/>

16. Attach a list of names, addresses (street and/or mailing), and telephone numbers of other offices/chapters/branches/affiliates.
17. Attach a list of names, titles, and addresses (street and/or mailing) of officers, directors, trustees, and the principal salaried executives of organization.
SEE STATEMENT 1
18. Attach a list of names, titles, and addresses (street and/or mailing) of any individual(s) authorized to sign checks, and any individual(s) responsible for: custody of funds; distribution of funds; fundraising; and custody of financial records.
19. Has this organization or any of its officers, directors, employees or fundraisers solicited funds in any other state? Yes No

If you attach list of states where solicitation was conducted, including registered agency, dates of registration, registration numbers, any other names under which the organization was/is registered, and the dates and type (mail, telephone, door to door, special events, etc.) of the solicitation conducted.

FORM PC OFFICERS, DIRECTORS, TRUSTEES AND EXECUTIVES STATEMENT 1

NAME AND ADDRESS

TITLE

JACK H. JONES
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

ASSISTANT SECRETARY

NAME AND ADDRESS

TITLE

GEORGE MITCHELL
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

CHAIRMAN OF THE BOARD, TRUST

NAME AND ADDRESS

TITLE

MICHAEL G. SEVERE
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

VICE PRESIDENT, TRUSTEE

NAME AND ADDRESS

TITLE

DOUGLAS MAXWELL
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

PRESIDENT, TRUSTEE

NAME AND ADDRESS

TITLE

GENE BRACEWELL
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TREASURER, TRUSTEE

NAME AND ADDRESS

TITLE

ALAN W. MADSEN
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

RALPH SEMB
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

W. BRANDT BEDE, M.D.
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

CHARLES CLAYPOOL
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

GARY DUNWOODY
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

RAOUL L. FREVAL
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

FRANK PREBLE
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

RODNEY PINKHAM
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

DAVID S. MCKECHNIE
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

HAROLD F. JENNINGS, CPA
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

CHARLES H. WEAVER
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

CLERK

NAME AND ADDRESS

TITLE

DAVID H. BURSTEIN
 POST OFFICE BOX 31356
 TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

KEVIN J. HECHT, ESQ.
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

RICHARD E. JOHNSON
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

ASSISTANT TREASURER, TRUSTEE

NAME AND ADDRESS

TITLE

BOBBY B. SIMMONS
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

NAME AND ADDRESS

TITLE

G. STEPHEN GETMAN, ESQ.
POST OFFICE BOX 31356
TAMPA, FL 33631-3356

TRUSTEE

20. Has this organization or any of its officers, directors, or employees:

If yes, please attach an explanation.

- (a) Been enjoined or otherwise prohibited by a government agency/court from operating or soliciting contributions? Yes No
- (b) Ever been refused registration or had its registration or tax exemption denied, suspended, modified or revoked by a governmental agency? Yes No
- (c) Been the subject of a proceeding regarding any solicitation or registration? Yes No
- (d) Entered into a voluntary agreement of compliance or consent judgment with any government agency or in a case before a court or administrative agency? Yes No

21. Have any restrictions been removed during the year from donor-restricted funds?

If yes, please attach an explanation.

Yes No

22. Have donor-restricted funds been loaned to unrestricted funds?

If yes, please attach an explanation.

Yes No

23. This question involves "Termination of Employment or Changes of Control Compensatory Arrangements" with certain "Related Parties" (see instructions and definition sections). Report only if payments made or promised to any individual are in excess of four months salary or \$100,000, whichever dollar amount is less.

- (a) Did you make actual payments or otherwise transfer value under such an arrangement to any individual described in Related Party definition, sections (a) or (b), which payments are not reported in Question 6 or 7 above? Yes No
- (b) Do you have an agreement with any individual described in Related Party definition, sections (a) or (b), containing such an agreement? Yes No

*If you answered **yes** for Question 23(a) or 23(b) above, please attach an explanation identifying the individual(s) involved, stating the amount of any payments made or value transferred, and describing the terms of each agreement.*

24. This question applies to related party transactions, which include transactions with officers, directors, trustees, certain employees, relative, and organizations they own or control. Please consult the instructions and definition sections for the definition of a "Related Party" and "Indebtedness" before answering. Note that transactions involving related parties must be reported even when there is no accounting recognition (e.g. in-kind gifts, waiver of interest not otherwise reported).

If the answer to any part of Question 24 is **yes**, attach a schedule stating the name and address of the related party, the nature of the transaction, the value or the amounts involved in the transaction, and the procedure followed in authorizing the transaction.

During the year:			
A.	Has your organization sold or transferred assets to or purchased assets from or exchanged assets with a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
B.	Has your organization leased assets to or leased assets from a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
C.	Has your organization been indebted to a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
D.	Has your organization allowed a related party to be indebted to it?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
E.	Has your organization made or held an investment in a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
F.	Has your organization furnished goods, services, or facilities to a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
G.	Has your organization acquired goods, services, or facilities from a related party who received compensation or other value in return?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
H.	Has your organization paid or became obligated to pay wages, salary, or other compensation to a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
I.	Has your organization transferred income or assets to or for use by a related party?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
J.	Was your organization a party to any transaction in which any of its officers, directors, or trustees has a material financial interest, or did any officer, director, or trustee receive anything of value not reported as compensation?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
K.	Has your organization invested in any corporate stock of a company in which any officer, director, or trustee owns more than 10% of the outstanding shares?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
L.	Is any property of the organization held in the name of or commingled with the property of any other person or organization?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
M.	Did your organization make a grant award or contribution to any other organization in which any of this organization's officers, directors, or trustees has a relationship?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Signature Required

Under penalty of perjury, I declare that the information furnished in this report, including all attachments, is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: DOUGLAS MAXWELL

Title: PRESIDENT

Name of Preparer: CBIZ KIRKLAND, RUSS, MURPHY & TAPP

Address 13577 FEATHER SOUND DRIVE, SUITE 400

City CLEARWATER State FL ZIP Code 33762

Phone Number (727)572-1400

**Schedule A-1
Solicitation Activities During Fiscal Year Covered By This Report**

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

Types of solicitation activities in which you expect to engage (*check all that apply*):

