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Part III

Statement of Program Service Accomplishments

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

☒

1

Briefly describe the organization's mission

To own, manage and operate hospitals in Central Oregon, as well as the care of sick, injured and infirm and the carrying on, participation in and sponsorship of health-related services and activities in the communities

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

☐ Yes ☒ No

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

3

Did the organization cease conducting, or make significant changes in how it conducts, any program services?

☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

4

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

4a

(Code) (Expenses \$ 337,132,965 including grants of \$ 546,610) (Revenue \$ 474,198,048)

St Charles BendSCMC-B provided services for 15,708 Inpatients, 1,723 births, 15,812 surgical cases, 39,368 Emergency Room visits, and 56,010 Other Outpatient visits in 2015. As one of the Pacific Northwest's leading regional health care facilities, St Charles Bend provides services typically found in markets many times its size. For almost 100 years, St Charles Bend has taken responsibility for the health and well-being of generations of Oregonians, developing into a Level II Regional Trauma Center with specialized partnerships in heart, cancer, orthopedics and neurosurgery.

4b

(Code) (Expenses \$ 58,459,632 including grants of \$) (Revenue \$ 79,746,285)

St Charles RedmondSCMC-R provided services for 2,574 inpatients, 463 births, 3,468 surgical cases, 22,029 Emergency Room visits, and 28,155 Other Outpatient Visits in 2015. At St Charles Redmond, the patient experience remains at the center of all we do and each patient is empowered to play an active role in his or her own care and healing. Surgeries are performed in four of Oregon's newest and most advanced surgical suites. Patients and their families enjoy the comfort of state-of-the-art patient rooms. Everyone receives the level of care that is expected of a leading regional health care facility.

4c

(Code) (Expenses \$ 51,755,214 including grants of \$) (Revenue \$ 32,247,834)

St Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Charles Health System. These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care. SCMG provided 147,863 visits in Bend clinics, 62,000 visits in Redmond clinics, 8,362 visits in the Sisters clinic, 26,620 visits in Prineville clinics and 6,585 in the Madras Clinic in 2015. SCMG also operates an immediate care clinic to provide low-cost urgent care services to the community; the immediate care clinic provided services for 16,167 patient visits in 2015.

4d




















Other program services (Describe in Schedule O)

(Expenses \$ 61,589,124 including grants of \$) (Revenue \$ 89,621,410)

4e

Total program service expenses ▶ 508,936,935

Part IV Checklist of Required Schedules

| | Yes | No |
|---|---------|----|
| 1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A  | 1 Yes | |
| 2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?  | 2 Yes | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I  | 3 | No |
| 4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II  | 4 Yes | |
| 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III  | 5 | No |
| 6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I  | 6 | No |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II  | 7 | No |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III  | 8 | No |
| 9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV  | 9 | No |
| 10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V  | 10 Yes | |
| 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable | | |
| a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI  | 11a Yes | |
| b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII  | 11b | No |
| c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII  | 11c | No |
| d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX  | 11d | No |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X  | 11e Yes | |
| f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X  | 11f Yes | |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII  | 12a | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional  | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 | No |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H  | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?  | 20b Yes | |

Part IV Checklist of Required Schedules *(continued)*

| | | | | |
|------------|--|------------|-----|----|
| 21 | Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> | 21 | Yes | |
| 22 | Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> | 22 | | No |
| 23 | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 23 | Yes | |
| 24a | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 24a | Yes | |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | No |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | No |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | No |
| 25a | Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> | 25a | | No |
| b | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> | 25b | | No |
| 26 | Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> | 26 | Yes | |
| 27 | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | 27 | | No |
| 28 | Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) | | | |
| a | A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | | No |
| b | A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | Yes | |
| c | An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | Yes | |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | | No |
| 30 | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 | | No |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | | No |
| 32 | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 32 | | No |
| 33 | Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> | 33 | Yes | |
| 34 | Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> | 34 | Yes | |
| 35a | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a | Yes | |
| b | If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b | | No |
| 36 | Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 36 | | No |
| 37 | Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> | 37 | | No |
| 38 | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O | 38 | Yes | |

Part V

Statements Regarding Other IRS Filings and Tax Compliance

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

| | | | | |
|-----|--|-----|-------|----|
| | | | Yes | No |
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. | 1a | 499 | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | 1b | 0 | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | Yes | |
| 2a | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. | 2a | 4,468 | |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions). | 2b | Yes | |
| 3a | Did the organization have unrelated business gross income of \$1,000 or more during the year? | 3a | Yes | |
| b | If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O. | 3b | | No |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | 4a | | No |
| b | If "Yes," enter the name of the foreign country: _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | 5a | | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5b | | No |
| c | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | 5c | | |
| 6a | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | 6a | | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | 6b | | |
| 7 | Organizations that may receive deductible contributions under section 170(c). | | | |
| a | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | 7a | | No |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year. | 7d | 0 | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | 7e | | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | 7f | | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | 7g | | No |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | 7h | | No |
| 8 | Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | 8 | | No |
| 9a | Did the sponsoring organization make any taxable distributions under section 4966? | 9a | | No |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | 9b | | No |
| 10 | Section 501(c)(7) organizations. Enter | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12. | 10a | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. | 10b | | |
| 11 | Section 501(c)(12) organizations. Enter | | | |
| a | Gross income from members or shareholders. | 11a | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them). | 11b | | |
| 12a | Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | 12a | | No |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year. | 12b | | |
| 13 | Section 501(c)(29) qualified nonprofit health insurance issuers. | | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O. | 13a | | No |
| b | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans. | 13b | | |
| c | Enter the amount of reserves on hand. | 13c | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | | No |
| b | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O. | 14b | | |

Part VI Governance, Management, and Disclosure

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

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

Section A. Governing Body and Management

| | | Yes | No |
|---|--------------|-----|----|
| 1a Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | 1a 13 | | |
| b Enter the number of voting members included in line 1a, above, who are independent | 1b 13 | | |
| 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | | No |
| 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | | No |
| 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | No |
| 5 Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | No |
| 6 Did the organization have members or stockholders? | 6 | | No |
| 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | | No |
| b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | | No |
| 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | |
| a The governing body? | 8a | Yes | |
| b Each committee with authority to act on behalf of the governing body? | 8b | Yes | |
| 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | | No |

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records
JENNIFER WELANDER 2500 NE Neff Rd BEND, OR 97701 (541) 706-7707

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

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

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

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

[illegible]

Part VII

[illegible]

| | | | | |
|-----------|--|-----------|--|---------|
| 1b | Sub-Total | | | |
| c | Total from continuation sheets to Part VII, Section A | | | |
| d | Total (add lines 1b and 1c) | 8,914,571 | | 965,935 |

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 ► 497

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

| (A) Name and business address | (B) Description of services | (C) Compensation |
|--|--------------------------------|---------------------|
| CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DR BEND, OR 97701 | Imaging Services | 25,335,664 |
| FOCUSONE SOLUTIONS PO BOX 3037 OMAHA, NE 68103 | STAFFING SERVICE PRO | 2,753,690 |
| CENTRAL OREGON MRI LLC PO BOX 6059 BEND, OR 97708 | MRI services | 3,289,019 |
| NEENAN COMPANY LLP 2607 MIDPOINT DRIVE FORT COLLINS, CO 80525 | CONSTRUCTION | 12,676,318 |
| CENTRAL OR RADIATION ONCOLOGY ASSOC 2500 NE NEFF ROAD BEND, OR 97701 | IMAGING SERVICES | 1,936,150 |

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 ▶ 61

Part VIII

Statement of Revenue

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

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|---|---|---|-----------------------|--|---|---|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns . . . | 1a | | | | |
| | b | Membership dues | 1b | | | | |
| | c | Fundraising events | 1c | | | | |
| | d | Related organizations | 1d | 1,727,652 | | | |
| | e | Government grants (contributions) | 1e | 753,614 | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 384,095 | | | |
| | g | Noncash contributions included in lines 1a-1f \$ | | 16,070 | | | |
| | h | Total. Add lines 1a-1f | | 2,865,361 | | | |
| Program Service Revenue | 2a | St Charles Bend | Business Code | 474,198,048 | 474,198,048 | | |
| | b | St Charles Madras | | 29,252,747 | 29,252,747 | | |
| | c | St Charles Medical Group | | 32,247,834 | 32,247,834 | | |
| | d | St Charles Prineville | | 29,459,653 | 29,459,653 | | |
| | e | St Charles Redmond | | 79,746,285 | 79,746,285 | | |
| | f | All other program service revenue | | 30,909,010 | 30,909,010 | | |
| | g | Total. Add lines 2a-2f | | 675,813,577 | | | |
| | Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | 10,496,254 | | |
| 4 | | Income from investment of tax-exempt bond proceeds . . . | | 211,779 | | | 211,779 |
| 5 | | Royalties | | 0 | | | |
| 6a | | Gross rents | (i) Real 146,834 | (ii) Personal | | | |
| b | | Less rental expenses | 5,215 | | | | |
| c | | Rental income or (loss) | 141,619 | | | | |
| d | | Net rental income or (loss) | | 141,619 | | 2,907 | 138,712 |
| 7a | | Gross amount from sales of assets other than inventory | (i) Securities 41,779,066 | (ii) Other 174,265 | | | |
| b | | Less cost or other basis and sales expenses | 41,887,922 | 394,265 | | | |
| c | | Gain or (loss) | -108,856 | -220,000 | | | |
| d | | Net gain or (loss) | | -328,856 | | | -328,856 |
| 8a | | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | a | | | | |
| b | | Less direct expenses | b | | | | |
| c | | Net income or (loss) from fundraising events . . . | | 0 | | | |
| 9a | | Gross income from gaming activities See Part IV, line 19 | a | | | | |
| b | | Less direct expenses | b | | | | |
| c | | Net income or (loss) from gaming activities | | 0 | | | |
| 10a | | Gross sales of inventory, less returns and allowances | a | | | | |
| b | | Less cost of goods sold | b | 520,489 | | | |
| c | | Net income or (loss) from sales of inventory . . . | | 298,379 | | | |
| | | | | 222,110 | 222,110 | | |
| | | Miscellaneous Revenue | Business Code | | | | |
| 11a | | Education Programs, etc | 900099 | 1,338,731 | 1,338,731 | | |
| b | Healthcare JV Income | 900099 | 40,015,599 | 40,015,599 | | | |
| c | Reimbursed Salaries | 446110 | 3,828,737 | 3,828,737 | | | |
| d | All other revenue | | 88,443 | | 88,443 | | |
| e | Total. Add lines 11a-11d | | 45,271,510 | | | | |
| 12 | Total revenue. See Instructions | | 734,693,354 | 721,218,754 | 91,350 | 10,517,889 | |

