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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2016

Open to Public Inspection

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

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

Department of the Treasury
Internal Revenue Service

A For the 2016 calendar year, or tax year beginning 01-01-2016 , and ending 12-31-2016

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final

☒ Return/terminated

☐ Amended return

☐ Application pending

C Name of organization

SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM INC

Doing business as

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

Room/suite

500 ELDORADO BLVD SUITE 4300

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

BROOMFIELD, CO 80021

F Name and address of principal officer

LYDIA JUMONVILLE

500 ELDORADO BLVD SUITE 4300

BROOMFIELD, CO 80021

H(a) Is this a group return for subordinates?

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

If "No," attach a list (see instructions)

H(c) Group exemption number ▶

D Employer identification number

23-7379161

E Telephone number

(303) 813-5190

G Gross receipts \$ 464,201,432

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) () ◀(insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.SCLHEALTH.ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1972

M State of legal domicile KS

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

WE REVEAL AND FOSTER GOD'S HEALING LOVE BY IMPROVING THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

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

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

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

5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

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

7b Net unrelated business taxable income from Form 990-T, line 34

3 20

4 19

5 2,954

6 0

7a -1,688,251

7b -1,962,849

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Prior Year

Current Year

1,844,653 2,510,868

374,990,782 423,557,861

65,683,477 27,121,930

8,549,478 8,554,927

451,068,390 461,745,586

Expenses

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

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

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

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

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

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses Subtract line 18 from line 12

15,517,172 5,917,019

0 0

223,489,307 261,229,095

0 0

297,828,263 324,602,026

536,834,742 591,748,140

-85,766,352 -130,002,554

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances Subtract line 21 from line 20

Beginning of Current Year

End of Year

2,439,912,230 2,405,899,688

2,972,946,859 2,302,998,525

-533,034,629 102,901,163

Part II Signature Block

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

Sign Here

Signature of officer

2017-11-06

Date

LYDIA JUMONVILLE PRESIDENT & CEO/CFO

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

KELLEY SIMON

Preparer's signature

KELLEY SIMON

Date

Check ☐ if self-employed

PTIN

P00791436

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶ 34-6565596

Firm's address ▶ 370 17TH STREET 3300

Phone no (720) 931-4000

DENVER, CO 80202

May the IRS discuss this return with the preparer shown above? (see instructions)

☐ Yes ☒ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2016)

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

WE REVEAL AND FOSTER GOD'S HEALING LOVE BY IMPROVING THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

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

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

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

If "Yes," describe these changes on Schedule O

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

| | | | | |
|---------------------|---------|--------------------------|------------------------------------|---------------------------|
| 4a | (Code) | (Expenses \$ 575,582,607 | including grants of \$ 5,917,019) | (Revenue \$ 431,973,750) |
| See Additional Data | | | | |

| | | | | |
|-----------|---------|--------------|------------------------|---------------|
| 4b | (Code) | (Expenses \$ | including grants of \$ | (Revenue \$) |
|-----------|---------|--------------|------------------------|---------------|

| | | | | |
|-----------|---------|--------------|------------------------|---------------|
| 4c | (Code) | (Expenses \$ | including grants of \$ | (Revenue \$) |
|-----------|---------|--------------|------------------------|---------------|

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

| | | |
|-----------|---|-------------|
| 4e | Total program service expenses ▶ | 575,582,607 |
|-----------|---|-------------|

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 Yes | |
| 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 Yes | |
| 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 | No |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII | 12a | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | 14b Yes | |
| 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 |

Part IV Checklist of Required Schedules (continued)

| | Yes | No |
|---|----------------|----|
| 20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b Yes | |
| 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <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 Yes | |
| 23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 23 Yes | |
| 24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 24a 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 | No |
| 27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | 27 | No |
| 28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | No |
| b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | No |
| c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | No |
| 29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | No |
| 30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 | No |
| 31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | No |
| 32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 32 | No |
| 33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> | 33 Yes | |
| 34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> | 34 Yes | |
| 35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a Yes | |
| b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b Yes | |
| 36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 36 | No |
| 37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> | 37 | No |
| 38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O | 38 Yes | |

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

| | | Yes | No |
|------------|--|-------|----|
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. | 490 | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | 0 | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 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. | 2,954 | |
| 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). | Yes | |
| 3a | Did the organization have unrelated business gross income of \$1,000 or more during the year? | 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. | Yes | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | Yes | |
| b | If "Yes," enter the name of the foreign country: CJ, EI 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? | | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | No |
| c | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | | |
| 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? | | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | |
| 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? | | No |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year. | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | |
| 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? | | |
| 9a | Did the sponsoring organization make any taxable distributions under section 4966? | | |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | | |
| 10 | Section 501(c)(7) organizations. Enter | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12. | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. | | |
| 11 | Section 501(c)(12) organizations. Enter | | |
| a | Gross income from members or shareholders. | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them). | | |
| 12a | Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year. | | |
| 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. | | |
| 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. | | |
| c | Enter the amount of reserves on hand. | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | | No |
| b | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O. | | |

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.Check if Schedule O contains a response or note to any line in this Part VI. ☒**Section A. Governing Body and Management**

| | | Yes | No |
|--|--------------|-----|----|
| 1a Enter the number of voting members of the governing body at the end of the tax year | 1a 20 | | |
| If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | | |
| b Enter the number of voting members included in line 1a, above, who are independent | 1b 19 | | |
| 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | | No |
| 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | | No |
| 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | No |
| 5 Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | No |
| 6 Did the organization have members or stockholders? | 6 | Yes | |
| 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | Yes | |
| b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | Yes | |
| 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | | |
| a The governing body? | 8a | Yes | |
| b Each committee with authority to act on behalf of the governing body? | 8b | Yes | |
| 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O. | 9 | | No |

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

| | Yes | No |
|---|------------|-----|
| 10a Did the organization have local chapters, branches, or affiliates? | 10a | 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▶ | |
| 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. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> 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. ▶KYLE ENGMAN 500 ELDORADO BLVD SUITE 4200 BROOMFIELD, CO 80021 (303) 813-5543 | |

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

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

Form **990** (2016)

[illegible]

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 ▶ 500

Section B. Independent Contractors

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|--------------------------------|---------------------|
| CHG COMPANIES INC PO BOX 972651 DALLAS, TX 75397 | CONTRACT LABOR | 6,263,510 |
| DENTONS US LLP 233 S WACKER DRIVE STE 7800 CHICAGO, IL 60606 | LEGAL SERVICES | 4,412,055 |
| WEATHERBY LOCUMS INC PO BOX 972633 DALLAS, TX 75397 | CONTRACT LABOR | 3,109,805 |
| ERNST & YOUNG US LLP 200 PLAZA DR SECAUCUS, NJ 07094 | AUDIT SERVICES | 1,861,566 |
| CONTINUUM HEALTH SOLUTIONS LLC 8100 E ARPAHOE ROAD CENTENNIAL, CO 80112 | CONSULTING SERVICES | 1,804,808 |

| | |
|--|--|
| <p>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 ► 100</p> | |
|--|--|

Part VIII Statement of RevenueCheck 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 | 2,077,223 | | | | |
| | e Government grants (contributions) | 1e | 433,645 | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | | |
| | g Noncash contributions included in lines 1a-1f \$ _____ | | | | | | |
| | h Total. Add lines 1a-1f | | 2,510,868 | | | | |
| Program Service Revenue | | Business Code | | | | | |
| | 2a MANAGEMENT SERVICES | 541900 | 340,416,425 | 340,386,425 | 30,000 | | |
| | b PATIENT SERVICE REVENUE | 622110 | 66,785,597 | 66,753,807 | 31,790 | | |
| | c PROGRAM RELATED INVESTMENTS | 900099 | 22,587,374 | 22,587,374 | | | |
| | d JOINT VENTURES - MEDICAL SERVICE | 622110 | -6,231,535 | -6,231,535 | | | |
| | e _____ | | | | | | |
| | f All other program service revenue | | | | | | |
| g Total. Add lines 2a-2f | | 423,557,861 | | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | 18,581,842 | | -1,750,041 | 20,331,883 | |
| | 4 Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 Royalties | | 67,929 | | | 67,929 | |
| | 6a Gross rents | (i) Real | (ii) Personal | | | | |
| | | 71,109 | | | | | |
| | | b Less rental expenses | 0 | | | | |
| | | c Rental income or (loss) | 71,109 | | | | |
| | d Net rental income or (loss) | | 71,109 | | | 71,109 | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | |
| | | 10,950,934 | 45,000 | | | | |
| | | b Less cost or other basis and sales expenses | 0 | 2,455,846 | | | |
| | | c Gain or (loss) | 10,950,934 | -2,410,846 | | | |
| | d Net gain or (loss) | | 8,540,088 | | | 8,540,088 | |
| | 8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | | | | | | |
| | a | | | | | | |
| | b Less direct expenses | | | | | | |
| | c Net income or (loss) from fundraising events | | | | | | |
| 9a Gross income from gaming activities See Part IV, line 19 | | | | | | | |
| a | | | | | | | |
| b Less direct expenses | | | | | | | |
| c Net income or (loss) from gaming activities | | | | | | | |
| 10a Gross sales of inventory, less returns and allowances | | | | | | | |
| a | | | | | | | |
| b Less cost of goods sold | | | | | | | |
| c Net income or (loss) from sales of inventory | | | | | | | |
| Miscellaneous Revenue | | Business Code | | | | | |
| 11a VENDOR ADMINISTRATION REBATE | | 900099 | 8,415,889 | 8,415,889 | | | |
| b _____ | | | | | | | |
| c _____ | | | | | | | |
| d All other revenue | | | | | | | |
| e Total. Add lines 11a-11d | | | 8,415,889 | | | | |
| 12 Total revenue. See Instructions | | | 461,745,586 | 431,911,960 | -1,688,251 | 29,011,009 | |