Mass Mailing	<input type="checkbox"/>	Via the Internet	<input type="checkbox"/>
Door-to-door	<input type="checkbox"/>	Raffle, beano, bingo or gaming event	<input type="checkbox"/>
Entertainment event	<input type="checkbox"/>	Sale of goods other than by telephone	<input type="checkbox"/>
Telemarketing without sale of goods or ads	<input type="checkbox"/>	Individual Mailings	<input type="checkbox"/>
Telemarketing with sale of goods	<input type="checkbox"/>	Corporate solicitations	<input type="checkbox"/>
Telemarketing with sale of ads	<input type="checkbox"/>	Grant Proposals	<input type="checkbox"/>

Other (*specify*): _____

Identify the method or methods you expect to use for the fundraising (*check all that apply*):

Professional solicitor*	<input type="checkbox"/>	Own employees	<input type="checkbox"/>
Professional fundraising counsel*	<input type="checkbox"/>	Volunteers	<input type="checkbox"/>
Commercial co-venturer*	<input type="checkbox"/>		

* Provide applicable names and addresses:

Professional Solicitor Name: _____

Address _____

City _____ State _____ ZIP Code _____

Professional Fundraising Counsel Name: _____

Address _____

City _____ State _____ ZIP Code _____

Commercial Co-Venturer Name: _____

Address _____

City _____ State _____ ZIP Code _____

Schedule A-1 ctd.
Solicitation Activities During Fiscal Year Covered By This Report

Identify the individuals who will have final responsibility for the charity's custody of contributions:

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Identify the individuals who will have final responsibility for the charity's distribution of contributions:

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Schedule A-2
Solicitation Activities Planned for Fiscal Year Which Follows the Reporting Year

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

Types of solicitation activities in which you expect to engage (*check all that apply*):

Mass Mailing	<input type="checkbox"/>	Via the Internet	<input type="checkbox"/>
Door-to-door	<input type="checkbox"/>	Raffle, beano, bingo or gaming event	<input type="checkbox"/>
Entertainment event	<input type="checkbox"/>	Sale of goods other than by telephone	<input type="checkbox"/>
Telemarketing without sale of goods or ads	<input type="checkbox"/>	Individual Mailings	<input type="checkbox"/>
Telemarketing with sale of goods	<input type="checkbox"/>	Corporate solicitations	<input type="checkbox"/>
Telemarketing with sale of ads	<input type="checkbox"/>	Grant Proposals	<input type="checkbox"/>

Other (*specify*): _____

Identify the method or methods you expect to use for the fundraising (*check all that apply*):

Professional solicitor*	<input type="checkbox"/>	Own employees	<input type="checkbox"/>
Professional fundraising counsel*	<input type="checkbox"/>	Volunteers	<input type="checkbox"/>
Commercial co-venturer*	<input type="checkbox"/>		

* Provide applicable names and addresses:

Professional Solicitor Name: _____

Address _____

City _____ State _____ ZIP Code _____

Professional Fundraising Counsel Name: _____

Address _____

City _____ State _____ ZIP Code _____

Commercial Co-Venturer Name: _____

Address _____

City _____ State _____ ZIP Code _____

Schedule A-2 ctd.
Solicitation Activities Planned for Fiscal Year Which Follows the Reporting Year

Identify the individuals who will have final responsibility for the charity's custody of contributions:

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Identify the individuals who will have final responsibility for the charity's distribution of contributions:

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Name and Title: _____

Address _____

City _____ State _____ ZIP Code _____

Certification by Organization

Two different signatures required. Signers must be organization president or other authorized officer or trustee.

Under penalty of perjury, we declare that the information furnished in this report, including all attachments, is true and correct to the best of our knowledge.

Signature: _____ Date: _____

Print Name: DOUGLAS MAXWELL

Title: PRESIDENT

Signature: _____ Date: _____

Print Name: _____

Title: _____

Schedule RO

1. Please read the instructions and definition of "Related Organization" carefully before completing this section. *(If you have more than five Related Organizations, please attach a list)*

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Name:		Primary purpose or activity:		
FYE	A. Donor restricted funds (-) liabilities	B. 3rd party restricted funds (-) liabilities	C. Unrestricted funds (-) liabilities	D. Total net assets (A+B+C)

Schedule RO ctd.

2. List the total compensation paid by your organization and/or any other related organization to your chief executive (e.g. executive director) and to the four other current or former directors, trustees, officers, or employees within the system of related organizations identified at question 1, above, receiving the highest aggregate compensation (*see instructions*). Use additional lines below to itemize by compensation source.

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

Name:		Title:	
Income Source:	Salary and Other Income:	Benefits Plan:	Other Compensation:

3. Is asset and/or compensation information for religious organizations and/or certain non-charitable entities related to foundations excluded pursuant to instructions? Yes No

Form **990**

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)

OMB No. 1545-0047

2011

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning and ending

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization THE SHRINERS' HOSPITAL FOR CHILDREN		D Employer identification number 04-2121377
	Doing Business As		
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	E Telephone number (813) 281-0300
	POST OFFICE BOX 31356		
City or town, state or country, and ZIP + 4 TAMPA, FL 33631-3356		G Gross receipts \$ 602,242,638.	
F Name and address of principal officer: DOUGLAS MAXWELL 2900 ROCKY POINT DRIVE, TAMPA, FL 33607		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: ▶ HTTP://WWW.SHRINERSHQ.ORG/			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1925
			M State of legal domicile: MA

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: WE PROVIDE PEDIATRIC SPECIALTY CARE WITHOUT FINANCIAL OBLIGATION TO PATIENTS OR THEIR FAMILIES.		
	2 Check this box <input type="checkbox"/> 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 19	
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 19	
	5 Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5 569	
	6 Total number of volunteers (estimate if necessary)	6 1000	
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 0.	
	b Net unrelated business taxable income from Form 990-T, line 34	7b 0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	39,827,375.	42,742,971.
	9 Program service revenue (Part VIII, line 2g)	0.	3,056,204.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	42,638,994.	74,899,338.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,000,324.	223,337.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	83,466,693.	120,921,850.
	Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.
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)		34,806,138.	35,707,985.
16a Professional fundraising fees (Part IX, column (A), line 11e)		0.	0.
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.			
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)		28,483,283.	26,050,145.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	63,289,421.	61,758,130.	
19 Revenue less expenses. Subtract line 18 from line 12	20,177,272.	59,163,720.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	852,520,775.	865,660,518.
	21 Total liabilities (Part X, line 26)	3,283,579.	32,939,050.
	22 Net assets or fund balances. Subtract line 21 from line 20	849,237,196.	832,721,468.