Part IX Statement of Functional Expenses

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

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



| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 | Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 546,610 | 546,610 | | |
| 2 | Grants and other assistance to domestic individuals. See Part IV, line 22 | 0 | | | |
| 3 | Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | 0 | | | |
| 4 | Benefits paid to or for members | 0 | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees | 4,677,246 | | 4,677,246 | |
| 6 | Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 | Other salaries and wages | 265,816,747 | 215,296,792 | 50,027,659 | 492,296 |
| 8 | Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 9,877,075 | 8,234,402 | 1,621,963 | 20,710 |
| 9 | Other employee benefits | 46,534,707 | 34,772,113 | 11,661,578 | 101,016 |
| 10 | Payroll taxes | 19,172,967 | 14,862,002 | 4,276,721 | 34,244 |
| 11 | Fees for services (non-employees) | | | | |
| a | Management | 0 | | | |
| b | Legal | 10,481,722 | | 10,481,722 | |
| c | Accounting | 494,314 | | 492,114 | 2,200 |
| d | Lobbying | 0 | | | |
| e | Professional fundraising services. See Part IV, line 17 | 0 | | | |
| f | Investment management fees | 134,301 | | 134,301 | |
| g | Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 78,573,481 | 58,830,236 | 19,694,797 | 48,448 |
| 12 | Advertising and promotion | 1,165,657 | 57,863 | 1,041,777 | 66,017 |
| 13 | Office expenses | 28,163,408 | 21,024,323 | 7,108,620 | 30,465 |
| 14 | Information technology | 10,235,903 | 1,027,098 | 9,187,328 | 21,477 |
| 15 | Royalties | 0 | | | |
| 16 | Occupancy | 9,521,288 | 3,880,793 | 5,640,495 | |
| 17 | Travel | 2,060,337 | 1,406,522 | 646,919 | 6,896 |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 | Conferences, conventions, and meetings | 1,503,817 | 857,245 | 645,446 | 1,126 |
| 20 | Interest | 8,530,169 | | 8,530,169 | |
| 21 | Payments to affiliates | 1,432,915 | 368,891 | 1,056,217 | 7,807 |
| 22 | Depreciation, depletion, and amortization | 29,876,980 | 8,984,803 | 20,892,177 | |
| 23 | Insurance | 3,488,480 | 33,742 | 3,454,738 | |
| 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 | 100,822,522 | 100,754,020 | 68,502 | |
| b | PROVIDER TAX EXPENSE | 26,724,715 | 26,724,715 | | |
| c | DEBT EXTINGUISHMENT | 24,514,524 | | 24,514,524 | |
| d | BAD DEBT EXPENSE | 7,191,817 | 7,191,817 | | |
| e | All other expenses | 4,751,042 | 4,082,948 | 654,080 | 14,014 |
| 25 | Total functional expenses. Add lines 1 through 24e | 696,292,744 | 508,936,935 | 186,509,093 | 846,716 |
| 26 | Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | | | | |

Part X

Balance Sheet

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

| | | | | (A) | | (B) | |
|-----------------------------|---|---|-------------|-------------------|-------------|-------------|-------------|
| | | | | Beginning of year | | End of year | |
| Assets | 1 | Cash—non-interest-bearing | | 27,623,247 | 1 | 54,784,962 | |
| | 2 | Savings and temporary cash investments | | 721,178 | 2 | 721,622 | |
| | 3 | Pledges and grants receivable, net | | | 3 | 0 | |
| | 4 | Accounts receivable, net | | 99,507,661 | 4 | 98,314,145 | |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | 9,559 | 5 | 7,044 | |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L | | | 6 | 0 | |
| | 7 | Notes and loans receivable, net | | | 7 | 0 | |
| | 8 | Inventories for sale or use | | 10,175,446 | 8 | 11,463,890 | |
| | 9 | Prepaid expenses and deferred charges | | 9,341,228 | 9 | 10,551,227 | |
| | 10a | Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D | 10a | 566,859,145 | | | |
| | b | Less: accumulated depreciation | 10b | 278,873,002 | 261,694,891 | 10c | 287,986,143 |
| | 11 | Investments—publicly traded securities | | 336,237,471 | 11 | 346,113,008 | |
| | 12 | Investments—other securities. See Part IV, line 11 | | 60,938,396 | 12 | 19,646,387 | |
| | 13 | Investments—program-related. See Part IV, line 11 | | 877,981 | 13 | -244,026 | |
| | 14 | Intangible assets | | 4,504,494 | 14 | 4,504,494 | |
| | 15 | Other assets. See Part IV, line 11 | | 7,471,367 | 15 | 6,938,497 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 819,102,919 | 16 | 840,787,393 | | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 69,702,069 | 17 | 77,506,496 | |
| | 18 | Grants payable | | | 18 | | |
| | 19 | Deferred revenue | | 1,051,085 | 19 | 516,620 | |
| | 20 | Tax-exempt bond liabilities | | 219,078,251 | 20 | 228,463,773 | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | 21 | | |
| | 22 | Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | | 22 | | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 15,966,350 | 23 | 3,364,783 | |
| | 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 | | 15,762,447 | 25 | 11,307,881 | |
| | 26 | Total liabilities. Add lines 17 through 25 | | 321,560,202 | 26 | 321,159,553 | |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | | | |
| | 27 | Unrestricted net assets | | 497,542,717 | 27 | 519,627,840 | |
| | 28 | Temporarily restricted net assets | | | 28 | | |
| | 29 | Permanently restricted net assets | | | 29 | | |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | | | | |
| | 30 | Capital stock or trust principal, or current funds | | | 30 | | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | | 31 | | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | | 32 | | |
| | 33 | Total net assets or fund balances | | 497,542,717 | 33 | 519,627,840 | |
| | 34 | Total liabilities and net assets/fund balances | | 819,102,919 | 34 | 840,787,393 | |

Part XI **Reconciliation of Net Assets**

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

| | | | |
|-----------|---|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 734,693,354 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 696,292,744 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 38,400,610 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 497,542,717 |
| 5 | Net unrealized gains (losses) on investments | 5 | -10,284,442 |
| 6 | Donated services and use of facilities | 6 | 239,529 |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -6,270,574 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 519,627,840 |

Part XII **Financial Statements and Reporting**

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

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

Additional Data

Software ID: 15000324
Software Version: 2015v2.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---------------------------------------|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|--|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | | |
| Gardner Mack Director | 4 00 0 00 | X | | | | | | | 20,000 | 0 | 0 |
| Sayeg Thomas Director | 4 00 0 00 | X | | | | | | | 25,000 | 0 | 0 |
| Schuetz Dan Chairman | 5 00 0 00 | X | | X | | | | | 30,000 | 0 | 0 |
| Hakala Robert MD Director | 5 00 0 00 | X | | | | | | | 20,000 | 0 | 0 |
| Dempsey Dennis Vice Chair | 5 00 0 00 | X | | X | | | | | 25,000 | 0 | 0 |
| Downer Doug Director | 2 00 0 00 | X | | | | | | | 25,000 | 0 | 0 |
| Miller Laun Director | 4 00 0 00 | X | | | | | | | 25,000 | 0 | 0 |
| Van Pelt Greg Director | 3 00 0 00 | X | | | | | | | 21,500 | 0 | 0 |
| O'Hollaren Brian Director | 4 00 0 00 | X | | | | | | | 20,000 | 0 | 0 |
| Buehler Knute MD Director | 5 00 0 00 | X | | | | | | | 20,000 | 0 | 0 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| Haase Megan Director | 4 00 0 00 | X | | | | | | 20,000 | 0 | |
| Lin Hartwell MD Director | 3 00 0 00 | X | | | | | | 20,000 | 0 | |
| Gordon Steve MD Director | 4 00 0 00 | X | | | | | | 25,000 | 0 | |
| Bryant Ron Secretary | 4 00 0 00 | | | X | | | | 0 | 0 | |
| Sluka Joseph President | 50 00 1 00 | | | X | | | | 698,626 | 0 | 132,928 |
| Welander Jennifer CFO | 48 00 0 00 | | | X | | | | 291,652 | 0 | 66,203 |
| Shepard Karen EXEC VP Finance | 50 00 0 00 | | | X | | | | 416,236 | 0 | 8,934 |
| Absalon Jeffrey MD CHIEF PHYSICAIN EXECUTIVE | 50 00 0 00 | | | | X | | | 449,495 | 0 | 87,075 |
| Gomes Robert CEO Bend & Redmond | 50 00 0 00 | | | | X | | | 404,708 | 0 | 80,670 |
| Gentry Jeanine CEO Prineville & Madras | 50 00 0 00 | | | | X | | | 254,956 | 0 | 65,244 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| Nunes John MD Chief Quality & Safety Officer | 50 00 0 00 | | | | X | | | 377,717 | 0 | 74,194 |
| Steinke Pamela VP Quality/CNE | 50 00 0 00 | | | | X | | | 344,344 | 0 | 77,519 |
| Weinsheim John PRESIDENT SCMG | 50 00 0 00 | | | | X | | | 166,702 | 0 | 48,599 |
| Brckhouse Jeremiah CIO | 50 00 0 00 | | | | X | | | 183,907 | 0 | 41,397 |
| Boileau Michel MD EVP/CCO | 50 00 0 00 | | | | X | | | 568,418 | 0 | 4,605 |
| McLellan Bruce Physician | 50 00 0 00 | | | | | X | | 521,399 | 0 | 44,172 |
| Blizzard John D Physician | 50 00 0 00 | | | | | X | | 818,691 | 0 | 40,197 |
| Martin William Physician | 50 00 0 00 | | | | | X | | 549,457 | 0 | 47,893 |
| Laughlin James Physician | 50 00 0 00 | | | | | X | | 635,080 | 0 | 51,305 |
| Boone Rob Physician | 50 00 0 00 | | | | | X | | 665,545 | 0 | 43,334 |

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| Martin Richard Former VP Service Lines | 40 00 0 00 | | | | | | X | 284,475 | 0 | 41,536 |
| Diegel James Former President/CEO | 0 00 0 00 | | | | | | X | 986,663 | 0 | 10,130 |

SCHEDULE A
(Form 990 or 990EZ)

Public Charity Status and Public Support

OMB No 1545-0047

2015

Open to Public Inspection

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.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization

St Charles Health System Inc

Employer identification number

93-0602940

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 (Form 990 or 990-EZ))

3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)

6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9

☐

An 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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g

a

☐

Type I. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b

☐

Type II. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c

☐

Type III functionally integrated. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d

☐

Type III non-functionally integrated. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e

☐

Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f

Enter the number of supported organizations

g

Provide the following information about the supported organization(s)

| (i) Name of supported organization | (ii)EIN | (iii) Type of organization (described on lines 1- 9 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|---------------------------------------|---------|---|--|----|--|--|
| | | | Yes | No | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | | | | | | |

Part II

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

| Section A. Public Support | | | | | | |
|---|---------|---------|---------|---------|---------|----------|
| Calendar year (or fiscal year beginning in) ► | (a)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (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)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (f)Total |
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc (see instructions) | | | | | 12 | |
| 13 First five years.If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/> | | | | | | |

| Section C. Computation of Public Support Percentage | | | | | | |
|---|--|----|--|--|--|--|
| 14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) | | 14 | | | | |
| 15 Public support percentage for 2014 Schedule A, Part II, line 14 | | 15 | | | | |
| 16a 33 1/3% support test—2015.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—2014.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—2015.If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| b 10%-facts-and-circumstances test—2014.If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| 18 Private foundation.If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/> | | | | | | |