Part IX Statement of Functional Expenses

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

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

| | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|-----------------------|---------------------------------|--|-----------------------------|
| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | | | |
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21. | 5,846,739 | 5,846,739 | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22. | 70,280 | 70,280 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16. | | | | |
| 4 Benefits paid to or for members. | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees. | 11,383,131 | 7,402,598 | 3,980,533 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). | | | | |
| 7 Other salaries and wages. | 201,274,936 | 201,274,936 | | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions). | 9,652,276 | 9,652,276 | | |
| 9 Other employee benefits. | 23,248,009 | 23,248,009 | | |
| 10 Payroll taxes. | 15,670,743 | 15,670,743 | | |
| 11 Fees for services (non-employees): | | | | |
| a Management. | | | | |
| b Legal. | 10,124,272 | | 10,124,272 | |
| c Accounting. | 1,672,422 | | 1,672,422 | |
| d Lobbying. | 164,802 | | 164,802 | |
| e Professional fundraising services. See Part IV, line 17. | | | | |
| f Investment management fees. | 223,504 | | 223,504 | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). | 23,808,816 | 23,808,816 | | |
| 12 Advertising and promotion. | 6,780,981 | 6,780,981 | | |
| 13 Office expenses. | 25,654,781 | 25,654,781 | | |
| 14 Information technology. | 9,724,231 | 9,724,231 | | |
| 15 Royalties. | | | | |
| 16 Occupancy. | 12,214,874 | 12,214,874 | | |
| 17 Travel. | 4,174,728 | 4,174,728 | | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials. | | | | |
| 19 Conferences, conventions, and meetings. | 1,746,608 | 1,746,608 | | |
| 20 Interest. | 126,516,709 | 126,516,709 | | |
| 21 Payments to affiliates. | | | | |
| 22 Depreciation, depletion, and amortization. | 38,942,855 | 38,942,855 | | |
| 23 Insurance. | 1,471,503 | 1,471,503 | | |
| 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 MAINTENANCE CONTRACTS | 34,208,922 | 34,208,922 | | |
| b BANK FEES | 8,302,946 | 8,302,946 | | |
| c COLLECTION AGENCIES | 5,244,674 | 5,244,674 | | |
| d MEDICAL SUPPLIES | 4,963,845 | 4,963,845 | | |
| e All other expenses | 8,660,553 | 8,660,553 | | |
| 25 Total functional expenses. Add lines 1 through 24e. | 591,748,140 | 575,582,607 | 16,165,533 | 0 |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). | | | | |

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

| | | | | (A) Beginning of year | | (B) End of year |
|------------------------------------|--|---|---------------|--------------------------|---------------|--------------------|
| Assets | 1 | Cash—non-interest-bearing | | | 1 | |
| | 2 | Savings and temporary cash investments | | 44,421,354 | 2 | 128,199,906 |
| | 3 | Pledges and grants receivable, net | | 150,227 | 3 | 47,906 |
| | 4 | Accounts receivable, net | | 5,947,634 | 4 | 5,777,838 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | | 5 | |
| | 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 | |
| | 7 | Notes and loans receivable, net | | 304,508 | 7 | 404,056 |
| | 8 | Inventories for sale or use | | | 8 | 6,127 |
| | 9 | Prepaid expenses and deferred charges | | 14,432,452 | 9 | 21,834,032 |
| | 10a | Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D | 10a | 430,747,212 | | |
| | b | Less: accumulated depreciation | 10b | 211,237,735 | | |
| | | | | 225,949,295 | 10c | 219,509,477 |
| | 11 | Investments—publicly traded securities | | 1,117,812,707 | 11 | 1,056,299,971 |
| | 12 | Investments—other securities. See Part IV, line 11 | | 506,412,767 | 12 | 483,727,675 |
| | 13 | Investments—program-related. See Part IV, line 11 | | 510,330,252 | 13 | 488,574,692 |
| | 14 | Intangible assets | | 1,417,333 | 14 | 195,072 |
| 15 | Other assets. See Part IV, line 11 | | 12,733,701 | 15 | 1,322,936 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 2,439,912,230 | 16 | 2,405,899,688 | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 127,128,973 | 17 | 123,530,581 |
| | 18 | Grants payable | | | 18 | |
| | 19 | Deferred revenue | | 94,412 | 19 | 609,742 |
| | 20 | Tax-exempt bond liabilities | | 1,487,706,042 | 20 | 1,296,666,898 |
| | 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 | | | 23 | |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | 24 | |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | | 1,358,017,432 | 25 | 882,191,304 |
| | 26 | Total liabilities. Add lines 17 through 25 | | 2,972,946,859 | 26 | 2,302,998,525 |
| 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 | | -549,999,666 | 27 | 84,640,146 |
| | 28 | Temporarily restricted net assets | | 14,965,037 | 28 | 16,261,017 |
| | 29 | Permanently restricted net assets | | 2,000,000 | 29 | 2,000,000 |
| | 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 | | -533,034,629 | 33 | 102,901,163 |
| | 34 | Total liabilities and net assets/fund balances | | 2,439,912,230 | 34 | 2,405,899,688 |

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

| | | | |
|-----------|---|-----------|--------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 461,745,586 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 591,748,140 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | -130,002,554 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | -533,034,629 |
| 5 | Net unrealized gains (losses) on investments | 5 | 63,425,630 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 702,512,716 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 102,901,163 |

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

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

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Form 990 (2016)

Form 990, Part III, Line 4a:

SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) IS A FAITH-BASED, NONPROFIT HEALTHCARE ORGANIZATION THAT OPERATES NINE HOSPITALS, TWO SAFETY NET CLINICS, ONE CHILDREN'S MENTAL HEALTH CENTER AND MORE THAN 190 AMBULATORY SERVICE CENTERS IN THREE STATES - COLORADO, KANSAS AND MONTANA. THE HEALTH SYSTEM INCLUDES 15,000 FULL-TIME ASSOCIATES AND MORE THAN 500 EMPLOYED PROVIDERS BASED IN DENVER, THE HEALTH NETWORK IS DEDICATED TO IMPROVING THE HEALTH OF THE COMMUNITIES AND INDIVIDUALS IT SERVES, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE. IN 2016, SCL HEALTH CONTRIBUTED \$257 MILLION IN COMMUNITY BENEFIT, INCLUDING SERVICES FOR THE POOR, HEALTH SCREENINGS, EDUCATIONAL PROGRAMS, COMMUNITY DONATIONS AND RESEARCH. SCL HEALTH WAS FOUNDED BY THE SISTERS OF CHARITY OF LEAVENWORTH (SCL), WHO TRACE THEIR ORIGIN AS A RELIGIOUS COMMUNITY TO THE 1600S IN FRANCE, WHERE VINCENT DE PAUL AND LOUISE DE MARILLAC ESTABLISHED THE DAUGHTERS OF CHARITY. THESE WOMEN WERE DEDICATED TO SERVING THE SICK AND POOR THROUGH AN ACTIVE MINISTRY. IN 1857, A SMALL CONGREGATION OF SISTERS FROM NASHVILLE, TENN., LED BY MOTHER XAVIER ROSS, VENTURED TO THE EDGE OF AN EXPANDING FRONTIER IN THE THEN-INDIAN TERRITORY OF KANSAS. THEY OPENED THE FIRST PRIVATE HOSPITAL IN THE STATE IN 1864, WITH THE FIRST TRAINED NURSE IN THE STATE AND SURELY THE FIRST WOMAN IN THE WESTERN TERRITORY TO RUN A HOSPITAL. IN 1873, THE SISTERS FOUNDED WHAT IS NOW SAINT JOSEPH HOSPITAL IN DENVER, THE OLDEST PRIVATE TEACHING HOSPITAL IN COLORADO, AND ONE OF THE FIVE COLORADO HOSPITALS OF SCL HEALTH. SCL HEALTH WAS FORMED IN 1972 TO STRENGTHEN AND UNIFY THE HEALTHCARE FACILITIES SPONSORED BY SCL. IN 2011, THE SISTERS TRANSFERRED SPONSORSHIP OF SCL HEALTH TO LEAVEN MINISTRIES. OUR ORGANIZATION'S RICH HERITAGE AND ENDURING LEGACY SERVE AS THE FOUNDATION FOR OUR HEALTH MINISTRY TODAY, AND OUR MISSION, VISION AND VALUES SERVE AS THE FRAMEWORK FOR OUR SUCCESS. SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) IS THE PARENT CORPORATION OF A LARGE HOSPITAL AND HEALTHCARE SYSTEM. SCLHS IS THE MANAGEMENT COMPANY PROVIDING CENTRALIZED SERVICES FOR ALL SCL HEALTH SUBSIDIARIES. SCLHS PERFORMS NUMEROUS COORDINATED AND CENTRALIZED SERVICES FOR THE ENTITIES & CARE SITES THAT COMPRISE ITS SYSTEM, SUCH AS ADMINISTERING FINANCING & CAPITAL FORMATION PROGRAMS, ETHICAL & RELIGIOUS DIRECTION, FINANCIAL REPORTING, TAX SERVICES, HUMAN RESOURCES FUNCTIONS INCLUDING EXECUTIVE RECRUITING & ADMINISTERING & MAINTAINING WELFARE, BENEFIT & RETIREMENT PLANS, INFORMATION TECHNOLOGY SERVICES INCLUDING ELECTRONIC MEDICAL RECORD SYSTEMS, BUSINESS MANAGEMENT SYSTEMS, EQUIPMENT & CONNECTIVITY, INTERNAL AUDIT FUNCTIONS, LEGAL SERVICES, PHYSICIAN NETWORK DEVELOPMENT, PROCUREMENT & SUPPLY CHAIN MANAGEMENT, INCLUDING MEDICAL DEVICES, SUPPLIES & EQUIPMENT, PROFESSIONAL LIABILITY INSURANCE THROUGH A CAPTIVE PROVIDER INCLUDING GROUP EXCESS COVERAGE AND REINSURANCE AND LITIGATION MANAGEMENT, PUBLIC RELATIONS, COMMUNICATIONS & LEGISLATIVE AFFAIRS, REAL ESTATE MANAGEMENT SERVICES, INCLUDING LEASING & CONSTRUCTION, PURCHASE & SALE, REGULATORY COMPLIANCE SERVICES, REVENUE CYCLE MANAGEMENT SERVICES INCLUDING BILLING & COLLECTIONS, RISK MANAGEMENT SERVICES INCLUDING SELF-INSURANCE, GROUP EXCESS COVERAGE & REINSURANCE, LITIGATION MANAGEMENT, INSPECTION & CONTROLS. THE CENTRALIZATION OF MANAGEMENT SERVICES PROVIDES FOR HIGH QUALITY, COST EFFECTIVE AND COMPASSIONATE HEALTH CARE MANAGEMENT AND MEDICAL SERVICES FOR THE COMMUNITIES WE SERVE. THEREFORE, THESE MANAGEMENT SERVICES RELATE DIRECTLY TO THE EXEMPT PURPOSE OF OWNING AND MANAGING PUBLIC HOSPITALS AND A HEALTHCARE SYSTEM. OUR MISSION, VISION AND VALUES ARE LISTED BELOW. MISSION: WE REVEAL AND FOSTER GOD'S HEALING LOVE BY IMPROVING THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE. VISION: INSPIRED BY OUR FAITH, WE WILL BE DISTINGUISHED AS THE TRUSTED PERSON-CENTERED PARTNER TO THOSE WHO ENGAGE WITH US IN THEIR PHYSICAL, MENTAL AND SPIRITUAL HEALTH DECISIONS. WE WILL SHARE ACCOUNTABILITY WITH OUR CLINICIANS, ASSOCIATES AND AFFILIATED STAKEHOLDERS TO DELIVER EXCEPTIONAL CARE THAT IS WELL-COORDINATED, ACCESSIBLE, AFFORDABLE, SAFE, AND RESULTS IN OPTIMAL OUTCOMES FOR INDIVIDUALS AND POPULATIONS. WE WILL GROW AS COMMUNITY-BASED HEALTH NETWORKS IN PARTNERSHIP WITH OTHERS WHO SHARE OUR VISION AND VALUES AND ALIGN WITH US TO BE AN ESSENTIAL PROVIDER TO THOSE WE SERVE. VALUES: CARING SPIRIT - WE HONOR THE SACRED DIGNITY OF EACH PERSON. EXCELLENCE - WE SET AND SURPASS HIGH STANDARDS. GOOD HUMOR - WE CREATE JOYFUL AND WELCOMING ENVIRONMENTS. INTEGRITY - WE DO THE RIGHT THING WITH OPENNESS AND PRIDE. SAFETY - WE DELIVER CARE THAT SEEKS TO ELIMINATE ALL HARM FOR PATIENTS AND ASSOCIATES. STEWARDSHIP - WE ARE ACCOUNTABLE FOR THE RESOURCES ENTRUSTED TO US.

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

(A)

(B)

(C)

(D)

(E)

(F)

| Name and Title | Average hours per week (list any hours for related organizations below dotted line) | Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | Reportable compensation from the organization (W- 2/1099-MISC) | Reportable compensation from related organizations (W- 2/1099-MISC) | Estimated amount of other compensation from the organization and related organizations |
|--|---|--|-----------------------|---------|--------------|------------------------------|--------|--|---|--|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| MAUREEN MAHONEY MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| KATHRYN PAUL VICE CHAIR | 2 00 0 00 | X | | X | | | | 0 | 0 | 0 |
| SISTER CONSTANCE PHELPS SCL MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| KENT RUSSELL MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| VINOD SAHNEY PHD MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| MICHAEL SALEM MD MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| MICHAEL SLUBOWSKI SYSTEM PRESIDENT AND CEO | 50 00 0 00 | X | | X | | | | 1,951,205 | 0 | 38,596 |
| J PAUL SOLVERSON MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| MARLA WILLIAMS MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |
| ALAN YORDY MEMBER | 1 00 0 00 | X | | | | | | 0 | 0 | 0 |

| Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors | | | | | | | | | | |
|---|--|---|-----------------------|---------|--------------|------------------------------|--------|---|--|---|
| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| LYDIA JUMONVILLE TREASURER & CFO/EVP | 50 00 0 00 | | | X | | | | 1,012,271 | 0 | 238,836 |
| ROSLAND MCLEOD SECRETARY/SVP CHIEF LEGAL OFFICER | 50 00 0 00 | | | X | | | | 570,645 | 0 | 168,979 |
| LYNN SMITH ASSISTANT SECRETARY/EXEC ASST-CEO | 50 00 0 00 | | | X | | | | 108,004 | 0 | 17,545 |
| MICHAEL TAYLOR CHIEF OPERATING OFF-HOSP OPS | 50 00 0 00 | | | X | | | | 849,356 | 0 | 156,505 |
| WILLIAM ANDERSON SVP-CHIEF HUMAN RESOURCES OFCR | 50 00 0 00 | | | | X | | | 549,453 | 0 | 39,826 |
| STEVEN CHYUNG CHIEF STEWARDSHP & TRNFMN OFC | 50 00 0 00 | | | | X | | | 529,038 | 0 | 96,488 |
| SHAWN DUFFORD SVP CHIEF MEDICAL OFFICER SYS | 50 00 0 00 | | | | X | | | 557,563 | 0 | 109,394 |
| TAJQUAH HUDSON SVP-CHIEF STRAT-BUS DEV OFCR | 50 00 0 00 | | | | X | | | 534,535 | 0 | 143,874 |
| KERRY KOHNEN SVP PAYER & POP HEALTH STRAT | 50 00 0 00 | | | | X | | | 317,041 | 0 | 201 |
| WILLIAM PACK VP FINANCE OPERATIONS 1/1-5/6 | 50 00 0 00 | | | | X | | | 192,388 | 0 | 66,404 |