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
	▶ DOUGLAS MAXWELL, PRESIDENT		Type or print name and title
Paid Preparer Use Only	Print/Type preparer's name NATHAN SMITH	Preparer's signature	Date
	Firm's name ▶ CBIZ KIRKLAND, RUSS, MURPHY & TAPP	Firm's EIN ▶ 27-3605969	Check if self-employed <input type="checkbox"/> PTIN P00543757
Firm's address ▶ 13577 FEATHER SOUND DRIVE, SUITE 400 CLEARWATER, FL 33762		Phone no. (727) 572-1400	

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: SEE SCHEDULE O

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 [X] No

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 36,198,803. including grants of \$) (Revenue \$ 1,921,860.) TREATMENT OF PEDIATRIC BURN VICTIMS: ADMISSIONS: 582 OUTPATIENT CLINIC VISITS: 5,535 OUTPATIENT CLINIC SURGERIES: 476

4b (Code:) (Expenses \$ 21,365,704. including grants of \$) (Revenue \$ 1,134,344.) TREATMENT OF ORTHOPEDIC PEDIATRIC PATIENTS: ADMISSIONS: 359 OUTPATIENT CLINIC VISITS: 15,699 OUTPATIENT CLINIC SURGERIES: 240

4c (Code:) (Expenses \$ 4,193,623. including grants of \$) (Revenue \$) MEDICAL RESEARCH IS PERFORMED AND HAS A STRONG, POSITIVE IMPACT ON THE CARE AND CURE OF CHILDREN WITH ORTHOPAEDIC PROBLEMS, BURN AND SPINAL CORD INJURIES. SHRINERS HOSPITALS FOR CHILDREN IS COMMITTED TO THE SUSTAINED INVESTMENT IN CLINICALLY USEFUL RESEARCH SO THAT FUNDAMENTAL KNOWLEDGE CAN BE ACQUIRED, IMPROVING THE QUALITY OF LIFE FOR CHILDREN WITH ORTHOPAEDIC PROBLEMS, BURN AND SPINAL CORD INJURIES.

4d Other program services (Describe in Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 61,758,130.

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)? <i>If "Yes," complete Schedule A</i>	X	
2	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		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? <i>If "Yes," complete Schedule C, Part II</i>		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? <i>If "Yes," complete Schedule C, Part III</i>		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		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? <i>If "Yes," complete Schedule D, Part II</i>		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		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? <i>If "Yes," complete Schedule D, Part IV</i>		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>		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? <i>If "Yes," complete Schedule D, Part VIII</i>		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? <i>If "Yes," complete Schedule D, Part IX</i>		X
e	Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>		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)? <i>If "Yes," complete Schedule D, Part X</i>		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI, XII, and XIII</i>		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional</i>	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?		X
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		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? <i>If "Yes," complete Schedule G, Part I</i>		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? <i>If "Yes," complete Schedule G, Part II</i>	X	
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	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 any government or organization in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		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? <i>If "Yes," complete Schedule I, Parts I and III</i>		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? <i>If "Yes," complete Schedule J</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25</i>		X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		X
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	X	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		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? <i>If "Yes," complete Schedule R, Part I</i>		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
b Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		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? <i>If "Yes," complete Schedule R, Part VI</i>		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	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

Input box for Schedule O response

Main table with columns for question number, description, and Yes/No responses. Includes rows 1a-1c, 2a-2b, 3a-3b, 4a-4a, 5a-5c, 6a-6b, 7, 7a-7h, 8, 9, 9a-9b, 10, 10a-10b, 11, 11a-11b, 12a, 12b, 13, 13a-13c, 14a, 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

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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?; 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done; 13 Did the organization have a written whistleblower policy?; 14 Did the organization have a written document retention and destruction policy?; 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?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 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?; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MA
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
Own website [] Another's website [X] Upon request [X]
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization:
SHARON RUSSELL - 813-281-0300
2900 ROCKY POINT DR., TAMPA, FL 33607-1435