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

(Complete only if you checked the box on line 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)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (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)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (f)Total |
|--|---------|---------|---------|---------|---------|----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2014 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2014 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2015. 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—2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain. | 1 | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2). | 2 | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below. | 3a | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination. | 3b | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use. | 3c | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below. | 4a | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. | 4b | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes. | 4c | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document). | 5a | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | 5b | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | 5c | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI . | 6 | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990). | 7 | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990). | 8 | |
| 9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI . | 9a | |
| b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI . | 9b | |
| c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI . | 9c | |
| 10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below. | 10a | |
| b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.) | 10b | |
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? | 11a | |
| b A family member of a person described in (a) above? | 11b | |
| c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI. | 11c | |

Part IV

Supporting Organizations (continued)

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

Part V

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

1

Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov 20, 1970 **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E

☐

| Section A - Adjusted Net Income | | (A) Prior Year | (B) Current Year (optional) |
|---------------------------------|--|----------------|-----------------------------|
| 1 | Net short-term capital gain | 1 | |
| 2 | Recoveries of prior-year distributions | 2 | |
| 3 | Other gross income (see instructions) | 3 | |
| 4 | Add lines 1 through 3 | 4 | |
| 5 | Depreciation and depletion | 5 | |
| 6 | Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | |
| 7 | Other expenses (see instructions) | 7 | |
| 8 | Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) | 8 | |

| Section B - Minimum Asset Amount | | (A) Prior Year | (B) Current Year (optional) |
|----------------------------------|--|----------------|-----------------------------|
| 1 | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year) | 1 | |
| a | Average monthly value of securities | 1a | |
| b | Average monthly cash balances | 1b | |
| c | Fair market value of other non-exempt-use assets | 1c | |
| d | Total (add lines 1a, 1b, and 1c) | 1d | |
| e | Discount claimed for blockage or other factors (explain in detail in Part VI) _____ | | |
| 2 | Acquisition indebtedness applicable to non-exempt use assets | 2 | |
| 3 | Subtract line 2 from line 1d | 3 | |
| 4 | Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |

| Section C - Distributable Amount | | Current Year | |
|----------------------------------|--|--------------|--|
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | |
| 2 | Enter 85% of line 1 | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | |
| 4 | Enter greater of line 2 or line 3 | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | |
| 7 | Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) <input type="checkbox"/> | | |

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

| Section D - Distributions | Current Year |
|---|---------------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2015 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2015 | (iii) Distributable Amount for 2015 |
|--|-------------------------------------|---|--|
| 1 Distributable amount for 2015 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2015 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2015 | | | |
| a | | | |
| b | | | |
| c | | | |
| d From 2013. | | | |
| e From 2014. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2015 distributable amount | | | |
| i Carryover from 2010 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2015 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2015 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2016. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b | | | |
| c Excess from 2013. | | | |
| d From 2014. | | | |
| e From 2015. | | | |

Part VI Supplemental Information.

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

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

| | |
|--|--|
| Name of the organization St Charles Health System Inc | Employer identification number 93-0602940 |
|--|--|

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

| | | |
|---|--|----|
| 1 | Provide a description of the organization's direct and indirect political campaign activities in Part IV | |
| 2 | Political expenditures | \$ |
| 3 | Volunteer hours | |

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

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

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

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

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

Part II-A

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

- A Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B Check ☐ if the filing organization checked box A and "limited control" provisions apply

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | | (a) Filing organization's totals | (b) Affiliated group totals | | | | | | | | | | | | |
|--|---|---|------------------------------------|--------------------|------------------------------|---|---|---|---|--|--|-------------------|-------------|--|--|
| 1a | Total lobbying expenditures to influence public opinion (grass roots lobbying) | | | | | | | | | | | | | | |
| b | Total lobbying expenditures to influence a legislative body (direct lobbying) | | | | | | | | | | | | | | |
| c | Total lobbying expenditures (add lines 1a and 1b) | | | | | | | | | | | | | | |
| d | Other exempt purpose expenditures | | | | | | | | | | | | | | |
| e | Total exempt purpose expenditures (add lines 1c and 1d) | | | | | | | | | | | | | | |
| f | Lobbying nontaxable amount Enter the amount from the following table in both columns | | | | | | | | | | | | | | |
| <table><tr><th>If the amount on line 1e, column (a) or (b) is:</th><th>The lobbying nontaxable amount is:</th></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table> | | If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | Not over \$500,000 | 20% of the amount on line 1e | Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | Over \$17,000,000 | \$1,000,000 | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e | | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000 | | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000 | | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000 | | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000 | | | | | | | | | | | | | | |
| g | Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | |
| h | Subtract line 1g from line 1a If zero or less, enter -0- | | | | | | | | | | | | | | |
| i | Subtract line 1f from line 1c If zero or less, enter -0- | | | | | | | | | | | | | | |
| j | If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | | | | | | | | | | | | | | |
| | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | |

4-Year Averaging Period Under section 501(h)

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|---|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2012 | (b) 2013 | (c) 2014 | (d) 2015 | (e) Total |
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

Part II-B

Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

| For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity | | (a) | | (b) |
|--|--|-----|----|--------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | Yes | | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | Yes | | 13,643 |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 41,167 |
| j | Total Add lines 1c through 1i | | | 54,810 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | No | |

Part III-A

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

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

Part III-B

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

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

Part IV

Supplemental Information

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

| Return Reference | Explanation |
|---|--|
| Part II-B, Line 1i - Other Activities Description | ST CHARLES UNDERTAKES LIMITED LOBBYING ACTIVITIES AIMED AT INFLUENCING STATE AND FEDERAL OFFICIALS ON HEALTHCARE MATTERS AFFECTING THE PROVISION AND FINANCING OF HEALTHCARE SERVICES BY NON-PROFIT HEALTH SYSTEMS IN OREGON |

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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

| | (a) Donor advised funds | (b) Funds and other accounts |
|---|---|------------------------------|
| 1 | Total number at end of year | |
| 2 | Aggregate value of contributions to (during year) | |
| 3 | Aggregate value of grants from (during year) | |
| 4 | Aggregate value at end of year | |
| 5 | Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |
| 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? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div> | |

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

1

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

☐ Preservation of land for public use (e g , recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space

☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2

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

| | Held at the End of the Year |
|---|--|
| a | Total number of conservation easements |
| b | Total acreage restricted by conservation easements |
| c | Number of conservation easements on a certified historic structure included in (a) |
| d | Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register |

3

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

4

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

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

6

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

7

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

8

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9

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

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

1a

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

b

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

(i)

Revenue included on Form 990, Part VIII, line 1

► \$

(ii)

Assets included in Form 990, Part X

► \$

2

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

a

Revenue included on Form 990, Part VIII, line 1

► \$

b

Assets included in Form 990, Part X

► \$

Part III

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

(continued)

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

Amount

1c

1d

1e

1f

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

| | (a)Current year | (b)Prior year | b (c)Two years back | (d)Three years back | (e)Four years back |
|--|-----------------|---------------|---------------------|---------------------|--------------------|
| 1a Beginning of year balance | 4,564,921 | 3,495,960 | 3,228,519 | 2,990,165 | 3,134,186 |
| b Contributions | 51,375 | 1,027,077 | | 50 | |
| c Net investment earnings, gains, and losses | -29,698 | 138,332 | 362,452 | 309,578 | -49,509 |
| d Grants or scholarships | 90,396 | 75,764 | 79,512 | 55,000 | 19,250 |
| e Other expenditures for facilities and programs | | | | 1,883 | 59,790 |
| f Administrative expenses | 20,821 | 20,684 | 15,499 | 14,394 | 15,472 |
| g End of year balance | 4,475,381 | 4,564,921 | 3,495,960 | 3,228,519 | 2,990,165 |

2

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

a

Board designated or quasi-endowment ▶ 59 000 %

b

Permanent endowment ▶ 34 000 %

c

Temporarily restricted endowment ▶ 7 000 %

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

3a

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

(i) unrelated organizations

(ii) related organizations

Yes

No

3a(i)

No

3a(ii)

Yes

3b

Yes

b

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

4

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

Part VI

Land, Buildings, and Equipment.

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

| Description of property | (a)Cost or other basis (investment) | (b)Cost or other basis (other) | Accumulated (c)depreciation | (d)Book value |
|--|-------------------------------------|--------------------------------|-----------------------------|---------------|
| 1a Land | | 9,789,560 | | 9,789,560 |
| b Buildings | | 297,471,602 | 119,784,551 | 177,687,051 |
| c Leasehold improvements | | 4,410,384 | 1,552,697 | 2,857,687 |
| d Equipment | | 224,509,714 | 148,118,354 | 76,391,360 |
| e Other | | 30,677,885 | 9,417,400 | 21,260,485 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) ▶ | | | | 287,986,143 |

Schedule D (Form 990) 2015

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

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

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

Part XII

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

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

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

Part XIII

Supplemental Information

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

| Return Reference | Explanation |
|--|--|
| Part V, Line 4 Intended uses of the endowment fund | Endowment Funds are reported in this section because they are held by St. Charles Foundation, Inc., a related entity of SCHS. Permanently restricted endowment funds are primarily to be used for continuing education scholarships for caregivers and the professional medical community, support of SCHS' Community Benefit Programs, and in the area of greatest need. The Floyd Dement Hospital Trust Fund Testamentary Trust is administered by the Union Bank of California under a trust agreement which provides that the annual income be distributed to the Foundation for charity care to be provided to St. Charles Bend St. Charles Foundation Board Designated endowments consist of two individual funds established for community benefit and indigent care. |

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

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

SCHEDULE H
(Form 990)

Department of the
Treasury
Internal Revenue
Service

Hospitals

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

▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public
Inspection

| | |
|--|--|
| Name of the organization St Charles Health System Inc | Employer identification number 93-0602940 |
|--|--|

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | | | | |
|--|---|-----|-----|----|
| | | Yes | No | |
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other 25000 0000000 % | 3a | Yes | |
| b | Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other % | 3b | Yes | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | No |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | No |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H. | | | | |

| 7 Financial Assistance and Certain Other Community Benefits at Cost | | | | | | |
|---|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
| a Financial Assistance at cost (from Worksheet 1) | | 14,174 | 5,872,929 | | 5,872,929 | 0 850 % |
| b Medicaid (from Worksheet 3, column a) | | 150,159 | 173,144,932 | 131,093,180 | 42,051,752 | 6 100 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | 164,333 | 179,017,861 | 131,093,180 | 47,924,681 | 6 950 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | 15,479 | 1,797,272 | 27,211 | 1,770,061 | 0 260 % |
| f Health professions education (from Worksheet 5) | | 2,480 | 1,018,700 | 358,651 | 660,049 | 0 100 % |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | 2,218 | 860,283 | 1,402 | 858,881 | 0 120 % |
| j Total. Other Benefits | | 20,177 | 3,676,255 | 387,264 | 3,288,991 | 0 480 % |
| k Total. Add lines 7d and 7j | | 184,510 | 182,694,116 | 131,480,444 | 51,213,672 | 7 430 % |

Part IICommunity Building Activities

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|----|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 | Physical improvements and housing | 1,006 | 211,045 | | 211,045 | 0.030 % |
| 2 | Economic development | | | | | |
| 3 | Community support | | | | | |
| 4 | Environmental improvements | | | | | |
| 5 | Leadership development and training for community members | | | | | |
| 6 | Coalition building | | | | | |
| 7 | Community health improvement advocacy | | | | | |
| 8 | Workforce development | | | | | |
| 9 | Other | | | | | |
| 10 | Total | 1,006 | 211,045 | | 211,045 | 0.030 % |

Part IIIBad 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?