| 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 | | | |
| DAVID PECORARO SVP-CHIEF INFORMATION OFFICER | 50 00 0 00 | | | | X | | | 599,562 | 0 | 37,290 |
| DAVID PRINGLE SVP MISSION INTEGRATION | 50 00 0 00 | | | | X | | | 378,720 | 0 | 68,345 |
| KAREN SCREMIN VP FINANCE OPERATIONS | 50 00 0 00 | | | | X | | | 342,779 | 0 | 54,820 |
| TROY SPRING VP REVENUE CYCLE | 50 00 0 00 | | | | X | | | 276,110 | 0 | 61,406 |
| GERALDINE TOWNDROW SVP CHIEF NURSING OFFICER SYS | 50 00 0 00 | | | | X | | | 402,244 | 0 | 22,315 |
| MARK WILKINSON VP TREASURER | 50 00 0 00 | | | | X | | | 355,496 | 0 | 53,651 |
| CHRISTINE WOOLSEY SVP AND CHIEF COMM-MKTG OFCR | 50 00 0 00 | | | | X | | | 384,431 | 0 | 97,819 |
| GRANT WICKLUND PRESIDENT-CEO LMC | 0 00 50 00 | | | | | X | | 555,162 | 0 | 263,703 |
| WILLIAM ANDERSON MEDICAL DIRECTOR | 0 00 50 00 | | | | | X | | 724,399 | 0 | 42,035 |
| DAVID HAMM PRESIDENT-CEO EGSM | 0 00 50 00 | | | | | X | | 530,418 | 0 | 208,359 |

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 | | | |
| STEVE LOVELESS PRESIDENT CEO SVH-MT REG | 0 00 50 00 | | | | | X | | 628,244 | 0 | 97,110 |
| THOMAS PETERSON CHIEF SAFETY OFFICER 1/1-9/9 | 50 00 0 00 | | | | | X | | 513,397 | 0 | 35,018 |
| ROBERT LADENBURGER FORMER KEY EMPLOYEE | 0 00 0 00 | | | | | | X | 323,002 | 0 | 6,893 |

SCHEDULE A

(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Employer identification number
23-7379161

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))
- 3

☐

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10

☐

An organization that normally receives (1) more than 33¹/₃% 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 33¹/₃% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☒

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- a

☐

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

☐

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

☒

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

☐

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

☐

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

Enter the number of supported organizations

11
- g

Provide the following information about the supported organization(s)

| (i)Name of supported organization | (ii)EIN | (iii) Type of organization (described on lines 1- 10 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|-----------------------------------|---------|--|---|----|---|---|
| | | | Yes | No | | |
| See Additional Data Table | | | | | | |
| Total | 11 | | | | 785,189 | 0 |

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, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

| Section A. Public Support | | | | | | |
|---|---------|---------|---------|---------|---------|----------|
| Calendar year (or fiscal year beginning in) ▶ | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (f)Total |
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public support. Subtract line 5 from line 4 | | | | | | |

| Section B. Total Support | | | | | | |
|---|---------|---------|---------|---------|---------|----------|
| Calendar year (or fiscal year beginning in) ▶ | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (f)Total |
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ | | | | | | |

Section C. Computation of Public Support Percentage

| | | | |
|-----|--|----|--|
| 14 | Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)) | 14 | |
| 15 | Public support percentage for 2015 Schedule A, Part II, line 14 | 15 | |
| 16a | 33 1/3% support test—2016. 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—2015. 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—2016. 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—2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/> | | |
| 18 | Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/> | | |

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | (a)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (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)2012 | (b)2013 | (c)2014 | (d)2015 | (e)2016 | (f)Total |
|---|---------|---------|---------|---------|---------|----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |

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

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2015 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2015 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2016. 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—2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

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> | | |
| 1 | | |
| 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> | | |
| 2 | | |

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> | | |
| 1 | | |

Section D. All Type III Supporting Organizations

| | Yes | No |
|---|-----|----|
| 1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided? | | |
| 1 | Yes | |
| 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> | | |
| 2 | Yes | |
| 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> | | |
| 3 | | No |

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 checked="" 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. | | Yes | No |
| 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> | | | |
| 2a | | | |
| 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> | | | |
| 2b | | | |
| 3 Parent of Supported Organizations Answer (a) and (b) below. | | | |
| a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i> | | Yes | |
| 3a | | | |
| b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i> | | | |
| 3b | Yes | | |

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 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) | | |

Part V

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

| Section D - Distributions | Current Year |
|--|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2016 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-2016 | (iii) Distributable Amount for 2016 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2016 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2016 | | | |
| a | | | |
| b | | | |
| c From 2013. | | | |
| d From 2014. | | | |
| e From 2015. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2016 distributable amount | | | |
| i Carryover from 2011 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2016 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2016 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2017. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b Excess from 2013. | | | |
| c Excess from 2014. | | | |
| d Excess from 2015. | | | |
| e Excess from 2016. | | | |

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**990 Schedule A, Supplemental Information**

| Return Reference | Explanation |
|--|--|
| SCHEDULE A, PART IV, SECTION A, LINE 1 | THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC IS THE PARENT OF EACH OF ITS SUPPORTED ORGANIZATIONS AND CONTROLS THEM AS PART OF AN INTEGRATED HEALTH SYSTEM EACH SUPPORTED ORGANIZATION IS CONTROLLED BY THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC A CLOSE AND HISTORIC ORGANIZATIONAL RELATIONSHIP ENSURES THAT SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC AND ITS SUPPORTED ORGANIZATIONS SHARE A SUBSTANTIAL IDENTITY OF INTERESTS |

990 Schedule A, Supplemental Information

| Return Reference | Explanation |
|---|--|
| SCHEDULE A, PART IV, SECTION A, LINE 5A | ORGANIZATION ADDED BRIGHTON COMMUNITY HOSPITAL ASSOCIATION 84-0482695 BRIGHTON COMMUNITY HOSPITAL ASSOCIATION WAS ACQUIRED IN LATE 2015 SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC CONSIDERS BRIGHTON COMMUNITY HOSPITAL ASSOCIATION A SUPPORTED ORGANIZATION STARTING IN 2016 |

990 Schedule A, Supplemental Information

| Return Reference | Explanation |
|--|--|
| SCHEDULE A, PART IV, SECTION A, LINE 6 | SUPPORT WAS PROVIDED TO MEDICAL AND OTHER CHARITABLE ORGANIZATIONS NOT CONSIDERED SUPPORTED ORGANIZATIONS HOWEVER, THESE INSTITUTIONS ARE SUPPORTING MEDICAL AND OTHER ACTIVITIES BENEFITING THE COMMUNITIES SERVED BY SUPPORTED ORGANIZATIONS AMOUNTS GRANTED ARE INSIGNIFICANT TO THE OVERALL OPERATIONS OF SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC |

990 Schedule A, Supplemental Information

| Return Reference | Explanation |
|---|--|
| SCHEDULE A, PART IV, SECTION E, LINE 3A | SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) IS THE SOLE MEMBER OF THE SUPPORTED ORGANIZATIONS SCLHS APPOINTS MEMBERS OF THE SUPPORTED ORGANIZATIONS' BOARD OF DIRECTORS |

990 Schedule A, Supplemental Information

| Return Reference | Explanation |
|---|--|
| SCHEDULE A, PART IV, SECTION E, LINE 3B | SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) HAS CERTAIN RESERVE POWERS TO APPROVE CHANGES TO THE ARTICLES OF INCORPORATION AND THE BYLAWS INCLUDING THE APPOINTMENT OR REMOVAL OF BOARD MEMBERS AND THE PRESIDENT/CEO SCLHS ALSO HAS CERTAIN RESERVE POWERS OVER ANY CHANGE IN OWNERSHIP OF THE CORPORATION, CHANGE IN MISSION, ACQUISITION OF ASSETS, DISPOSAL OF ASSETS, LEASING OF ASSETS, INCURRENCE OF DEBT, MERGER OR DISSOLUTION, APPROVAL OF STRATEGIC PLANS AND BUDGETS, APPOINTMENT OF AUDITORS AND OVERSIGHT AND APPROVAL OF COMPENSATION AND BENEFITS FOR DIRECTORS, OFFICERS, KEY EMPLOYEES AND PHYSICIANS |



Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Form 990, Sch A, Part I, Line 12g - 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 | | |
| (A) ST FRANCIS HEALTH CENTER INC | 480547719 | 3 | | No | 0 | 0 |
| (A) ST FRANCIS HEALTH CENTER INC | 480547719 | 3 | | No | 0 | 0 |
| (A) ST JAMES HEALTHCARE | 810231785 | 3 | | No | 0 | 0 |
| (A) ST JAMES HEALTHCARE | 810231785 | 3 | | No | 0 | 0 |
| (B) SAINT JOSEPH HOSPITAL INC | 840417134 | 3 | | No | 0 | 0 |
| (B) SAINT JOSEPH HOSPITAL INC | 840417134 | 3 | | No | 0 | 0 |
| (C) SCL HEALTH - FRONT RANGE INC | 841103606 | 3 | | No | 0 | 0 |
| (C) SCL HEALTH - FRONT RANGE INC | 841103606 | 3 | | No | 0 | 0 |
| (D) ST MARY'S HOSPITAL AND MEDICAL CENTER INC | 840425720 | 3 | | No | 0 | 0 |
| (D) ST MARY'S HOSPITAL AND MEDICAL CENTER INC | 840425720 | 3 | | No | 0 | 0 |
| (E) ST VINCENT HEALTHCARE | 810232124 | 3 | | No | 0 | 0 |
| (E) ST VINCENT HEALTHCARE | 810232124 | 3 | | No | 0 | 0 |
| (F) HOLY ROSARY HEALTHCARE | 810231792 | 3 | | No | 0 | 0 |
| (F) HOLY ROSARY HEALTHCARE | 810231792 | 3 | | No | 0 | 0 |
| (G) CARITAS CLINICS INC | 481009910 | 3 | | No | 64,929 | 0 |
| (G) CARITAS CLINICS INC | 481009910 | 3 | | No | 64,929 | 0 |
| (H) MARIAN CLINIC INC | 481046905 | 3 | | No | 92,411 | 0 |
| (H) MARIAN CLINIC INC | 481046905 | 3 | | No | 92,411 | 0 |
| (I) MOUNT ST VINCENT HOME | 840405260 | 10 | | No | 627,849 | 0 |
| (I) MOUNT ST VINCENT HOME | 840405260 | 10 | | No | 627,849 | 0 |
| (J) BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | 840482695 | 3 | | No | 0 | 0 |
| (J) BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | 840482695 | 3 | | No | 0 | 0 |

| | | |
|---|--|---|
| SCHEDULE C (Form 990 or 990-EZ) | 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 2016 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 SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM INC | Employer identification number 23-7379161 |
|--|---|

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 type="checkbox"/> No |
| 4a | Was a correction made? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b | If "Yes," describe in Part IV | |

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

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

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

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**A** Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)**B** Check ☐ if the filing organization checked box A and "limited control" provisions apply**Limits on Lobbying Expenditures**
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing
organization's
totals**(b)** Affiliated
group totals**1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)**b** Total lobbying expenditures to influence a legislative body (direct lobbying)**c** Total lobbying expenditures (add lines 1a and 1b)**d** Other exempt purpose expenditures**e** Total exempt purpose expenditures (add lines 1c and 1d)**f** Lobbying nontaxable amount Enter the amount from the following table in both columns

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

g Grassroots nontaxable amount (enter 25% of line 1f)**h** Subtract line 1g from line 1a If zero or less, enter -0-**i** Subtract line 1f from line 1c If zero or less, enter -0-**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

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

Lobbying Expenditures During 4-Year Averaging Period

| Calendar year (or fiscal year beginning in) | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) Total |
|---|----------|----------|----------|----------|-----------|
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

| | | (a) | | (b) |
|-----------|--|-----|----|---------|
| | | Yes | No | Amount |
| 1 | During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 164,802 |
| j | Total. Add lines 1c through 1i | | | 164,802 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

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

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

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

Part IV Supplemental Information

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

| Return Reference | Explanation |
|-------------------|---|
| PART II-B, LINE 1 | LOBBYING EXPENSES OF \$64,802 WERE DERIVED AS A PERCENTAGE OF DUES PAID TO THE AMERICAN HOSPITAL ASSOCIATION. ADDITIONAL LOBBYING EXPENSES OF \$100,000 WERE DERIVED FROM FEES FOR ADVOCACY SERVICES TO DEFEAT COLORADO AMENDMENT 69. |

| | | | | | | | | | | | | | |
|---|---|--|--|---|--|----|-----------------------------|----|--|----|--|----|--|
| efile GRAPHIC print - DO NOT PROCESS | | As Filed Data - | | DLN: 93493310019757 | | | | | | | | | |
| <div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div> | | <div>Supplemental Financial Statements</div> <div>► 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.</div> <div>Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.</div> | | | <div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div> | | | | | | | | |
| <div>Name of the organization</div> <div>SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM INC</div> | | | | <div>Employer identification number</div> <div>23-7379161</div> | | | | | | | | | |
| <div>Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 6.</div> | | | | | | | | | | | | | |
| | | (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</div> <div><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</div> <div><input type="checkbox"/> No</div> | | | | | | | | |
| <div>Part II Conservation Easements.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 7.</div> | | | | | | | | | | | | | |
| 1 | Purpose(s) of conservation easements held by the organization (check all that apply) <div><div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education)</div><div><input type="checkbox"/> Preservation of an historically important land area</div><div><input type="checkbox"/> Protection of natural habitat</div><div><input type="checkbox"/> Preservation of a certified historic structure</div><div><input type="checkbox"/> Preservation of open space</div></div> | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | |
| a | Total number of conservation easements | <table><tr><td>2a</td><td>Held at the End of the Year</td></tr><tr><td>2b</td><td></td></tr><tr><td>2c</td><td></td></tr><tr><td>2d</td><td></td></tr></table> | | | | 2a | Held at the End of the Year | 2b | | 2c | | 2d | |
| 2a | Held at the End of the Year | | | | | | | | | | | | |
| 2b | | | | | | | | | | | | | |
| 2c | | | | | | | | | | | | | |
| 2d | | | | | | | | | | | | | |
| 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? | | | | <div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div> | | | | | | | | |
| 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)? | | | | <div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div> | | | | | | | | |
| 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 | | | | | | | | | | | | |
| <div>Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, line 8.</div> | | | | | | | | | | | | | |
| 1a | If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items | | | | | | | | | | | | |
| b | If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items | | | | | | | | | | | | |
| (i) Revenue included on Form 990, Part VIII, line 1 | | ► \$ | | | | | | | | | | | |
| (ii) Assets included in Form 990, Part X | | ► \$ | | | | | | | | | | | |
| 2 | If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items | | | | | | | | | | | | |
| a | Revenue included on Form 990, Part VIII, line 1 | ► \$ | | | | | | | | | | | |
| b | Assets included in Form 990, Part X | ► \$ | | | | | | | | | | | |
| For Paperwork Reduction Act Notice, see the Instructions for Form 990. | | | | | | | | | | | | | |
| | | Cat No 52283D | | Schedule D (Form 990) 2016 | | | | | | | | | |

Part III

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

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

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

2a

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

☐ Yes

☐ No

b

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

☐

Part V

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

| | (a)Current year | (b)Prior year | (c)Two years back | (d)Three years back | (e)Four years back |
|--|-----------------|---------------|-------------------|---------------------|--------------------|
| 1a Beginning of year balance | 2,000,000 | 3,813,121 | 3,663,849 | 3,521,063 | 3,524,552 |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | | 25,463 | 149,272 | 142,786 | 140,511 |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | 1,838,584 | | | 144,000 |
| f Administrative expenses | | | | | |
| g End of year balance | 2,000,000 | 2,000,000 | 3,813,121 | 3,663,849 | 3,521,063 |

2

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

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶ 100 000 %

c

Temporarily restricted endowment ▶

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

b

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

Yes

No

3a(i)

No

3a(ii)

No

3b

4

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

Part VI

Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 37,697,596 | | 37,697,596 |
| b Buildings | | 16,533,199 | 9,428,286 | 7,104,913 |
| c Leasehold improvements | | 15,511,278 | 6,573,306 | 8,937,972 |
| d Equipment | | 338,216,369 | 195,236,143 | 142,980,226 |
| e Other | | 22,788,770 | | 22,788,770 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶ | | | | 219,509,477 |

Part VII

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

| (a)Description of security or category (including name of security) | (b)Book value | (c)Method of valuation Cost or end-of-year market value |
|--|------------------|--|
| (1)Financial derivatives | | |
| (2)Closely-held equity interests | | |
| (3)Other | | |
| See Additional Data Table (A) | | |
| (B) | | |
| (C) | | |
| (D) | | |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 12) | ▶ 483,727,675 | |