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

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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) RALPH SEMB TRUSTEE	5.00	X					0.	0.	0.	
(2) W. BRANDT BEDE, M.D. TRUSTEE	5.00	X					0.	0.	0.	
(3) CHARLES CLAYPOOL TRUSTEE	5.00	X					0.	0.	0.	
(4) GARY DUNWOODY TRUSTEE	5.00	X					0.	0.	0.	
(5) RAOUL L. FREVAL TRUSTEE	5.00	X					0.	0.	0.	
(6) DOUGLAS MAXWELL PRESIDENT, TRUSTEE	20.00	X		X			0.	18,000.	0.	
(7) GEORGE MITCHELL CHAIRMAN OF THE BOARD, TRUSTEE	5.00	X		X			0.	96,800.	0.	
(8) GENE BRACEWELL TREASURER, TRUSTEE	5.00	X		X			0.	4,900.	0.	
(9) FRANK PREBLE TRUSTEE	5.00	X					0.	0.	0.	
(10) RODNEY PINKHAM TRUSTEE	5.00	X					0.	0.	0.	
(11) DAVID S. MCKECHNIE TRUSTEE	5.00	X					0.	0.	0.	
(12) HAROLD F. JENNINGS, CPA TRUSTEE	5.00	X					0.	0.	0.	
(13) MICHAEL G. SEVERE VICE PRESIDENT, TRUSTEE	5.00	X		X			0.	49,000.	0.	
(14) DAVID H. BURSTEIN TRUSTEE	5.00	X					0.	0.	0.	
(15) KEVIN J. HECHT, ESQ. TRUSTEE	5.00	X					0.	0.	0.	
(16) RICHARD E. JOHNSON ASSISTANT TREASURER, TRUSTEE	5.00	X		X			0.	0.	0.	
(17) BOBBY B. SIMMONS TRUSTEE	5.00	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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) G. STEPHEN GETMAN, ESQ. TRUSTEE	5.00	X						0.	0.	0.
(19) ALAN W. MADSEN TRUSTEE	5.00	X						0.	1,800.	0.
(20) JACK H. JONES ASSISTANT SECRETARY	35.00			X				0.	158,833.	0.
(21) CHARLES H. WEAVER CLERK	5.00			X				0.	0.	0.
(22) DAVID M. DRVARIC, M.D. CHIEF OF STAFF	40.00					X		412,354.	0.	19,288.
(23) PETER D. MASSO, M.D. ASSISTANT CHIEF OF STAFF	40.00					X		300,880.	0.	22,883.
(24) CLIFFORD D'ESMOND ADMINISTRATOR	40.00					X		212,607.	0.	2,454.
(25) ALAN J. FISCHMAN SR. INVESTIGATOR	40.00					X		181,138.	0.	6,774.
(26) PHILIP W. MACK, M.D. FORMER ORTHOPAEDIC SURGEON	40.00						X	262,293.	0.	5,585.
1b Sub-total								1,369,272.	329,333.	56,984.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								1,369,272.	329,333.	56,984.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **42**

	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	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	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		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. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
MASSACHUSETTS GENERAL HOSPITAL P.O. BOX 350096, BOSTON, MA 02241	OUTSIDE PATIENT CARE	8,068,201.
HEALTH NEW ENGLAND, 1 MONARCH PLACE #1500, SPRINGFIELD, MA 01144	EMPLOYEE BENEFITS	1,627,922.
SPRINGFIELD ANESTHESIA SERVICE 908 ALLEN ST., SPRINGFIELD, MA 01101	ANESTHESIOLOGY SERVICES	1,052,691.
OWENS & MINOR, 9120 LOCKWOOD BLVD, MECHANICSVILLE, VA 23116	MEDICAL SUPPLIES	948,744.
PHILIPS ELECTRONICS 22100 BOTHELL EVERTT HWY, BOTHELL, WA 98041	MEDICAL SUPPLIES	610,561.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **37**

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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	39,797,428.				
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,945,543.				
	g Noncash contributions included in lines 1a-1f: \$		1,226,900.				
	h Total. Add lines 1a-1f		42,742,971.				
	Program Service Revenue	2 a PATIENT SERVICE	Business Code 621110	3,056,204.	3,056,204.		
b							
c							
d							
e							
f All other program service revenue							
g Total. Add lines 2a-2f			3,056,204.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		25,908,370.			25,908,370.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real					
		(ii) Personal					
		b Less: rental expenses					
		c Rental income or (loss)					
	d Net rental income or (loss)						
	7 a Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other					
		b Less: cost or other basis and sales expenses		481,264,694.	44,974.		
		c Gain or (loss)		49,035,942.	-44,974.		
	d Net gain or (loss)		48,990,968.			48,990,968.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a	89,620.				
		b Less: direct expenses	b	11,120.			
c Net income or (loss) from fundraising events			78,500.			78,500.	
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
10 a 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					
11 a MISCELLANEOUS	900099	144,837.			144,837.		
b							
c							
d All other revenue							
e Total. Add lines 11a-11d		144,837.					
12 Total revenue. See instructions.		120,921,850.	3,056,204.	0.	75,122,675.		

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).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	25,918,755.	25,918,755.		
8 Pension plan accruals and contributions (include section 401(k) and section 403(b) employer contributions)	4,958,065.	4,958,065.		
9 Other employee benefits	2,960,611.	2,960,611.		
10 Payroll taxes	1,870,554.	1,870,554.		
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	547,612.	547,612.		
g Other	10,773,024.	10,773,024.		
12 Advertising and promotion	35,412.	35,412.		
13 Office expenses	128,954.	128,954.		
14 Information technology				
15 Royalties				
16 Occupancy	3,483,161.	3,483,161.		
17 Travel	273,909.	273,909.		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	4,374,246.	4,374,246.		
23 Insurance	452,784.	452,784.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	5,270,742.	5,270,742.		
b PATIENT COSTS	486,465.	486,465.		
c DUES AND REGISTRATIONS	149,100.	149,100.		
d POSTAGE	66,239.	66,239.		
e All other expenses	8,497.	8,497.		
25 Total functional expenses. Add lines 1 through 24e	61,758,130.	61,758,130.	0.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

		(A)		(B)	
		Beginning of year		End of year	
Assets	1 Cash - non-interest-bearing	490,797.	1	382,551.	
	2 Savings and temporary cash investments		2		
	3 Pledges and grants receivable, net	87,207.	3	0.	
	4 Accounts receivable, net		4		
	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		7		
	8 Inventories for sale or use	887,932.	8	884,084.	
	9 Prepaid expenses and deferred charges	807,719.	9	635,784.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 145,182,720.			
	b Less: accumulated depreciation	10b 65,213,611.	81,161,618.	10c 79,969,109.	
	11 Investments - publicly traded securities	769,085,502.	11	783,580,205.	
	12 Investments - other securities. See Part IV, line 11		12		
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11	0.	15	208,785.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	852,520,775.	16	865,660,518.		
Liabilities	17 Accounts payable and accrued expenses	2,946,045.	17	32,411,880.	
	18 Grants payable		18		
	19 Deferred revenue	337,534.	19	527,170.	
	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		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		25		
	26 Total liabilities. Add lines 17 through 25	3,283,579.	26	32,939,050.	
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	849,237,196.	27	832,721,468.	
	28 Temporarily restricted net assets		28		
	29 Permanently restricted net assets		29		
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building, or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
	33 Total net assets or fund balances	849,237,196.	33	832,721,468.	
34 Total liabilities and net assets/fund balances	852,520,775.	34	865,660,518.		