1

Yes

2

Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

2

7,191,817

3

Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.

3

4

Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

Section B. Medicare

5

Enter total revenue received from Medicare (including DSH and IME).

5

155,259,240

6

Enter Medicare allowable costs of care relating to payments on line 5.

6

187,484,529

7

Subtract line 6 from line 5. This is the surplus (or shortfall).

7

-32,225,289

8

Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.
☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a

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

9a

Yes

b

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

9b

Yes

Part IVManagement Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|-------------------------------|---|--|--|---|
| 1 Cascade Medical Imaging LLC | CT, Mammography and Other | 70.000 % | | 30.000 % |
| 2 Central Oregon Magnetic Res | Magnetic Resonance Imaging | 33.300 % | | 66.700 % |
| 3 Heart Center of the Cascade | Owns & manages a medical bu | 50.000 % | | 50.000 % |
| 4 Cascade SurgiCenter LLC | Outpatient surgery | 50.000 % | 2.780 % | 50.000 % |
| 5 Institute of the Cascades L | Administration & Marketing | 50.000 % | | 50.000 % |
| 6 Cascade Medical Buildings L | Owns & manages a medical bu | 50.000 % | 3.110 % | 50.000 % |
| 7 Cascade Property Holdings L | Owns bare land for investme | 50.000 % | 2.710 % | 50.000 % |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?

4

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

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

| | Yes | No |
|---|------------------|----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) 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 significant 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 Section C) 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>13</u> 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 3 Yes | |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 5 Yes | |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6a Yes | |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.STCHARLESHEALTHCARE.ORG/HEAL</u> b <input type="checkbox"/> Other website (list url) _____ c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input type="checkbox"/> Other (describe in Section C) 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u> 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) <u>https://www.stcharleshealthcare.org/Healthy-Communities/</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 6b No | |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | 7 Yes | |
| | 8 Yes | |
| | 10 Yes | |
| | 10b No | |
| | 12a No | |
| | 12b | |

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

St Charles Bend

Name of hospital facility or letter of facility reporting group

| | | Yes | No | |
|----|--|-----|-----|--|
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP <div><div>a</div><div><input type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %</div><div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div><div><div>c</div><div><input type="checkbox"/> Asset level</div><div><div>d</div><div><input type="checkbox"/> Medical indigency</div><div><div>e</div><div><input type="checkbox"/> Insurance status</div><div><div>f</div><div><input type="checkbox"/> Underinsurance discount</div><div><div>g</div><div><input type="checkbox"/> Residency</div><div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div><td>13</td><td>Yes</td><td></td></div></div></div> | 13 | Yes | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) <div><div>a</div><div><input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div><div><div>b</div><div><input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div><div><div>c</div><div><input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</div><div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div><div><div>e</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div><td>15</td><td>Yes</td><td></td></div> | 15 | Yes | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) <div><div>a</div><div><input type="checkbox"/> The FAP was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>b</div><div><input type="checkbox"/> The FAP application form was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>c</div><div><input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>d</div><div><input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>e</div><div><input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>f</div><div><input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>g</div><div><input type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility</div><div><div>h</div><div><input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</div><div><div>i</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div><td>16</td><td>Yes</td><td></td></div></div></div></div> | 16 | Yes | |

Billing and Collections

| | | | | |
|----|--|----|-----|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | 17 | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP <div><div>a</div><div><input type="checkbox"/> Reporting to credit agency(ies)</div><div><div>b</div><div><input type="checkbox"/> Selling an individual's debt to another party</div><div><div>c</div><div><input type="checkbox"/> Actions that require a legal or judicial process</div><div><div>d</div><div><input type="checkbox"/> Other similar actions (describe in Section C)</div><div><div>e</div><div><input type="checkbox"/> None of these actions or other similar actions were permitted</div></div></div></div></div></div> | | | |

Part V

Facility Information (continued)

St Charles Bend

Name of hospital facility or letter of facility reporting group

| | | | |
|---|--|-----|-----|
| | | Yes | No |
| 19 | Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply) | | |
| a | <input type="checkbox"/> Notified individuals of the financial assistance policy on admission | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | |
| c | <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | |
| d | <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| f | <input type="checkbox"/> None of these efforts were made | | |
| Policy Relating to Emergency Medical Care | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) | | | |
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | |
| a | <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 type="checkbox"/> Other (describe in Section C) | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | 23 | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | No |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

| | Yes | No |
|--|------------|-----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report 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 significant 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 Section C) | 3 | Yes |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>13</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.STCHARLESHEALTHCARE.ORG/HEAL</u> b <input type="checkbox"/> Other website (list url) _____ c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input type="checkbox"/> Other (describe in Section C) | 7 | Yes |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) <u>https //www.stcharleshealthcare.org/Healthy-Communities/</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10 | Yes |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

St Charles Redmond

Name of hospital facility or letter of facility reporting group

| | | Yes | No | |
|----|--|-----|-----|--|
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP <div><div>a</div><div><input type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 % <div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div><div><div>c</div><div><input type="checkbox"/> Asset level</div><div><div>d</div><div><input type="checkbox"/> Medical indigency</div><div><div>e</div><div><input type="checkbox"/> Insurance status</div><div><div>f</div><div><input type="checkbox"/> Underinsurance discount</div><div><div>g</div><div><input type="checkbox"/> Residency</div><div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div></div></div></div></div> | 13 | Yes | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) <div><div>a</div><div><input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div><div><div>b</div><div><input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div><div><div>c</div><div><input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</div><div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div><div><div>e</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div> | 15 | Yes | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) <div><div>a</div><div><input type="checkbox"/> The FAP was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>b</div><div><input type="checkbox"/> The FAP application form was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>c</div><div><input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <div>http //www stcharleshealthcare org/For-P</div></div><div><div>d</div><div><input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>e</div><div><input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>f</div><div><input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>g</div><div><input type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility</div><div><div>h</div><div><input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</div><div><div>i</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div></div></div></div></div> | 16 | Yes | |

Billing and Collections

| | | | | |
|----|--|----|-----|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | 17 | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP <div><div>a</div><div><input type="checkbox"/> Reporting to credit agency(ies)</div><div><div>b</div><div><input type="checkbox"/> Selling an individual's debt to another party</div><div><div>c</div><div><input type="checkbox"/> Actions that require a legal or judicial process</div><div><div>d</div><div><input type="checkbox"/> Other similar actions (describe in Section C)</div><div><div>e</div><div><input type="checkbox"/> None of these actions or other similar actions were permitted</div></div></div></div></div></div> | | | |

Part V

Facility Information (continued)

St Charles Redmond

| Name of hospital facility or letter of facility reporting group | | | Yes | No |
|---|--|----|-----|----|
| 19 | Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply) | | | |
| a | <input type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) | | | | |
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | | |
| a | <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 type="checkbox"/> Other (describe in Section C) | | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 3

| | Yes | No |
|---|-------------------------|---------------|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report 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 significant 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 Section C) 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>13</u> 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 3 5 | Yes |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>HTTPS://WWW.STCHARLESHEALTHCARE.ORG/HEAL</u> b <input type="checkbox"/> Other website (list url) _____ c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input type="checkbox"/> Other (describe in Section C) 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 7 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u> 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) <u>https://www.stcharleshealthcare.org/Healthy-Communities/</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10 10b | Yes No |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

St Charles Prineville

Name of hospital facility or letter of facility reporting group

| | | Yes | No | |
|----|---|-----|-----|--|
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP <div><div>a</div><div><input type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %</div><div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div><div><div>c</div><div><input type="checkbox"/> Asset level</div><div><div>d</div><div><input type="checkbox"/> Medical indigency</div><div><div>e</div><div><input type="checkbox"/> Insurance status</div><div><div>f</div><div><input type="checkbox"/> Underinsurance discount</div><div><div>g</div><div><input type="checkbox"/> Residency</div><div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div><td>13</td><td>Yes</td><td></td></div></div></div> | 13 | Yes | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) <div><div>a</div><div><input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div><div><div>b</div><div><input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div><div><div>c</div><div><input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</div><div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div><div><div>e</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div><td>15</td><td>Yes</td><td></td></div> | 15 | Yes | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) <div><div>a</div><div><input type="checkbox"/> The FAP was widely available on a website (list url) http://www.stcharleshealthcare.org/For-P</div><div><div>b</div><div><input type="checkbox"/> The FAP application form was widely available on a website (list url) http://www.stcharleshealthcare.org/For-P</div><div><div>c</div><div><input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) http://www.stcharleshealthcare.org/For-P</div><div><div>d</div><div><input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>e</div><div><input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>f</div><div><input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div><div>g</div><div><input type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility</div><div><div>h</div><div><input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</div><div><div>i</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div></div></div></div><td>16</td><td>Yes</td><td></td></div></div></div></div> | 16 | Yes | |

Billing and Collections

| | | | | |
|----|--|----|-----|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | 17 | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP <div><div>a</div><div><input type="checkbox"/> Reporting to credit agency(ies)</div><div><div>b</div><div><input type="checkbox"/> Selling an individual's debt to another party</div><div><div>c</div><div><input type="checkbox"/> Actions that require a legal or judicial process</div><div><div>d</div><div><input type="checkbox"/> Other similar actions (describe in Section C)</div><div><div>e</div><div><input type="checkbox"/> None of these actions or other similar actions were permitted</div></div></div></div></div></div> | | | |

Part V

Facility Information (continued)

St Charles Prineville

| Name of hospital facility or letter of facility reporting group | | | Yes | No |
|---|--|----|-----|----|
| 19 | Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply) | | | |
| a | <input type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) | | | | |
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | | |
| a | <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 type="checkbox"/> Other (describe in Section C) | | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

| | Yes | No |
|--|------------|-----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | 1 | No |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report 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 significant 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 Section C) | 3 | Yes |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>13</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 5 | Yes |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) a <input type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.STCHARLESHEALTHCARE.ORG/HEAL</u> b <input type="checkbox"/> Other website (list url) _____ c <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input type="checkbox"/> Other (describe in Section C) | 7 | Yes |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>13</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? a If "Yes" (list url) <u>https //www.stcharleshealthcare.org/Healthy-Communities/</u> b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10 | Yes |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