Part VIII

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

| (a)Description of investment | (b)Book value | (c)Method of valuation Cost or end-of-year market value |
|---|---------------|--|
| (1)NOTES REC - ST JOSEPH HOSPITAL, INC | 193,659,180 | C |
| (2)NOTES REC - SCL HEALTH - FRONT RANGE, INC | 274,650,000 | C |
| (3)NOTES REC - ST JAMES HEALTHCARE | 5,637,379 | C |
| (4)NOTES REC - ST MARY'S HOSPITAL & MEDICAL CENTER, INC | 14,628,133 | C |
| (4) | | |
| (5) | | |
| (6) | | |
| (7) | | |
| (8) | | |
| (9) | | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 13) | ▶ 488,574,692 | |

Part IX

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

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

Part X

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

| 1.(a)Description of liability | (b)Book value |
|---|---------------|
| (1)Federal income taxes | |
| INTERCOMPANY PAYABLE | 819,760,694 |
| DEFERRED COMPENSATION PLAN PAYABLE | 43,741,875 |
| INTEREST RATE SWAP PAYABLE | 18,496,758 |
| INFORMATION TECHNOLOGY SERVICES PAYABLE | 191,977 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25) | ▶ 882,191,304 |

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

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

Part XIII Supplemental Information *(continued)*

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

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Form 990, Schedule D, Part VII - Investments Other Securities

| (a) Description of security or cateory (including name of security) | (b)Book value | (c) Method of valuation Cost or end-of-year market value |
|--|---------------|---|
| (3)Other (A) VHA STOCK INVESTMENT | 621,978 | F |
| (3)Other (A) ABSOLUTE RETURN INVESTMENTS | 7,317,967 | F |
| (B) TACTICAL - PINEBRIDGE | 92,106,252 | F |
| (C) OPPORTUNISTIC INVESTMENTS | 40,815,125 | F |
| (D) EXECUTIVE DB PLAN INVESTMENTS | 19,360,345 | F |
| (E) JOINT VENTURE - LUTHERAN CAMPUS ASC, LLC | 814,283 | F |
| (F) JOINT VENTURE - DENVER WEST ENDOSCOPY CTR, LLC | 786,374 | F |
| (G) JOINT VENTURE - E + PET IMAGING X, LP | 251,077 | F |
| (H) JOINT VENTURE - SCL HEALTH - EMERUS, LLC | 4,917,015 | F |
| (I) JOINT VENTURE - NORTHERN ROCKIES HEALTHCARE ALLIANCE, LLC | 426,217 | F |

Form 990, Schedule D, Part VII - Investments Other Securities

| (a) Description of security or category (including name of security) | (b) Book value | (c) Method of valuation Cost or end-of-year market value |
|---|-----------------------|--|
| (K) JOINT VENTURE - SCLTDI JV, LLC | 6,469,839 | F |
| (3) Other (A) JOINT VENTURE - SCLH-GI ENDOSCOPY CENTER HOLDINGS, LLC | 1,305,000 | F |
| (B) REAL RETURN INVESTMENTS | 273,656,510 | F |
| (C) SWEEP ACCOUNTS | 34,879,693 | F |

Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART V, LINE 4 | SCLHS HAS A PERMANENT ENDOWMENT IN THE AMOUNT OF \$2,000,000 THE EARNINGS FROM THE PERMANENT ENDOWMENT ARE A TERM ENDOWMENT TO BE USED FOR EDUCATIONAL PURPOSES AS DETERMINED BY SCLHS MANAGEMENT |

**SCHEDULE F
(Form 990)**

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990,
Part IV, line 14b, 15, or 16.

► Attach to Form 990. ► See separate instructions.

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

OMB No 1545-0047

2016

**Open to Public
Inspection**

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Employer identification number

23-7379161

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

- 1 For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?

☐ Yes ☐ No

- 2 For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

- 3** Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed)

| (a) Region | (b) Number of offices in the region | (c) Number of employees, agents, and independent contractors in region | (d) Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region) | (e) If activity listed in (d) is a program service, describe specific type of service(s) in region | (f) Total expenditures for and investments in region |
|---|-------------------------------------|--|---|--|--|
| See Add'l Data | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 3a Sub-total | 0 | 0 | | | 14,858,907 |
| b Total from continuation sheets to Part I | 0 | 0 | | | 0 |
| c Totals (add lines 3a and 3b) | 0 | 0 | | | 14,858,907 |

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

| 1 | (a) Name of organization | (b) IRS code section and EIN (if applicable) | (c) Region | (d) Purpose of grant | (e) Amount of cash grant | (f) Manner of cash disbursement | (g) Amount of non-cash assistance | (h) Description of non-cash assistance | (i) Method of valuation (book, FMV, appraisal, other) |
|----------|---------------------------------|---|-------------------|-----------------------------|---------------------------------|--|--|---|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

- 2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶ _____
- 3 Enter total number of other organizations or entities ▶ _____

| | |
|-----------------|---|
| Part III | Grants and Other Assistance to Individuals Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 16. |
|-----------------|---|

Part III can be duplicated if additional space is needed.

[illegible]

Part IV Foreign Forms

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* ☒ Yes ☐ No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A)* ☐ Yes ☒ No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)* ☒ Yes ☐ No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* ☒ Yes ☐ No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* ☒ Yes ☐ No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713)* ☐ Yes ☒ No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

| Return Reference | Explanation |
|-------------------------------|---|
| SCHEDULE F, PART I, LINE 3 | INVESTMENTS REPORTED IN SCHEDULE F ARE ACCOUNTED FOR ON THE ACCRUAL BASIS OF ACCOUNTING SCLHS' EXPENDITURES (PREMIUMS PAID) FOR ITS CAPTIVE INSURANCE PREMIUMS WERE \$12,823,650 NET OF PREMIUM DISCOUNTS |

Additional Data

Software ID:

Software Version:

EIN: 23-7379161

Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Form 990 Schedule F Part I - Activities Outside The United States

| (a) Region | (b) Number of offices in the region | (c) Number of employees or agents in region | (d) Activities conducted in region (by type) (i.e., fundraising, program services, grants to recipients located in the region) | (e) If activity listed in (d) is a program service, describe specific type of service(s) in region | (f) Total expenditures for region |
|---------------------------|-------------------------------------|---|--|--|-----------------------------------|
| CENTRAL AMERICA/CARIBBEAN | 0 | 0 | PROGRAM SERVICES | CAPTIVE INSURANCE PREMIUM | 12,823,650 |
| CENTRAL AMERICA/CARIBBEAN | 0 | 0 | INVESTMENTS, PROGRAM-RELATED | | 58,542 |
| EUROPE | 0 | 0 | INVESTMENTS, PROGRAM-RELATED | | 1,976,715 |

| | | |
|--|--|--|
| SCHEDULE H (Form 990) Department of the Treasury Internal Revenue Service | <h2 style="margin:0;">Hospitals</h2> <p>► 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.</p> | OMB No 1545-0047 <div style="font-size: 2em; font-weight: bold; text-align: center;">2016</div> Open to Public Inspection |
| Name of the organization SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM INC | | Employer identification number 23-7379161 |

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | | Yes | No |
|--|-----------|-----|----|
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b If "Yes," was it a written policy? | 1b | Yes | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | | |
| <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | 3a | Yes | |
| b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 50000 0000000000 % | 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 | | No |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | |
| c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | |
| 6a Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b If "Yes," did the organization make it available to the public? | 6b | Yes | |
| 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) | | | 541,881 | 0 | 541,881 | 0.090 % |
| b Medicaid (from Worksheet 3, column a) | | | 11,075,893 | 5,876,161 | 5,199,732 | 0.880 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 11,617,774 | 5,876,161 | 5,741,613 | 0.970 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | | | | |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | 9,451,079 | 5,898,066 | 3,553,013 | 0.600 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 785,189 | 0 | 785,189 | 0.130 % |
| j Total. Other Benefits | | | 10,236,268 | 5,898,066 | 4,338,202 | 0.730 % |
| k Total. Add lines 7d and 7j | | | 21,854,042 | 11,774,227 | 10,079,815 | 1.700 % |

Part II

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|-----------------|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 | Physical improvements and housing | | | | | |
| 2 | Economic development | | | | | |
| 3 | Community support | | | | | |
| 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 | | | | | | |

Part III

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | | Yes | No |
|----------|--|--------------------|----|
| 1 | Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 Yes | |
| 2 | Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount | 2 1,607,661 | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 0 | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements | | |

Section B. Medicare

| | | |
|----------|---|----------------------|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 17,849,465 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 35,897,252 |
| 7 | Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 -18,047,787 |
| 8 | Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | |

Section C. Collection Practices

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

Part IV

Management Companies and Joint Ventures

(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 1 DENVER WEST ENDOSCOPY CENTER LLC | OUTPATIENT ENDOSCOPY SERVICES | 51.000 % | 0 % | 49.000 % |
| 2 2 LUTHERAN CAMPUS ASC LLC | OUTPATIENT SURGERY | 52.520 % | 0 % | 47.480 % |
| 3 3 SCLH-GI ENDOSCOPY CENTER HOLDINGS LLC | ENDOSCOPY SERVICES | 51.000 % | 0 % | 49.000 % |
| 4 4 NORTHGLENN ENDOSCOPY CENTER LLC | ENDOSCOPY SERVICES | 51.000 % | 0 % | 49.000 % |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

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

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

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

2

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

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

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
FACILITY REPORTING GROUP - A**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):** _____

| | | 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 | Yes | |
| 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 | Yes | |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | 3 | | No |
| 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"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | | |
| j <input type="checkbox"/> Other (describe in Section C) | | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA 20 ____ | | | |
| 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 | | |
| 6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | | |
| 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 | | |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | 7 | | |
| a <input type="checkbox"/> Hospital facility's website (list url) _____ | | | |
| 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 | 8 | | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 ____ | | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) _____ | 10 | | |
| a _____ | | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | | |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | | |

Part V

Facility Information (continued)

Financial Assistance Policy (FAP)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|----|-----|----|--|--|--|--|---------------|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--|---------------|--|---|---------------|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|---------------|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| FACILITY REPORTING GROUP - A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of hospital facility or letter of facility reporting group | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP</td><td>13 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 500 000000000000 %</td><td></td><td></td></tr><tr><td>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</td><td></td><td></td></tr><tr><td>c <input type="checkbox"/> Asset level</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> Medical indigency</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Insurance status</td><td></td><td></td></tr><tr><td>f <input type="checkbox"/> Underinsurance discount</td><td></td><td></td></tr><tr><td>g <input type="checkbox"/> Residency</td><td></td><td></td></tr><tr><td>h <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>14 Explained the basis for calculating amounts charged to patients?</td><td>14 Yes</td><td></td></tr><tr><td>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)</td><td>15 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</td><td></td><td></td></tr><tr><td>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</td><td></td><td></td></tr><tr><td>e <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr><tr><td>16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)</td><td>16 Yes</td><td></td></tr><tr><td>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS</td><td></td><td></td></tr><tr><td>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS</td><td></td><td></td></tr><tr><td>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS</td><td></td><td></td></tr><tr><td>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</td><td></td><td></td></tr><tr><td>g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention</td><td></td><td></td></tr><tr><td>h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</td><td></td><td></td></tr><tr><td>i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations</td><td></td><td></td></tr><tr><td>j <input type="checkbox"/> Other (describe in Section C)</td><td></td><td></td></tr></table> | | Yes | No | Did the hospital facility have in place during the tax year a written financial assistance policy that | | | 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | | a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 500 000000000000 % | | | b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | | c <input type="checkbox"/> Asset level | | | d <input checked="" type="checkbox"/> Medical indigency | | | e <input type="checkbox"/> Insurance status | | | f <input type="checkbox"/> Underinsurance discount | | | g <input type="checkbox"/> Residency | | | h <input type="checkbox"/> Other (describe in Section C) | | | 14 Explained the basis for calculating amounts charged to patients? | 14 Yes | | 15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | | a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | | b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | e <input type="checkbox"/> Other (describe in Section C) | | | 16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | | a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | j <input type="checkbox"/> Other (describe in Section C) | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Did the hospital facility have in place during the tax year a written financial assistance policy that | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | 13 Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 500 000000000000 % | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input type="checkbox"/> Asset level | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input checked="" type="checkbox"/> Medical indigency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e <input type="checkbox"/> Insurance status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f <input type="checkbox"/> Underinsurance discount | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g <input type="checkbox"/> Residency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h <input type="checkbox"/> Other (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 Explained the basis for calculating amounts charged to patients? | 14 Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | 15 Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e <input type="checkbox"/> Other (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | 16 Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW.SCLHEALTHCOMMUNITY.ORG/HELPINGHANDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| j <input type="checkbox"/> Other (describe in Section C) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

FACILITY REPORTING GROUP - A

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

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

FACILITY REPORTING GROUP - A

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

| | Yes | No |
|-----------|-----|----|
| 22 | | |
| 23 | | No |
| 24 | | No |

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

[illegible]