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	120,921,850.
2	Total expenses (must equal Part IX, column (A), line 25)	2	61,758,130.
3	Revenue less expenses. Subtract line 2 from line 1	3	59,163,720.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	849,237,196.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-75,679,448.
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	832,721,468.

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: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
2b	Were the organization's financial statements audited by an independent accountant?	X	
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
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: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> 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?		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.		

Form **990** (2011)

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

2011

Open to Public Inspection

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
--	---

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?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2010 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2011. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2010. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2011. 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		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2010. 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		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

(Complete only if you checked the box on line 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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2011 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2010 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2011. 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 - 2010. 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 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, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

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

Part II Conservation Easements. Complete if the organization answered "Yes" 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	760,025,402.	698,824,389.	604,354,755.	834,575,000.	
b Contributions					
c Net investment earnings, gains, and losses	29,611,840.	83,046,382.	117,592,699.	-216,021,898.	
d Grants or scholarships					
e Other expenditures for facilities and programs	14,805,920.	21,845,369.	23,123,065.	14,198,347.	
f Administrative expenses					
g End of year balance	774,831,322.	760,025,402.	698,824,389.	604,354,755.	

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

- a Board designated or quasi-endowment 100.00 %
- b Permanent endowment .00 %
- c Temporarily restricted endowment .00 %

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

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

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

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 property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		303,990.		303,990.
b Buildings		107,659,792.	37,044,597.	70,615,195.
c Leasehold improvements		416,959.	374,151.	42,808.
d Equipment		36,466,676.	27,794,863.	8,671,813.
e Other		335,303.		335,303.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				79,969,109.

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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15.) ▶	

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

1. (a) Description of liability	(b) Book value	
(1) Federal income taxes		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
(11)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 25.) ▶		

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	120,921,850.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	61,758,130.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	59,163,720.
4	Net unrealized gains (losses) on investments	4	-75,679,448.
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	-75,679,448.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-16,515,728.

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	4,908,482.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	-75,679,448.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	-547,612.
e	Add lines 2a through 2d	2e	-76,227,060.
3	Subtract line 2e from line 1	3	81,135,542.
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	39,786,308.
c	Add lines 4a and 4b	4c	39,786,308.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	120,921,850.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements	1	61,221,638.
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	11,120.
e	Add lines 2a through 2d	2e	11,120.
3	Subtract line 2e from line 1	3	61,210,518.
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	547,612.
c	Add lines 4a and 4b	4c	547,612.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	61,758,130.

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: THE ENDOWMENT FUNDS (INCLUDING UNRESTRICTED FUND

BALANCES) ARE THE PRIMARY SOURCE OF SUPPORT FROM WHICH SHRINERS HOSPITALS

FOR CHILDREN PERFORMS ITS PROGRAM SERVICES TO ACHIEVE ITS PRIMARY EXEMPT

PURPOSE.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

INVESTMENT MANAGEMENT FEES RECLASSIFIED TO EXPENSES -547,612.

Part XIV Supplemental Information (continued)

PART XII, LINE 4B - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSES RECLASSIFIED FROM EXPENSES -11,120.

FUNDING REVENUES RECLASSIFIED FROM OTHER CHANGES IN FUND

BALANCE 39,797,428.

TOTAL TO SCHEDULE D, PART XII, LINE 4B 39,786,308.

PART XIII, LINE 2D - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSES RECLASSIFIED TO NET WITH REVENUES 11,120.

PART XIII, LINE 4B - OTHER ADJUSTMENTS:

INVESTMENT MANAGEMENT FEES RECLASSIFIED FROM REVENUES 547,612.

SCHEDULE G
(Form 990 or 990-EZ)

Supplemental Information Regarding
Fundraising or Gaming Activities

OMB No. 1545-0047

2011

Open To Public
Inspection

Department of the Treasury
Internal Revenue Service

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.

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN
Employer identification number 04-2121377

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 e Solicitation of non-government grants
b Internet and email solicitations f Solicitation of government grants
c Phone solicitations g Special fundraising events
d In-person solicitations
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?
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.

Table with 6 columns: (i) Name and address of individual or entity (fundraiser), (ii) Activity, (iii) Did fundraiser have custody or control of contributions?, (iv) Gross receipts from activity, (v) Amount paid to (or retained by) fundraiser listed in col. (i), (vi) Amount paid to (or retained by) organization. Includes a Total row at the bottom.

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

Part II Fundraising Events. Complete if the organization answered "Yes" 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))
		GOLF TOURNAMENT (event type)	FOOTBALL GAMES (event type)	6 (total number)	
Revenue	1 Gross receipts	15,311.	52,947.	21,362.	89,620.
	2 Less: Charitable contributions				
	3 Gross income (line 1 minus line 2)	15,311.	52,947.	21,362.	89,620.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	1,900.	6,570.	2,650.	11,120.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				(11,120)
	11 Net income summary. Combine line 3, column (d), and line 10				78,500.

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))
		1 Gross revenue			
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> 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)**

Hospitals

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
--	---

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	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. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300</u> %			
b Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	X	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %			
c If the organization 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"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		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?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			57,564,507.	3,056,204.	54,508,303.	88.26%
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			57,564,507.	3,056,204.	54,508,303.	88.26%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			4,193,623.		4,193,623.	6.79%
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			4,193,623.		4,193,623.	6.79%
k Total. Add lines 7d and 7j			61,758,130.	3,056,204.	58,701,926.	95.05%

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.

Table with 7 columns: (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. Rows include Physical improvements and housing, Economic development, Community support, Environmental improvements, Leadership development and training for community members, Coalition building, Community health improvement advocacy, Workforce development, Other, and Total.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

Table for Section A with columns Yes and No. Row 1: Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? (Yes, No). Row 2: Enter the amount of the organization's bad debt expense. Row 3: Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Row 4: Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense.