St Charles Madras

Name of hospital facility or letter of facility reporting group

| | | Yes | No | |
|----|---|-----|-----|--|
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP <div><div>a</div><div><input type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 % <div></div><div></div></div><div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div></div><div><div>c</div><div><input type="checkbox"/> Asset level</div></div><div><div>d</div><div><input type="checkbox"/> Medical indigency</div></div><div><div>e</div><div><input type="checkbox"/> Insurance status</div></div><div><div>f</div><div><input type="checkbox"/> Underinsurance discount</div></div><div><div>g</div><div><input type="checkbox"/> Residency</div></div><div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div></div> | 13 | Yes | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) <div><div>a</div><div><input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div></div> <div><div>b</div><div><input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div></div> <div><div>c</div><div><input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</div></div> <div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div></div> <div><div>e</div><div><input type="checkbox"/> Other (describe in Section C)</div></div> | | | |

Billing and Collections

| | | | | |
|----|--|----|-----|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | 17 | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP <div><div>a</div><div><input type="checkbox"/> Reporting to credit agency(ies)</div></div> <div><div>b</div><div><input type="checkbox"/> Selling an individual's debt to another party</div></div> <div><div>c</div><div><input type="checkbox"/> Actions that require a legal or judicial process</div></div> <div><div>d</div><div><input type="checkbox"/> Other similar actions (describe in Section C)</div></div> <div><div>e</div><div><input type="checkbox"/> None of these actions or other similar actions were permitted</div></div> | | | |

Part V

Facility Information (continued)

St Charles Madras

| Name of hospital facility or letter of facility reporting group | | | Yes | No |
|---|--|----|-----|----|
| 19 | Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | 19 | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply) | | | |
| a | <input type="checkbox"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | | |
| f | <input type="checkbox"/> None of these efforts were made | | | |
| Policy Relating to Emergency Medical Care | | | | |
| 21 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why | 21 | Yes | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | | |
| Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) | | | | |
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | | |
| a | <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 type="checkbox"/> Other (describe in Section C) | | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | 23 | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | 24 | | No |

Part V **Facility Information** *(continued)*

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

Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

| Form and Line Reference | Explanation |
|-------------------------|-------------|
| | |
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| | |

Part V **Facility Information** *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 29

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

Part VI Supplemental Information

Provide the following information

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

| Form and Line Reference | Explanation |
|---|---|
| Part I, Line 7 - Explanation of Costing Methodology | The costing methodology used was derived from SCHS's financial and cost accounting systems, which address all hospital-based patient segments and other services provided A cost-to-charge ratio from these financial systems was used to calculate the cost of Financial Assistance in line 7a Numbers reported in column (b) in lines 7a and 7b refer to the number of patient encounters |

| Form and Line Reference | Explanation |
|--|-------------|
| Part I, Line 7, Column F - Explanation of Bad Debt Expense | 7,191,817 |

| Form and Line Reference | Explanation |
|--|---|
| Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense | <p>When SCHS provides care to patients, it does not require collateral, however, it maintains an estimated allowance for doubtful accounts. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (generally deductibles and copayments) remain outstanding. The allowance for doubtful accounts is estimated based primarily upon SCHS historical collection experience, the age of the patient's account, management's estimate of the patient's economic ability to pay, and the effectiveness of collection efforts. Patient accounts receivable balances are routinely reviewed in conjunction with historical collection rates and other economic conditions that might ultimately affect the collectability of patient accounts when considering the adequacy of the amounts recorded in the allowance for doubtful accounts. Actual write offs have historically been within management's expectations.</p> |

| Form and Line Reference | Explanation |
|---|--|
| Part III, Line 3 - Methodology of Estimated Amount & Rationale for Including in Community Benefit | SCHS currently has no reasonable way to track or estimate the amount of bad debt expense attributable to charity care, and accordingly this line has been left blank |

| Form and Line Reference | Explanation |
|-------------------------------------|--|
| Part III, Line 4 - Bad Debt Expense | See page 9, footnote 1 (f) "Patient Accounts Receivable, Allowance for Doubtful Accounts, and Other Receivables", in the attached Audited Financial Statements |

| Form and Line Reference | Explanation |
|--|---|
| Part III, Line 8 - Explanation Of Shortfall As Community Benefit | <p>As a response to efforts to improve the health and quality of life of people living in the community, SCHS provided \$32,225,289 in unreimbursed services to patients enrolled in traditional Medicare programs. SCHS believes that the Medicare shortfall should be treated as a community benefit since it has a clear mission to serving and improving the health status of the elderly. If SCHS should cease to exist, this shortfall would have to be absorbed by another health care provider. Costs are from the Medicare Cost Report, but none of these costs are being claimed as a community benefit in Part I, line 7. Our community benefit report shows a Medicare shortfall of \$59,497,261 which differs from the shortfall of \$32,225,289 reported in Part III Section B because Part III Section B includes only those costs allowed in the Medicare Cost Report which excludes the Medicare Advantage shortfall, this shortfall is included in our annual community benefit report.</p> |

| Form and Line Reference | Explanation |
|---|---|
| Part III, Line 9b - Provisions On Collection Practices For Qualified Patients | <p>Collection policies are the same for all patients Every effort will be made to identify patients who may need financial assistance at the earliest point during the patients experience with St Charles</p> <p>Patients may be identified as a candidate for financial assistance at any time before, during or after services are delivered If at any point during the collection process documentation or information is received that indicates the patient may be eligible for our financial assistance program, the account will be reviewed by our financial assistance team for presumptive eligibility If the responsible party does not respond to statements, letters or phone calls within 120 days of billing the patient balance due, St Charles will run all accounts through charity advisor software and the probability of payment will be determined electronically If the probability of payment is low, the encounter will be written off to free care</p> |

| Form and Line Reference | Explanation |
|----------------------------|--|
| Part VI - Needs Assessment | <p>St Charles Health System (SCHS) assesses the needs of each of our communities in many different ways other than the facility community health needs assessments SCHS partners with Healthy Communities Institute (HCI) to purchase a dashboard of each community and population risk profiling data that is continuously updated, accessible to the community, easy to understand and directly embeddable in our existing website This information helps SCHS to keep a finger on the pulse of each population's many health indicators, helping us to continually assess each community's needs, positive changes and/or opportunities for improvement This information can be found at http://www.stcharleshealthcare.org/Healthy-Communities/CHNA Each year St Charles also produces the St Charles Health System Annual Report This report is comprised of a summary of each of the following Community BenefitTotalsFinancial OverviewDays cash on handOperating marginExcess marginOperating ExpensesFull time employee countEach health system facility (St Charles Bend, St Charles Redmond, St Charles Prineville and St Charles Madras) BirthsDischargesIn-patient casesOut-patient casesEmergency visitsSt Charles Medical GroupPatient visits for each clinicsThe 2014 Annual Report is posted online on the St Charles Health System website at https://www.stcharleshealthcare.org/~media/Files/Publications/2014%20Annual%20Report_2015_F2.pdf This report and the primary data collected for its creation let us know what the trends are for different hospital stays, conditions and out-patient visits, helping to decide what services we offer and where the needs are St Charles also plays a significant role in local, regional and State groups in order to stay abreast of the newest information, trends, health data and best practices SCHS has representation on the Central Oregon Health Council (COHC), the governance entity over the region's Coordinated Care Organization and PacificSource Community Solutions Representatives from the three counties, PacificSource Health Plan, county commissioners, local medical clinics and the regional dental clinic also participate on the COHC By participating on this council, St Charles is able to work with the experts in each of the three counties to hear firsthand how each community is doing and what their health needs are St Charles also sits on different committees for the Oregon Association for Hospitals and Health Systems (OAHS) and local non-profits Being part of these groups helps St Charles to better understand the needs of our communities while also learning how to better collect, track, report and improve upon collected information</p> |

| Form and Line Reference | Explanation |
|---|---|
| Part VI - Patient Education of Eligibility for Assistance | <p>Financial assistance policy is posted on the SCHS website</p> <p>Financial counselors and registration staff in our facilities & primary care clinics offer FAP to patients, both upon request and when patients are uninsured</p> <p>Change Healthcare - Change Healthcare has a contractual arrangement with SCHS to identify patients who may qualify for coverage through the following government programs (uninsured patients seen in our Emergency departments & those admitted to all of our facilities are automatically referred to "Change Healthcare")</p> <p>Cobra (these are referred to Financial Counselors)</p> <p>Crime Victims Assistance</p> <p>Emergency Medicaid for Aliens</p> <p>Medicaid for pregnant women and children</p> <p>Medicaid, Medicare Supplemental Security Income (SSI)</p> <p>Temporary Aid for Needy Families (TANF)</p> <p>Veterans</p> <p>"Change Healthcare" will work with these individuals through the process of qualifying for coverage until SCHS receives reimbursement from any of the above referenced programs for the services we have rendered to patients</p> <p>Patients working with "Change Healthcare" have their accounts put on hold from collections activities during these activities</p> <p>Only "Change Healthcare" will work with these patients</p> <p>Patients that "Change Healthcare" cannot help will be referred to Patient Access Services</p> <p>Financial Counseling for follow-up</p> |

| Form and Line Reference | Explanation |
|---------------------------------|--|
| Part VI - Community Information | <p>Deschutes County (St Charles Bend and St Charles Redmond) Information taken from HCI (http://www.stcharleshealthcare.org/Healthy-Communities/CHNA) unless otherwise noted Urban/Land area in square miles (2010) 3,018.19 Population per square mile (2010) 52.3 Population (2014 estimate) 170,388 Population (2013) Under 5 years 5.4% Under 18 years 21.8% 65 years and over 17.4% Female 50.7% Households (2009-2013) 64,568 Persons per household (2009-2013) 2.47 Median Household income (2009-2013) \$50,209 Percentage of persons below poverty level (2009-2013) 14.5% Adults with health insurance (2014) 85.7% Children with health insurance (2014) 94.5% High school graduate or higher, percent of persons age 25+ (2009-2013) 93.1% Population by race (2013) White alone, not Hispanic 88.1% Hispanic or Latino 7.7% Two or more races 2.4% American Indian and Alaska Native alone 1.1% Asian alone 1.0% Black or African American alone 1.1% Native Hawaiian or other Pacific Islander 0.2% Health care provider assets in Deschutes County (Outside of St Charles Bend and Redmond) Mosaic Medical Clinic, Bend and Redmond (FQHC) Lynch Community Clinic (school-based health center partnership between Mosaic Medical, Redmond School District and Deschutes County) Ensforth Community School-Based Health Center (partnership between Mosaic Medical, Bend-Lapine School District and Deschutes County) Bend Memorial Clinic, Bend, Redmond and Sisters High Lakes Health Care (Bend, Redmond, Sisters) Crook County (St Charles Prineville) Information taken from HCI (http://www.stcharleshealthcare.org/Healthy-Communities/CHNA) unless otherwise noted Rural/Medically underserved area (MUA) Land area in square miles (2010) 2,979.09 Population per square mile (2010) 7.0 Population (2014 estimate) 20,998 Population (2013) Under 5 years 4.4% Under 18 years 19.5% 65 years and over 23.6% Female 50.5% Households (2009-2013) 8,880 Persons per household (2009-2013) 2.33 Median Household income (2009-2013) \$38,795 Percentage of persons below poverty level (2009-2013) 19.5% Adults with health insurance (2014) 84.0% Children with health insurance (2014) 93.7% High school graduate or higher, percent of persons age 25+ (2009-2013) 84.9% Population by race (2013) White alone, not Hispanic 95.6% Hispanic or Latino 7.4% Two or more races 2.0% American Indian and Alaska Native alone 1.4% Asian alone 0.7% Black or African American alone 0.3% Native Hawaiian or Other Pacific Islander 0.1% Health care provider assets in Deschutes County (Outside of St Charles Prineville) Mosaic Medical (FQHC) Crook Kids Clinic (school-based health center partnership between Mosaic Medical and Crook County School District) Jefferson County (St Charles Madras) Information taken from HCI (http://www.stcharleshealthcare.org/Healthy-Communities/CHNA) unless otherwise noted Rural/Medically underserved area (MUA) Land area in square miles (2010) 1,780.79 Population per square mile (2010) 12.2 Population (2014 estimate) 22,192 Population (2013) Under 5 years 7.1% Under 18 years 25.1% 65 years and over 17.9% Female 49.8% Households (2009-2013) 7,882 Persons per household (2009-2013) 2.62 Median Household income (2009-2013) \$43,373 Percentage of persons below poverty level (2009-2013) 19.8% Adults with health insurance (2014) 79.1% Children with health insurance (2014) 91.2% High school graduate or higher, percent of persons age 25+ (2009-2013) 84.7% Population by race (2013) White alone, not Hispanic 60.2% Hispanic or Latino 19.9% Two or more races 3.3% American Indian and Alaska Native alone 19.1% Asian alone 0.8% Black or African American alone 0.8% Native Hawaiian or Other Pacific Islander 0.2% Health care provider assets in Deschutes County (Outside of St Charles Prineville) Mosaic Medical (FQHC) Confederated Tribes of Warm Springs/Madras Medical Group</p> |

| Form and Line Reference | Explanation |
|---|---|
| Part VI - Community Building Activities | Our community building activities focused on workforce development activities which support the community by offering the expertise and resources of our hospital systems caregivers for the betterment of the community. Specifically these programs address community-wide workforce issues, potentially providing health care workers for promoting the health of the community. |

| Form and Line Reference | Explanation |
|---|---|
| Part VI - Explanation Of How Organization Furthers Its Exempt Purpose | <p> SCHS provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. SCHS criteria for the determination of charity care include the patients or other responsible party's annual household income, number of people in the home and amount claimed on taxes, credit history, existing medical debt obligations and other indicators of the patients ability to pay. Generally, those individuals with an annual household income at or less than 250% of the Federal Poverty Guidelines (the Guidelines) qualify for charity care under SCHS policy. In addition, SCHS provides discounts on a sliding scale to those individuals with an annual household income of between 250% and 400% of the Guidelines. Since SCHS does not pursue collection of amounts determined to qualify as charity care, those amounts are not reported as net patient service revenue. Because both Madras and Prineville are located in medically underserved areas (MUAs), the resources used for provider recruitment in those communities are counted as community benefit. St. Charles also allows nursing students, high school students and other providers to partake in job-shadowing with our paid caregivers to help them complete their course work and/or earn credits, without restrictions related to future employment. The St. Charles Health System Board of Directors is comprised of members from all communities served by the system: Bend, Redmond, Prineville and Madras, etc. allowing for diverse views and leadership related to promoting the health of the community. Various community classes are offered at each campus, including Preventing Osteoporosis, NEW Start (nutrition education), Childbirth Education, Diabetes Education, etc. In order to continue to promote health in the community and eliminate barriers, scholarships are available for those who are unable to pay but would still like to participate in any of these classes. Being the only health care system in Central Oregon, many non-profit community organizations come to St. Charles needing funds and other donations, such as in-kind support. During 2015, St. Charles facility caregivers provided thousands of hours of in-kind support to these organizations who share in St. Charles vision of Creating Americas healthiest community, together. In-kind support activities include but are not limited to membership on non-profit community organization boards, below fair market value rent fees, free cleaning and landscaping services and hours spent coordinating events promoting health improvement for vulnerable and low-income community members. </p> |

| Form and Line Reference | Explanation |
|--|-------------|
| Part VI - States Where Community Benefit Report Filed | O R |

Schedule H (Form 990) 2015

Additional Data

Software ID: 15000324
Software Version: 2015v2.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year?
4

Name, address, primary website address, and state license number

| | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER—24 hours | ER—other | Other (Describe) | Facility reporting group |
|---|--|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| 1 | St Charles Bend 2500 NE NEFF ROAD BEND,OR 97701 | X | X | | | | | X | | | |
| 2 | St Charles Redmond 1253 NW Canal Blvd Redmond,OR 97756 | X | X | | | | | X | | | |
| 3 | St Charles Prineville 384 SE Combs Flat Rd Prineville,OR 97754 | X | X | | | X | | X | | | |
| 4 | St Charles Madras 470 NE A Madras,OR 97741 | X | X | | | X | | X | | | |

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

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

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

| Name and address | Type of Facility (describe) |
|---|-----------------------------|
| 1 St Charles Cancer Center 2500 NE Neff Road Bend, OR 97701 | Outpatient Cancer Center |
| 1 Cascade Medical Imaging 1460 NE Medical Center Dr Bend, OR 97701 | Diagnostic Imaging Clinic |
| 2 St Charles Heart & Lung Specialists 2500 NE Neff Rd Bend, OR 97701 | Cardiothoracic Surgery |
| 3 St Charles Family Care - Redmond 211 NW Larch Ave Redmond, OR 97756 | Primary Care Clinic |
| 4 Sage View Psychiatric Center 1885 NE Purcell Blvd Bend, OR 97701 | Mental Health Services |
| 5 Redmond Surgical Specialists 1245 NW 4th Street Redmond, OR 97756 | Surgical Specialists |
| 6 Central Oregon Magnetic Resonance Imaging 1460 NE Medical Center Dr Bend, OR 97701 | MRI Center |
| 7 St Charles Family Care Prineville 384 SE Combs Flat Road Prineville, OR 97754 | Rural Health Clinic |
| 8 St Charles Hospice 2500 NE Neff Rd Bend, OR 97754 | Hospice Care |
| 9 St Charles Immediate Care 2600 NE Neff Rd Bend, OR 97701 | Immediate Care Clinic |
| 10 St Charles Center for Womens Health Redmond 340 NW 5th Street Ste 101 Redmond, OR 97756 | OB/GYN Clinic |
| 11 St Charles Pulmonary Clinic 2500 NE Neff Rd Bend, OR 97701 | Lung Clinic |
| 12 Behavioral Health - Bend 2542 Courtney Dr Bend, OR 97701 | Behavioral Health Clinic |
| 13 St Charles Family Care Madras 480 NE A St Madras, OR 97741 | Primary Care Clinic |
| 14 St Charles Sleep Center - Bend 2042 Williamson Ct Bend, OR 97701 | Sleep Lab |

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

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

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

| Name and address | Type of Facility (describe) |
|---|---|
| 16 St Charles Paliative Care 2500 NE Neff Rd Bend, OR 97701 | Paliative Care Clinic |
| 1 St Charles Sleep Center - Redmond 655 NW Jackpine Ave Redmond, OR 97756 | Sleep Lab |
| 2 St Charles Preoperative Medicine 2500 NE Neff Rd Bend, OR 97701 | Comprehensive Care for Surgery Patients |
| 3 St Charles Infectious Disease 2965 NE Conners Ave Suite 127 Bend, OR 97701 | Infectious Disease Clinic |
| 4 St Charles Pulmonary Clinic - Redmond 655 NW Jackpine Ave Redmond, OR 97756 | Lung Clinic |
| 5 St Charles Family Care - Sisters 630 Arrowleaf Trail Sisters, OR 97759 | Primary Care Clinic |
| 6 St Charles Family Care - Bend 2965 NE Conners Ave Ste 127 Bend, OR 97701 | Primary Care Clinic |
| 7 Cascade SurgiCenter 2200 NE Neff Rd 100 Bend, OR 97701 | Surgery Center |
| 8 Behavioral Health Redmond 413 Larch Ave Ste 203 Redmond, OR 97756 | Behavioral Health Clinic |
| 9 St Charles Anticoagulation Clinic 2500 NE Neff Road Bend, OR 97701 | Anticoag Clinic |
| 10 Sisters Diagnostic Radiology 630 N Arrowleaf Trail Sisters, OR 97759 | Radiology |
| 11 St Charles Sisters Lab Services 630 N Arrowleaf Trail Sisters, OR 97759 | Outpatient Lab |
| 12 Redmond School Based Health Clinic 675 SW Rimrock Way Redmond, OR 97756 | School Based Clinic |
| 13 Sisters School Based Health Clinic 1680 W McKimmey Butte Rd Sisters, OR 97759 | School Based Clinic |

2015

93-0602940

Schedule I (Form 990) 2015

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22
Part III can be duplicated if additional space is needed