Section B. Medicare

Table for Section B with columns Yes and No. Row 5: Enter total revenue received from Medicare (including DSH and IME). Row 6: Enter Medicare allowable costs of care relating to payments on line 5. Row 7: Subtract line 6 from line 5. This is the surplus (or shortfall). Row 8: Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit.

Section C. Collection Practices

Table for Section C with columns Yes and No. Row 9a: Did the organization have a written debt collection policy during the tax year? Row 9b: 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?

Part IV Management Companies and Joint Ventures (see instructions)

Table with 5 columns: (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, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

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 SHRINERS HOSPITAL FOR CHILDREN 51 BLOSSOM STREET BOSTON, MA 02114-2699	X		X	X		X			
2 SHRINERS HOSPITAL FOR CHILDREN 516 CAREW STREET SPRINGFIELD, MA 01104	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: SHRINERS HOSPITAL FOR CHILDREN

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 tax year 2011)		
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		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> 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		
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		
5 Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> 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 <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> 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		
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?	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>300</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: _____ 400 %		
If "No," explain in Part VI the criteria the hospital facility used.		
11 Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input type="checkbox"/> Medical indigency		
d <input type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input checked="" type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	X	
13 Included measures to publicize the policy within the community served by the hospital facility?		X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> 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 (FAP) that explained actions the hospital facility may take upon non-payment?	14		X
15 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:			
a <input type="checkbox"/> Reporting to credit agency			
b <input type="checkbox"/> Lawsuits			
c <input type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input type="checkbox"/> Other similar actions (describe in Part VI)			
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a <input type="checkbox"/> Reporting to credit agency			
b <input type="checkbox"/> Lawsuits			
c <input type="checkbox"/> Liens on residences			
d <input type="checkbox"/> Body attachments			
e <input type="checkbox"/> Other similar actions (describe in Part VI)			
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission			
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge			
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e <input type="checkbox"/> Other (describe in Part VI)			

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

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?		X
If "No," indicate why:			
a	<input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?		X
If "Yes," explain in Part VI.			

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: SHRINERS HOSPITAL FOR CHILDREN

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)		
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		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a <input type="checkbox"/> A definition of the community served by the hospital facility		
b <input type="checkbox"/> Demographics of the community		
c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input type="checkbox"/> How data was obtained		
e <input type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> 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		
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		
5 Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input type="checkbox"/> Hospital facility's website		
b <input type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> 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 <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input type="checkbox"/> 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		
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?	X	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>300</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

	Yes	No
10 Used FPG to determine eligibility for providing <i>discounted care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>400</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		
11 Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a <input checked="" type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input type="checkbox"/> Medical indigency		
d <input type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input checked="" type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance?	X	
13 Included measures to publicize the policy within the community served by the hospital facility?		X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> 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 (FAP) that explained actions the hospital facility may take upon non-payment?		X
15 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) SHRINERS HOSPITAL FOR CHILDREN

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?		X
If "No," indicate why:			
a	<input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?		X
If "Yes," explain in Part VI.			

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, 9, 10, 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: SHRINERS HOSPITALS FOR CHILDREN OFFERS SPECIALIZED

MEDICAL SERVICES PERTAINING TO ORTHOPAEDIC CONDITIONS, BURNS, SPINAL CORD

INJURIES AND CLEFT LIP AND PALATE. UPON PATIENT ADMITTANCE FOR ONE OF

THESE CONDITIONS, SHRINERS HOSPITALS FOR CHILDREN REVIEWS THE PATIENT'S

"ABILITY TO PAY" USING FEDERAL POVERTY GUIDELINES SPECIFIED IN SCHEDULE H,

PART I, LINES 3A AND 3B, AND PROVIDES FREE OR DISCOUNTED CARE PURSUANT TO

THESE GUIDELINES. NEVERTHELESS, SHRINERS HOSPITALS FOR CHILDREN WILL

ALWAYS SERVE THESE SPECIALIZED NEEDS FOR ALL OF ITS PATIENTS, REGARDLESS

OF THEIR "ABILITY TO PAY". AS SUCH, SHRINERS HOSPITALS FOR CHILDREN DID

NOT APPLY ANY INCOME-BASED CRITERIA, ASSET TEST, OR OTHER MEANS TEST OR

THRESHOLD FOR PROVIDING FREE CARE TO PATIENTS IN 2011.

PART I, LINE 7: A GENERAL LEDGER ACCOUNTING SYSTEM WAS USED TO

CALCULATE THE AMOUNTS REPORTED IN PART I, LINE 7. THE SYSTEM ADDRESSES

ALL PATIENT SEGMENTS (INPATIENT AND OUTPATIENT). A COST-TO-CHARGE RATIO

IS NOT PART OF THE SYSTEM AND IS NOT APPLICABLE TO SHRINERS HOSPITALS FOR

CHILDREN.

Part VI Supplemental Information

PART III, LINE 4: BAD DEBT EXPENSE IS NOT APPLICABLE TO SHRINERS

HOSPITALS FOR CHILDREN, AND AS SUCH, IS NOT PART OF THE FOOTNOTES IN ITS

FINANCIAL STATEMENTS. SHRINERS HOSPITALS FOR CHILDREN PROVIDES PATIENT

CARE WITHOUT COST TO THE PATIENT. AS SUCH, THERE ARE NO REVENUES AGAINST

WHICH A BAD DEBT COULD ARISE.

PART III, LINE 9B: SHRINERS HOSPITALS FOR CHILDREN PROVIDES PATIENT

CARE WITHOUT COST TO THE PATIENT OR THE PATIENT'S FAMILY. AS SUCH, THERE

IS NO DEBT COLLECTION POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 11H: PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE

BASED UPON THEIR INCOME LEVEL COMPARED TO THE FEDERAL POVERTY GUIDELINES

AND INTERNAL POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 11H: PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE

BASED UPON THEIR INCOME LEVEL COMPARED TO THE FEDERAL POVERTY GUIDELINES

AND INTERNAL POLICY.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 19D: THE AMOUNT CHARGED IS CONSISTENT FOR ALL

PAYER CLASSES, PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE BASED ON THEIR

INCOME AND FEDERAL POVERTY GUIDELINES.