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

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

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

Additional Data

Software ID: 15000324
Software Version: 2015v2.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|------------|-------------------------------|--------------------------|-----------------------------------|---|--|-------------------------------------|
| BESTCARE TREATMENT SERVICES po box 1710 Redmond, OR 97756 | 93-1269087 | 501(c)(3) | 700 | 104,077 | RATE COMPARISON | SUBSIDIZED RENT | TREATMENT & PREVENTION OF ADDICTION |
| BETHLEHEM INN 3705 N Hwy 97 BEND, OR 97701 | 93-1323419 | 501(C)(3) | 7,000 | 0 | | | Homeless shelter and services |
| BLOOM PROJECT 70 SW Century Dr BEND, OR 97702 | 26-2061664 | 501(C)(3) | 10,500 | 0 | | | Provides fresh floral bouquets to h |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| BOYS & GIRLS CLUB OF BEND 500 NW WALL STREET BEND, OR 97701 | 93-1127536 | 501(C)(3) | 10,000 | 0 | | | ENABLE YOUNG PEOPLE TO REACH THEIR |
| Boys and Girls Club REDMOND PO Box 1810 Redmond, OR 97756 | 47-1465358 | 501(C)(3) | 7,200 | 0 | | | CLUB PROGRAM FOR CHILDREN |
| CO INTERGOVERNMENTAL COUNCIL 334 NE Hawthorne Ave BEND, OR 97756 | 93-0709787 | QUASI GOVERNMENTAL | 25,000 | 0 | | | Community health system grant |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| CO REGIONAL HOUSING AUTHORITY 405 SW 6th REDMOND, OR 97756 | 93-0709787 | QUASI GOVERNMENTAL | 0 | 41,956 | RATE COMPARISON | SUBSIDIZED RENT | PROVIDE SAFE & AFFORDABLE HOUSING |
| ECONOMIC DEVELOPMENT CO 705 SW Bonnett Way Ste 1000 BEND, OR 97702 | 93-0796784 | 501(C)(6) | 7,500 | 0 | | | Create a diversified local economy |
| FAMILY RESOURCE CENTER 1130 NW Harriman St Ste B BEND, OR 97701 | 93-0990542 | 501(C)(3) | 10,000 | 0 | | | PARTNERING WITH PARENTS |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| JEFFERSON COUNTY 66 SE D ST Suite C MADRAS, OR 97741 | 93-6002299 | COUNTY | 6,490 | 0 | | | Community Programs |
| JEFFERSON COUNTY YOUTH ORGANI PO BOX 571 MADRAS, OR 97741 | 26-1377894 | 501(C)(3) | 12,500 | 0 | | | Youth development program |
| KIDS CENTER 1375 NW KINGSTON AVE BEND, OR 97701 | 94-3169200 | 501(C)(3) | 20,000 | 0 | | | CHILD ABUSE PREVENTION & TREATMENT |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| MADRAS AQUATIC CENTER 1195 SE Kemper Way MADRAS, OR 97741 | 20-5757201 | SPECIAL DISTRICT | 10,249 | 0 | | | After school and summer programs fo |
| MOUNTAIN STAR FAMILY RELIEF 2125 NE Daggett Ln BEND, OR 97701 | 42-1560891 | 501(C)(3) | 15,000 | 0 | | | Help prevent Child Abuse & Neglect |
| OR STATE UNIVERSITY FNDTN 850 SW 35TH ST CORVALLIS, OR 97333 | 93-6022772 | 501(C)(3) | 21,516 | 0 | | | Nutrition education program |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| REACH ANOTHER 2568 NW First Street BEND, OR 97701 | 27-1440140 | 501(C)(3) | 10,000 | 0 | | | BETTER ACCESS TO HEALTHCARE |
| RONALD MCDONALD HOUSE 1700 NE PURCELL BLVD BEND, OR 97701 | 93-1125838 | 501(c)(3) | 13,280 | 58,225 | RATE COMPARISON | SUBSIDIZED RENT | LODGING FOR FAMILIES W/ MEDICAL NEE |
| ST CHARLES FOUNDATION 2500 NE Neff Rd BEND, OR 97701 | 94-3076293 | 501(C)(3) | 9,500 | 0 | | | To support fundraising activities |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|----------------|--------------------------------------|---------------------------------|--|--|---|---|
| UNITED WAY OF DESCHUTES PO BOX 5969 BEND, OR 97708 | 93-6012576 | 501(C)(3) | 20,000 | 0 | | | SUPPORT LOCAL HUMAN SERVICES |
| VOLUNTEERS IN MEDICINE 2300 NE NEFF ROAD BEND, OR 97701 | 93-1327847 | 501(c)(3) | 0 | 35,271 | RATE COMPARISON | SUBSIDIZED RENT | FREE MEDICAL CARE |

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I

Questions Regarding Compensation

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

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

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

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

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---------------------------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| See Additional Data Table | | | | | | | |

Part III **Supplemental Information**

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

| Return Reference | Explanation |
|---|---|
| Part I, Line 1a Relevant information in regards to selections on 1a | THREE PHYSICIANS RECEIVED FOREGIVENESS OF A PORTION OF DEBT IN 2015, WHICH WAS TREATED AS GROSSED-UP TAXABLE EARNINGS. LOANS WITH REMAINING BALANCES ARE REPORTED ON SCHEDULE L. JOSEPH SLUKA & JEREMIAH BRICKHOUSE RECEIVED HOUSING ALLOWANCES AND THESE AMOUNTS HAVE BEEN INCLUDED AS TAXABLE INCOME IN THE 990 PART VII, COLUMN D. |

Additional Data

Software ID: 15000324

Software Version: 2015v2.0

EIN: 93-0602940

Name: St Charles Health System Inc

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1Absalon Jeffrey MD CHIEF PHYSICAIN EXECUTIVE | (i) | 353,925 | 39,916 | 55,654 | 53,367 | 33,708 | 536,570 | 31,686 |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 1Blizzard John DPhysician | (i) | 817,274 | | 1,417 | 15,900 | 24,297 | 858,888 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 2Boileau Michel MDEV/CCO | (i) | 498,884 | 51,427 | 18,107 | 3,222 | 1,383 | 573,023 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 3Boone RobPhysician | (i) | 636,692 | 3,995 | 24,858 | 15,900 | 27,434 | 708,879 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 4Brckhouse JeremiahCIO | (i) | 161,267 | | 22,640 | 16,250 | 25,147 | 225,304 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 5Diegel James Former President/CEO | (i) | 86,253 | 94,961 | 805,449 | 6,644 | 3,486 | 996,793 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 6Gentry Jeanine CEO Prineville & Madras | (i) | 206,737 | 22,551 | 25,668 | 35,538 | 29,706 | 320,200 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 7Gomes Robert CEO Bend & Redmond | (i) | 330,011 | 36,926 | 37,771 | 49,654 | 31,016 | 485,378 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 8Laughlin JamesPhysician | (i) | 628,002 | | 7,078 | 15,900 | 35,405 | 686,385 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 9Martin Richard Former VP Service Lines | (i) | 232,755 | 25,230 | 26,490 | 15,784 | 25,752 | 326,011 | 23,670 |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 10Martin WilliamPhysician | (i) | 529,930 | 2,397 | 17,130 | 15,900 | 31,993 | 597,350 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 11McLellan BrucePhysician | (i) | 494,704 | | 26,695 | 15,900 | 28,272 | 565,571 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 12Nunes John MD Chief Quality & Safety Officer | (i) | 318,285 | 31,007 | 28,425 | 47,680 | 26,514 | 451,911 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 13Shepard Karen EXEC VP Finance | (i) | 70,887 | 44,042 | 301,307 | 5,738 | 3,196 | 425,170 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 14Sluka JosephPresident | (i) | 622,962 | | 75,664 | 96,891 | 36,037 | 831,554 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 15Steinke Pamela VP Quality/CNE | (i) | 262,184 | 29,955 | 52,205 | 45,172 | 32,347 | 421,863 | 17,861 |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 16Weinsheim John PRESIDENT SCMG | (i) | 166,381 | | 321 | 16,901 | 31,698 | 215,301 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |
| 17Welander JenniferCFO | (i) | 289,096 | | 2,556 | 41,734 | 24,469 | 357,855 | |
| | (ii) | ----- | ----- | ----- | ----- | - | - | ----- |

| Part I Bond Issues | | | | | | | | | | | |
|-----------------------------|----------------|-------------|-----------------|-----------------|----------------------------|--------------|----|-------------------------|----|--------------------|----|
| (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased | | (h) On behalf of issuer | | (i) Pool financing | |
| | | | | | | Yes | No | Yes | No | Yes | No |
| A HOSPITAL FACILITY AUTHORI | 93-0991182 | 250336BY9 | 12-21-2005 | 51,800,000 | SEE PART VI | | X | | X | | X |
| B HOSPITAL FACILITY AUTHORI | 93-0991182 | 000000000 | 04-01-2014 | 75,000,000 | SEE PART VI | | X | | X | | X |

| Part II Proceeds | | | | | | | | | | | |
|---|--|--|--|--|--|------------|----|------------|----|-----|----|
| | | | | | | A | | B | | C | |
| 1 Amount of bonds retired | | | | | | 8,150,000 | | | | | |
| 2 Amount of bonds legally defeased | | | | | | | | | | | |
| 3 Total proceeds of issue | | | | | | 53,449,239 | | 75,120,777 | | | |
| 4 Gross proceeds in reserve funds | | | | | | | | | | | |
| 5 Capitalized interest from proceeds | | | | | | | | | | | |
| 6 Proceeds in refunding escrows | | | | | | | | | | | |
| 7 Issuance costs from proceeds | | | | | | 489,902 | | 335,038 | | | |
| 8 Credit enhancement from proceeds | | | | | | 1,021,665 | | | | | |
| 9 Working capital expenditures from proceeds | | | | | | | | | | | |
| 10 Capital expenditures from proceeds | | | | | | 51,937,672 | | 63,141,429 | | | |
| 11 Other spent proceeds | | | | | | | | | | | |
| 12 Other unspent proceeds | | | | | | | | 11,644,309 | | | |
| 13 Year of substantial completion | | | | | | 2007 | | | | | |
| | | | | | | Yes | No | Yes | No | Yes | No |
| 14 Were the bonds issued as part of a current refunding issue? | | | | | | | X | | X | | |
| 15 Were the bonds issued as part of an advance refunding issue? | | | | | | | X | | X | | |
| 16 Has the final allocation of proceeds been made? | | | | | | X | | | X | | |
| 17 Does the organization maintain adequate books and records to support the final allocation of proceeds? | | | | | | X | | X | | | |

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

Part III Private Business Use (Continued)

| | | A | | B | | C | | D | |
|----|--|-----|----|---------|----|-----|----|-----|----|
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 3a | Are there any management or service contracts that may result in private business use of bond-financed property? | X | | X | | | | | |
| b | If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | X | | X | | | | | |
| c | Are there any research agreements that may result in private business use of bond-financed property? | X | | X | | | | | |
| d | If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | X | | X | | | | | |
| 4 | Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶ | | | 0 200 % | | | | | |
| 5 | Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶ | | | | | | | | |
| 6 | Total of lines 4 and 5 | | | 0 200 % | | | | | |
| 7 | Does the bond issue meet the private security or payment test? | | X | | X | | | | |
| 8a | Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?. | | X | | X | | | | |
| b | If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of | | | | | | | | |
| c | If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?. | | | | | | | | |
| 9 | Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?. | X | | X | | | | | |

Part IV Arbitrage

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

Part IV

Arbitrage (Continued)

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

Part V

Procedures To Undertake Corrective Action

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

Part VI

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

| Return Reference | Explanation |
|------------------|---|
| Part VI | DIFFERENCE BETWEEN PART 1 (e) AND PART II, Line 3 IS DUE TO INTEREST EARNINGS ON BOND PROCEEDS PART I (A), COL (f) CAPITAL ADDITIONS AND IMPROVEMENTS OF BORROWER FACILITIES PART I (B), COL (f) PAY OR REIMBURSE COST OF CAPITALIZED ASSETS OF BORROWER FACILITIES AND SUPPORT THE PROVISION OF HEALTHCARE PART III, QUESTION 7 AS PROVIDED IN TREASURY REGULATION SECTION 1 141-4(C)(2)(i)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE ACCORDINGLY, THE AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE AMOUNT STATED IN PART III, LINE 6 THE ORGANIZATION HAS NOT UNDERTAKEN AN ANALYSIS OF THE PRIVATE SECURITY TEST WITH RESPECT TO THE BONDS, AS THE LEVEL OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS REPORTED IN PART III, LINE 6, IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF THE CODE (2005B)PART IV, LINE 2(B) THE BONDS MET THE 2-YEAR EXPENDITURE EXCEPTION (2014) Part IV, LINE 4(C) THE QUALIFIED HEDGE WAS TERMINATED SUBSTANTIALLY CONTEMPORANEOUSLY WITH THE ISSUE DATE OF THE BONDS, WITHIN THE MEANING OF TREASURY REGULATION, SECTION 1 148(h)(5)(ii)(A) |

Part IV Business Transactions Involving Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| (1) MARIAN BOILEAU | EMPLOYEE | 103,397 | COMPENSATION | | No |
| | | | | | |
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Part V Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| Schedule L, Part V Supplemental Information | Part II SCHS paid certain expenses on behalf of physicians upon employment and made further retention payments. These retention payments were treated as loans, which will be forgiven as long as the physicians remain employed in good standing over the forgiveness period. This method is consistent with SCHS's normal business practices. The Board has delegated the authority to executive management to make such loans to physicians; the loans are reviewed by legal counsel. The forgiveness of these loans, where applicable, has been reported in Form 990, Part VII and Schedule J. Dr. Laughlin and Dr. McLellan are current highest compensated employees. Part IV: Marian Boileau was employed at St. Charles Health System Inc. and she is the spouse of a Michel Boileau, a former of St. Charles listed on Form 990, Part VII. |

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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.

OMB No 1545-0047

2015**Open to Public
Inspection**Name of the organization
St Charles Health System Inc**Employer identification number**

93-0602940

**Return
Reference****Explanation**Form 990, Part III,
Line 4d Other
Program Services
Description

OTHER PROGRAM SERVICES 4 Sage View mental health, Community Education and rents from affiliates OTHER PROGRAM SERVICES 5 St Charles Prineville OTHER PROGRAM SERVICES 6 St Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Charles Health System These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care SCMG provided 147,863 visits in Bend clinics, 62,000 visits in Redmond clinics, 8,362 visits in the Sisters clinic, 26,620 visits in Prineville clinics and 6,585 in the Madras Clinic in 2015 SCMG also operates an immediate care clinic to provide low-cost urgent care services to the community, the immediate care clinic provided services for 16,167 patient visits in 2015 OTHER PROGRAM SERVICES 7 Home Health/Hospice

| Return Reference | Explanation |
|---|---|
| Form 990, Part VI, Line 11b Form 990 Review Process | The 990 was prepared internally and reviewed by an external consultant. It was reviewed by the organization's Director of Finance and the CFO, both CPAs. It was also sent to each Board member and an acknowledgment of receipt and review is required by each member. It was presented to the Finance and Strategy Committee on behalf of the Board of Directors for final review and approval before filing. |

| Return Reference | Explanation |
|---|--|
| Form 990, Part VI, Line 12c Explanation of Monitoring and Enforcement of Conflicts | <p>The policy covers any SCHS director, principal officer, or member of a committee (hereinafter referred to as fiduciary) with powers delegated by the SCHS Board of Directors (the Board) who has a direct or indirect financial interest in SCHS or any entity within SCHS. This policy is intended to ensure that the business conducted by SCHS is free from the influence of actual or potential conflicts of interests by any SCHS fiduciary. Each fiduciary shall annually complete the Conflict of Interest Questionnaire. This completed form is automatically submitted to the SCHS Compliance Officer who will evaluate the completed forms and present a report to the Governance Committee. The fiduciary is also required to update his/her responses to the Conflict of Interest Questionnaire should any new information regarding an actual or potential conflict of interest for that fiduciary arise. In addition, should a subsequent conflict arise after the submission of the previously completed Conflict of Interest Questionnaire each fiduciary shall orally disclose, prior to the Board's or the relevant committee's consideration of a proposed transaction or arrangement, the existence of any financial interest that he or she may have with respect to the transaction or arrangement. The board will then review the transaction or arrangement to determine if it is in SCHS's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination, it shall make its decision as to whether to enter into the transaction or arrangement.</p> |

| Return Reference | Explanation |
|---|---|
| Form 990, Part VI, Line 15a Compensation Review & Approval Process - CEO, Top Management | SCHS utilizes an independent outside consultant to provide comparability data regarding compensation for the CEO and top management officials. The analysis covers all elements of total compensation. The CEO compensation is reviewed and approved by the Board of Directors following an annual performance evaluation and compensation review. The evaluation and review process is detailed in the CEO's contract. The most recent study for the CEO and top management officials was performed in November of 2015. |

| Return Reference | Explanation |
|---|---|
| Form 990, Part VI, Line 15b Compensation Review and Approval Process for Officers and Key Employees | <p>SCHS utilizes an independent outside consultant to provide comparability data regarding compensation for the Key Employees. The analysis covers all elements of total compensation. The compensation is reviewed by the Board of Directors following an annual performance evaluation and compensation review. The evaluation and review process is prescribed in an internal policy and the process is documented. The most recent study for the key employees was performed in November of 2015. SCHS utilized an independent outside consultant to determine the pros and cons of establishing board compensation. In February 2010 the consultant presented its findings to the St. Charles board governance committee advising that board members not be involved in determining any level of compensation for the board. An external committee was selected to review the consultants analysis along with management recommendations and agreed that compensation for the SCHS board of directors is warranted and will assist in retaining and recruiting highly qualified board members.</p> |

| Return Reference | Explanation |
|--|--|
| Form 990, Part VI, Line 19 Other Organization Documents Publicly Available | Governing documents are available upon request The Conflict of Interest policy is available to employees through a shared document management system Financial reports are shared with employees monthly Audited financial statements are available to the public upon request and on the internet at www.DACBond.com |

| Return Reference | Explanation |
|--|--|
| Other Changes In Net Assets Or Fund Balances - Other Decreases | DISTRIBUTIONS PAID TO NONCONTROLLING OWNERS = -\$6276931 |

| Return Reference | Explanation |
|--|---|
| Other Changes In Net Assets Or Fund Balances - Other Increases | JOINT VENTURE ASSET ADJUSTMENT = \$6357 |

| Return Reference | Explanation |
|--|--|
| Other Changes In Net Assets Or Fund Balances - Other Decreases | UNRESTRICTED NET ASSETS NON CONTROLLING = -\$0 |

SCHEDULE R
(Form 990)

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

► Attach to Form 990. ► Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

| | |
|--|--|
| Name of the organization St Charles Health System Inc | Employer identification number 93-0602940 |
|--|--|

| Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33. | | | | | |
|--|-------------------------------|--|---------------------|---------------------------|----------------------------------|
| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
| (1) ST CHARLES MANAGEMENT SERVICES ORGANIZA 2500 NE NEFF RD BEND, OR 97701 20-5310273 | PHYS BUS SCVS SEE PART VII | OR | | | SCHS |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year. | | | | | | | |
|---|---|--|----------------------------|---|----------------------------------|--|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
| | | | | | | Yes | No |
| (1)ST CHARLES FOUNDATION 2500 NE NEFF ROAD BEND, OR 97701 94-3076293 | RAISES FUNDS FOR SCHS & CMNTY PROGRAMS | OR | 501(C)(3) | 7 | SCHS | Yes | |
| | | | | | | | |
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| | | | | | | | |
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| | | | | | | | |

Part III

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512- 514) | (f) Share of total income | (g) Share of end- of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|-------------------------|--|--|--|---------------------------------|---|---|----|--|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| (1) CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DRIVE BEND, OR 97701 93-1320712 | IMAGING SERVICES | OR | SCHS | RELATED | 14,554,200 | 13,127,587 | | No | | Yes | | 70 000 % |
| (2) HEART CENTER OF THE CASCADES 2500 NE NEFF RD BEND, OR 97701 38-3724947 | MEDICAL BUILDING | OR | NA | EXCLUDED | 174,020 | -1,712,656 | | No | | Yes | | 50 000 % |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
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Part IV

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end- of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|--|-------------------------|---|-------------------------------------|---|---------------------------------|---|--------------------------------|--|----|
| | | | | | | | | Yes | No |
| | | | | | | | | | |
| | | | | | | | | | |
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Part V

Transactions With Related Organizations

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

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

1

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

a

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

1a

No

b

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

1b

No

c

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

1c

Yes

d

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

1d

Yes

e

Loans or loan guarantees by related organization(s)

1e

No

f

Dividends from related organization(s)

1f

No

g

Sale of assets to related organization(s)

1g

No

h

Purchase of assets from related organization(s)

1h

No

i

Exchange of assets with related organization(s)

1i

No

j

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

1j

Yes

k

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

1k

Yes

l

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

1l

No

m

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

1m

Yes

n

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

1n

Yes

o

Sharing of paid employees with related organization(s)

1o

Yes

p

Reimbursement paid to related organization(s) for expenses

1p

Yes

q

Reimbursement paid by related organization(s) for expenses

1q

Yes

r

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

1r

Yes

s

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

1s

Yes

| 2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds | | | |
|---|----------------------------------|------------------------|--|
| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
| See Additional Data Table | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

[illegible]

Part VII **Supplemental Information**

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

| Return Reference | Explanation |
|------------------|--|
| PART I | ST CHARLES MANAGEMENT SERVICES ORGANIZATION (SCMSO) INCLUDES BOTH MANAGEMENT SERVICES AND PHYSICIAN CLINICS ST CHARLES CEASED PROVIDING THESE PHYSICIAN BUSINESS SERVICES IN 2013 AND THEREFORE NO ACTIVITY IS IN INCLUDED IN ST CHARLES 2015 INCOME OR EXPENSES END-OF-YEAR ASSETS FOR SCMSO ARE NOT REPORTED IN PART I BECAUSE SEPARATE BALANCE SHEETS WERE NOT MAINTAINED FOR THIS ORGANIZATION |

Additional Data

Software ID: 15000324
Software Version: 2015v2.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

| (a) Name of related organization | | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|-------------------------------------|------------------------------|---------------------------------|------------------------|---|
| (1) | ST CHARLES FOUNDATION | c | 1,727,652 | CASH/BOOK VALUE |
| (1) | ST CHARLES FOUNDATION | o | 648,267 | BOOK VALUE |
| (2) | ST CHARLES FOUNDATION | r | 195,622 | BOOK VALUE |
| (3) | CASCADE MEDICAL IMAGING LLC | j | 170,330 | BOOK VALUE |
| (4) | CASCADE MEDICAL IMAGING LLC | m | 23,912,198 | BOOK VALUE |
| (5) | CASCADE MEDICAL IMAGING LLC | p | 96,839 | BOOK VALUE |
| (6) | CASCADE MEDICAL IMAGING LLC | q | 2,305,419 | BOOK VALUE |
| (7) | CASCADE MEDICAL IMAGING LLC | s | 14,646,173 | CASH |
| (8) | HEART CENTER OF THE CASCADES | d | 4,463,000 | BOOK VALUE |
| (9) | HEART CENTER OF THE CASCADES | k | 1,512,000 | CASH |
| (10) | HEART CENTER OF THE CASCADES | m | 326,162 | BOOK VALUE |
| (11) | HEART CENTER OF THE CASCADES | s | 320,000 | CASH |