SHRINERS HOSPITAL FOR CHILDREN:

PART V, SECTION B, LINE 19D: THE AMOUNT CHARGED IS CONSISTENT FOR ALL

Part VI Supplemental Information

PAYER CLASSES, PATIENTS QUALIFY FOR FINANCIAL ASSISTANCE BASED ON THEIR

INCOME LEVEL AND FEDERAL POVERTY GUIDELINES.

PART VI, LINE 2: SHRINERS HOSPITALS FOR CHILDREN PROVIDES PEDIATRIC,

ORTHOPAEDIC, AND BURN CARE AT NO COST TO ITS PATIENTS.

PART VI, LINE 3: SHRINERS HOSPITALS FOR CHILDREN POSTS ITS CHARITY

CARY POLICY IN ADMISSION AREAS, EMERGENCY ROOMS, AND OTHER AREAS OF

FACILITIES WHERE ELIGIBLE PATIENTS ARE LIKELY TO BE PRESENT, AND PROVIDES

A COPY OF ITS POLICY TO PATIENTS AS PART OF THE INTAKE PROCESS AND WITH

DISCHARGE MATERIALS.

PART VI, LINE 4: SHRINERS HOSPITALS FOR CHILDREN (THROUGH THIS ENTITY

AND ITS RELATED ENTITY) SERVE CHILDREN IN NEED OF SPECIALIZED ORTHOPAEDIC

AND BURN CARE ACROSS THE ENTIRE UNITED STATES.

**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

2011

Open to Public Inspection

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

Part I Questions Regarding Compensation

	Yes	No								
<p>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.</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input checked="" type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input checked="" type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input checked="" type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input checked="" type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input checked="" type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p>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</p>	X									
<p>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?</p>	X									
<p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee									
<p>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:</p> <p>a Receive a severance payment or change-of-control payment?</p>		X								
<p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	X									
<p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>		X								
<p>Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.</p>										
<p>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:</p> <p>a The organization?</p>		X								
<p>b Any related organization?</p> <p>If "Yes" to line 5a or 5b, describe in Part III.</p>		X								
<p>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:</p> <p>a The organization?</p>		X								
<p>b Any related organization?</p> <p>If "Yes" to line 6a or 6b, describe in Part III.</p>		X								
<p>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</p>		X								
<p>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</p>		X								
<p>9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>										

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

Schedule J (Form 990) 2011

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) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name		(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 as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JACK H. JONES	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	158,833.	0.	0.	0.	0.	158,833.	0.
2 DAVID M. DRVARIC, M.D.	(i)	412,354.	0.	0.	16,500.	2,788.	431,642.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 PETER D. MASSO, M.D.	(i)	300,880.	0.	0.	16,500.	6,383.	323,763.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 CLIFFORD D'ESMOND	(i)	212,607.	0.	0.	0.	2,454.	215,061.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 ALAN J. FISCHMAN	(i)	181,138.	0.	0.	0.	6,774.	187,912.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 PHILIP W. MACK, M.D.	(i)	262,293.	0.	0.	0.	5,585.	267,878.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organizations answered "Yes" on Form
990, Part IV, lines 29 or 30.
▶ Attach to Form 990.**

Name of the organization
THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number
04-2121377

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (<u>MEDICAL EQUIP</u>)	X	1	1,226,900.	COMPARABLE SALES
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

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

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

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

2011

Open to Public
Inspection

Name of the organization

THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number

04-2121377

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

SHRINERS HOSPITALS FOR CHILDREN IN BOSTON AND SPRINGFIELD OFFER

"CHARITY CARE" AS PART OF AN INTERNATIONAL NETWORK OF PEDIATRIC

HOSPITALS DEDICATED TO PROVIDING EXCELLENT PATIENT CARE, RESEARCH, AND

EDUCATION FOR ORTHOPAEDIC CONDITIONS AND BURNS.

SHRINERS HOSPITALS FOR CHILDREN-BOSTON SPECIALIZES IN PROVIDING

COMPREHENSIVE ACUTE CARE AND RECONSTRUCTIVE AND REHABILITATIVE CARE TO

CHILDREN WHO HAVE BEEN BURNED, INCLUDING ACUTE BURNS, SMOKE INHALATION

INJURY, RECONSTRUCTIVE SURGERY FOR HEALED BURNS, AND OTHRE RELATED

CONDITIONS.

SHRINERS HOSPITALS FOR CHILDREN-SPRINGFIELD SPECIALIZES IN CARING FOR

CHILDREN WITH ORTHOPAEDIC CONDITIONS AND INJURIES SUCH AS SCOLIOSIS,

CLUBFOOT, AND ORTHOPAEDIC CONDITIONS RELATED TO CEREBRAL PALSY AND

SPINAL BIFIDA. FOR MORE INFORMATION, VISIT [HTTP://WWW.SHRINERSHQ.ORG/](http://www.shrinershq.org/)

OR CALL 1-800-241-GIFT.

FORM 990, PART VI, SECTION A, LINE 6: THE ORGANIZATION IS ORGANIZED AS A

NONPROFIT CORPORATION WITH MEMBERS. MEMBERS HAVE THE RIGHT TO ELECT

PERSONS BELONGING TO THE GOVERNING BODY, AND TO APPROVE SIGNIFICANT

DECISIONS OF THE GOVERNING BODY. COMPENSATION IS NOT PROVIDED FOR BEING A

MEMBER.

FORM 990, PART VI, SECTION A, LINE 7A: THE ORGANIZATION HAS APPROXIMATELY

1,400 MEMBERS WHOM ARE APPOINTED FROM THE TOTAL MEMBERSHIP OF SHRINERS

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule O (Form 990 or 990-EZ) (2011)

132211
01-23-12

Name of the organization THE SHRINERS' HOSPITAL FOR CHILDREN	Employer identification number 04-2121377
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INTERNATIONAL (A RELATED ORGANIZATION). MEMBERS MAY ELECT PERSONS ON THE ORGANIZATION'S GOVERNING BODY, AND MAY APPROVE SIGNIFICANT DECISIONS OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7B: UNDER THE BYLAWS OF THE ORGANIZATION, SIGNIFICANT DECISIONS OF THE GOVERNING BODY REQUIRE APPROVAL BY THE ORGANIZATION'S 1,400 MEMBERS (SUCH AS CHANGES TO THE BYLAWS, OR SIGNIFICANT RESTRUCTURING OR EXTRAORDINARY EVENTS). THE ORGANIZATION'S MEMBERS ALSO MAY ELECT PERSONS TO SERVE ON THE ORGANIZATION'S GOVERNING BODY. THE ORGANIZATION'S MEMBERS DO NOT HAVE CONTROL OVER THE GENERAL OPERATIONS OR FINANCIAL MATTERS OF THE ORGANIZATION. ELECTIONS ARE HELD ANNUALLY BY THE MEMBERS AT VARYING LOCATIONS IN THE U.S.. VOTING IS DECIDED WITH SIMPLE MAJORITY, WHERE EACH MEMBER'S VOTE IS EQUAL WEIGHTED. ELECTED PERSONS SERVE A THREE-YEAR TERM ON THE BOARD OF TRUSTEES, A ONE-YEAR TERM ON THE BOARD OF DIRECTORS, A ONE-YEAR TERM FOR THE ORGANIZATION'S PRESIDENT, AND A ONE-YEAR TERM FOR THE ORGANIZATION'S TREASURER. THE ORGANIZATION'S OFFICERS ARE NOT ELECTED, AND INSTEAD ARE HIRED BY COMMITTEE.

FORM 990, PART VI, SECTION B, LINE 11: A FULL VERSION OF FORM 990 AS FILED WITH THE IRS IS MADE AVAILABLE TO EACH VOTING MEMBER OF THE GOVERNING BODY AND/OR DESIGNATED COMMITTEE RESPONSIBLE FOR PERFORMING A REVIEW PROCESS PRIOR TO FILING.

FORM 990, PART VI, SECTION B, LINE 12C: THE ORGANIZATION HAS A WRITTEN CONFLICT OF INTEREST POLICY AND ALL MEMBERS ARE REQUIRED TO DISCLOSE ANY CONFLICTING INTERESTS OR STATE "NONE" ON THE ANNUAL CONFLICT OF INTEREST

FORM. POTENTIAL CONFLICTS ARE DETERMINED BY THE BOARD OF DIRECTORS. THE

Name of the organization
THE SHRINERS' HOSPITAL FOR CHILDREN

Employer identification number
04-2121377

PERSON(S) HAVING A POTENTIAL CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN DELIBERATIONS/DECISIONS IN THE TRANSACTION.

FORM 990, PART VI, SECTION B, LINE 15: A SALARY & PERSONNEL COMMITTEE IS INVOLVED WITH ALL COMPENSATION AND APPROVES WAGES FOR MANAGEMENT AND COMPARES THESE SALARIES TO VARIOUS MARKET INDICATORS.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION'S GOVERNING DOCUMENTS (INCLUDING ITS CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS) ARE AVAILABLE TO THE PUBLIC UPON WRITTEN REQUEST.

FORM 990, PART XI, LINE 5, CHANGES IN NET ASSETS:
NET UNREALIZED LOSSES ON INVESTMENTS: -75,679,448.

FORM 990, PART XII, LINE 2C EXPLANATION:
AUDIT COMMITTEE OVERSIGHT PROCESS
THE ORGANIZATION HAS NOT CHANGED (DURING THE CURRENT YEAR) ITS OVERSIGHT PROCESS OR ITS SELECTION PROCESS REGARDING THE COMMITTEE RESPONSIBLE FOR THE OVERSIGHT OF THE AUDIT OF THE FINANCIAL STATEMENTS AND THE SELECTION OF THE INDEPENDENT ACCOUNTANT.

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.**

Name of the organization: **THE SHRINERS' HOSPITAL FOR CHILDREN**
Employer identification number: **04-2121377**

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	No
SHRINERS HOSPITALS FOR CHILDREN EMPLOYEE DISASTER RELIEF FUND - 26-3733381, 2900 ROCKY POINT DRIVE, TAMPA, FL 33607	DISASTER RELIEF	DISTRICT OF COLUMBIA	501(C)(3)	9	NO		X
SHRINERS HOSPITALS FOR CHILDREN - 36-2193608 POST OFFICE BOX 31356 TAMPA, FL 33631-3356	HOSPITAL SYSTEM	COLORADO	501(C)(3)	3	NO		X
SHRINERS INTERNATIONAL - 36-2158164 POST OFFICE BOX 31356 TAMPA, FL 33631-3356	FOUNDED SHRINERS HOSPITALS FOR CHILDREN	IOWA	501(C)(10)	N/A	NO		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) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" 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

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

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

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

	Yes	No
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)		X
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)	X	
f Sale of assets to related organization(s)		X
g Purchase of assets from related organization(s)		X
h Exchange of assets with related organization(s)		X
i Lease of facilities, equipment, or other assets to related organization(s)		X
j Lease of facilities, equipment, or other assets from related organization(s)		X
k Performance of services or membership or fundraising solicitations for related organization(s)		X
l Performance of services or membership or fundraising solicitations by related organization(s)		X
m Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
n Sharing of paid employees with related organization(s)	X	
o Reimbursement paid to related organization(s) for expenses		X
p Reimbursement paid by related organization(s) for expenses		X
q Other transfer of cash or property to related organization(s)		X
r Other transfer of cash or property from related organization(s)		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) SHRINERS HOSPITALS FOR CHILDREN	C	39,797,428.	
(2) SHRINERS HOSPITALS FOR CHILDREN	N	0.	
(3) SHRINERS HOSPITALS FOR CHILDREN	E	29,832,222.	
(4)			
(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) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.?		(f) Share of total income	(g) Share of end-of-year assets	(h) Dispropor- tionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

Lined area for supplemental information.