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **105**

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART I, LINE 6A | |
| PART I, LINE 7 | <p>THE AMOUNTS REPORTED ON FORM 990, SCHEDULE H, PART I, LINE 7A, 7B AND 7C WERE DETERMINED USING THE COST TO CHARGE RATIO DERIVED FROM WORKSHEET 2, IN THE SCHEDULE H, FORM 990 INSTRUCTIONS FORM 990, SCHEDULE H, PART I, LINES 7E, 7F, 7G, 7H AND 7I ARE REPORTED AT COST AS REPORTED IN THE ORGANIZATION'S FINANCIAL STATEMENTS PART I, LINE 7, COLUMN (A) - (F) THE SCL HEALTH WESTMINSTER, LLC HOSPITAL OPENED IN LATE NOVEMBER 2015 AND THE SCL HEALTH SOUTH WEST, LLC HOSPITAL OPENED IN JUNE 2016 THE HOSPITALS WERE NOT CERTIFIED FOR MEDICARE AND MEDICAID UNTIL DECEMBER 2016 BECAUSE THE HOSPITALS WERE NOT CERTIFIED FOR MEDICARE AND MEDICAID UNTIL DECEMBER 2016, THERE WERE NO UNREIMBURSED COSTS FOR MEDICAID AND OTHER MEANS-TESTED GOVERNMENT PROGRAMS FOR THESE TWO HOSPITALS REPORTED ON SCHEDULE H, PART I, LINES 7B AND 7C DUE TO LIMITED FINANCIAL RESOURCES AND THE SHORT PERIOD OF TIME THE TWO HOSPITAL FACILITIES HAVE BEEN OPERATIONAL, THERE WERE NO COMMUNITY BENEFIT EXPENSES FOR THESE TWO HOSPITALS REPORTED ON SCHEDULE H, PART I, LINES 7E-7H</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|--|
| PART I, LINE 7, COLUMN (F) | |
| PART II, COMMUNITY BUILDING ACTIVITIES | <p>DUE TO LIMITED FINANCIAL RESOURCES AND THE SHORT PERIOD OF TIME THE TWO HOSPITAL FACILITIES HAVE BEEN OPERATIONAL, THERE WERE NO COMMUNITY BUILDING ACTIVITIES EXPENSE TO REPORT ON</p> <p>SCHEDULE H, PART II PART III, LINE 1 THE ORGANIZATION REPORTS BAD DEBT IN ACCORDANCE WITH HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA) STATEMENT NO 15 TO THE EXTENT THAT HFM</p> <p>A STATEMENT NO 15 FOLLOWS THE GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) FOR THE REPORTING OF BAD DEBT</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 2 | |
| PART III, LINE 4 | <p>THE ALLOWANCE FOR BAD DEBT IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING THE BUSINESS AND GENERAL ECONOMIC CONDITIONS IN ITS SERVICE AREA, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS THE BAD DEBT ALLOWANCE IS CALCULATED AS A PERCENTAGE OF PATIENT RECEIVABLES AFTER DEDUCTIONS FOR ESTIMATED PROVISIONS FOR CONTRACTUAL ADJUSTMENTS (DISCOUNTS) ON SERVICES PROVIDED TO ENROLLEES OF MEDICAID, THIRD-PARTY PAYOR PROGRAMS, CHARITY CARE, UNINSURED DISCOUNTS, AND OTHER ADMINISTRATIVE ADJUSTMENTS THE ORGANIZATION HAS A FINANCIAL ASSISTANCE PROGRAM THAT PROVIDES PATIENTS OPPORTUNITIES TO APPLY FOR FREE OR DISCOUNTED CARE OR TO BE ENROLLED IN A GOVERNMENT SPONSORED MEDICAL CARE PROGRAM THE PROCESS INCLUDES IDENTIFYING PATIENTS WITH A FINANCIAL CONCERN AND PROVIDING FINANCIAL COUNSELING AND ASSISTANCE IN APPLYING FOR THE ORGANIZATION'S CHARITY CARE AND OTHER FINANCIAL ASSISTANCE PROGRAMS CERTAIN PATIENT ACCOUNTS ARE WRITTEN OFF TO BAD DEBT BECAUSE THE ORGANIZATION DOES NOT HAVE SUFFICIENT INFORMATION TO DETERMINE IF THE PATIENT WOULD QUALIFY FOR FREE CARE OR FINANCIAL AID THEREFORE, IT IS POSSIBLE THAT SOME BAD DEBT IS ACTUALLY CHARITY CARE HOWEVER, IF A PATIENT ACCOUNT IS WRITTEN OFF TO BAD DEBT AND THE COLLECTION AGENCY LATER DETERMINES THAT THE PATIENT WOULD HAVE QUALIFIED FOR FREE CARE OR FINANCIAL AID, THEN THE BAD DEBT EXPENSE IS RECLASSIFIED TO CHARITY CARE THE FOLLOWING IS THE TEXT OF THE FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENT THAT DESCRIBE THE BAD DEBT ALLOWANCE AND BAD DEBT EXPENSE THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING THE BUSINESS AND GENERAL ECONOMIC CONDITION IN ITS SERVICE AREA, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL COLLECTION EXPERIENCE BY PAYOR CATEGORY AND OTHER FACTORS THE RESULTS OF THESE REVIEWS ARE THEN USED TO MAKE MODIFICATIONS TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS INCLUDES A RESERVE FOR BOTH UNINSURED PATIENTS AND BALANCES DUE FROM PATIENTS AFTER INSURANCE</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART III, LINE 8 | |
| PART III, LINE 9B | <p>AN INTEGRAL COMPONENT OF OUR MISSION IS TO BE GOOD FINANCIAL STEWARDS THIS REQUIRES US TO DETERMINE WHICH PATIENTS ARE IN NEED OF CHARITY CARE AND WHICH ARE ABLE TO CONTRIBUTE SOME PAYMENT FOR CARE RECEIVED WE MAINTAIN A BALANCE THAT ENABLES US TO CONTINUE TO PROVIDE CHARITY CARE TO THOSE WHO NEED IT MOST AND ENSURE THAT WE MANAGE OUR RESOURCES SO WE CAN CONTINUE TO BE HERE WHEN PEOPLE NEED US MOST THE ORGANIZATION NOTIFIES PATIENTS ABOUT THE FINANCIAL ASSISTANCE POLICY BY PROVIDING A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY TO ALL PATIENTS NOTICES ABOUT THE FINANCIAL ASSISTANCE POLICY ARE DISPLAYED IN THE HOSPITAL IN ADDITION, THE PATIENTS RECEIVE INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY WITH THEIR PATIENT BILLS UNINSURED/UNDERINSURED PATIENTS WHO QUALIFY FOR FINANCIAL ASSISTANCE WILL HAVE DISCOUNTS APPLIED TO OUTSTANDING BALANCES BASED ON THE CORRESPONDING DISCOUNT GUIDELINES PROVIDED WITHIN THE FINANCIAL ASSISTANCE POLICY REASONABLE EFFORT TO QUALIFY PATIENTS FOR FINANCIAL ASSISTANCE THROUGH THE PRESUMPTIVE ELIGIBILITY PROCESS WILL BE MADE IN ACCORDANCE WITH THE FINANCIAL ASSISTANCE POLICY IF PATIENTS DO NOT QUALIFY UNDER THIS PROCESS, THEY MAY INITIATE AND SUBMIT A FINANCIAL APPLICATION FOR FURTHER CONSIDERATION PATIENTS ARE CONTACTED MULTIPLE TIMES ABOUT UNPAID BALANCES PRIOR TO INITIATING ANY COLLECTION ACTION IF A PATIENT IS DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THE COLLECTION PROCESS, THE ACCOUNT IS RECLASSIFIED AS FINANCIAL ASSISTANCE AND DEBT COLLECTION EFFORTS ARE CEASED</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 2 | |
| PART VI, LINE 3 | <p>THE ORGANIZATION NOTIFIES PATIENTS ABOUT THE FINANCIAL ASSISTANCE POLICY BY PROVIDING A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY TO ALL PATIENTS. NOTICES ABOUT THE FINANCIAL ASSISTANCE POLICY ARE DISPLAYED IN THE HOSPITAL. IN ADDITION, PATIENTS RECEIVE INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY WITH THEIR PATIENT BILLS. THE FINANCIAL ASSISTANCE POLICY AND APPLICATION ARE POSTED ON THE HOSPITAL'S WEBSITE. THE POLICY AND APPLICATION ARE ALSO AVAILABLE UPON REQUEST. THE ORGANIZATION HAS A FINANCIAL ASSISTANCE PROGRAM THAT PROVIDES PATIENTS OPPORTUNITIES TO APPLY FOR FREE OR DISCOUNTED CARE OR TO BE ENROLLED IN A GOVERNMENT SPONSORED MEDICAL CARE PROGRAM. THE PROCESS INCLUDES IDENTIFYING PATIENTS WITH A FINANCIAL CONCERN, PROVIDING FINANCIAL COUNSELING AND ASSISTANCE IN APPLYING FOR THE ORGANIZATION'S CHARITY CARE AND OTHER FINANCIAL ASSISTANCE PROGRAMS.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART VI, LINE 4 | |
| PART VI, LINE 5 | <p>SCL HEALTH COMMUNITY HOSPITALS IS A NATIONALLY RECOGNIZED INNOVATIVE LEADER IN THE DELIVERY OF EMERGENCY, INPATIENT AND DIAGNOSTIC MEDICAL HEALTH CARE THAT STRIVES TO BE THERE FOR ANYONE, ANYWHERE, ANYTIME WE UNDERSTAND THAT SUPPORTING OUR PATIENTS AND THEIR FAMILIES AS THEY HEAL IS AN IMPORTANT PART OF HEALTH AND WELL-BEING WE STRIVE TO OFFER PATIENT-CENTERED CARE AND OPERATIONALLY EFFICIENT FACILITIES THAT ARE STAFFED BY MEDICAL PROFESSIONALS WHO TREAT YOU LIKE THEIR OWN FAMILY OUR COMMUNITY HOSPITALS PRIORITIZE LIMITED INPATIENT STAYS, EFFICIENT EMERGENCY ROOMS AND COST-EFFECTIVE PRICING IN A SMALLER-CAMPUS SETTING AS PART OF THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM (SCL HEALTH), OUR NEW SCL HEALTH COMMUNITY HOSPITALS SHARE OUR MISSION TO REVEAL AND FOSTER GOD'S HEALING LOVE BY IMPROVING THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE WITH OUR INITIAL OUTREACH FOR OUR SERVICE MARKETS, GREAT FOCUS HAS BEEN PLACED ON CONNECTING WITH PRIMARY DEMOGRAPHIC AREAS SUCH AS YOUNG FAMILIES, SENIORS AND THOSE HAVING LOW SOCIO-ECONOMIC STATUS OUR COMMUNITY BENEFIT INITIATIVES HAVE FAVORED GENERAL HEALTH AND WELLNESS APPROACHES LIKE PREVENTIVE EDUCATION, HEALTH SCREENINGS, EVENT SPONSORSHIP IN SUPPORT OF COMMUNITY BASED ORGANIZATIONS AND HEALTH CAUSES WHEN THE COMMUNITY HEALTH NEEDS ASSESSMENT IS COMPLETED, A MORE ROBUST STRATEGY AND IMPLEMENTATION PLAN WILL BE CREATED TO ADDRESS HEALTH PRIORITIES HAVING THE GREATEST NEED AND THAT REPRESENT MEANINGFUL IMPACT OPPORTUNITIES FOR OUR COMMUNITY HOSPITALS THE FOLLOWING REPRESENTS SOME SPECIFIC EXAMPLES OF OUR SUPPORT FOR COMMUNITY HEALTH IMPROVEMENT - ACCESS TO CARE - HOST PARTNER WITH SENIOR LIVING FACILITY TO OFFER A HEALTH LITERACY EVENT EVENT WELCOMED OVER 100 SENIOR RESIDENTS TO MEET PROVIDERS, ASK-THE-DOC, TOUR AND PRESENTATION ON UNDERSTANDING APPROPRIATE ACCESS TO CARE POINTS IN THE COMMUNITY (E G URGENT, PRIMARY CARE, AMBULATORY, ETC) - COMMUNITY PARTNER WITH BONFILS BLOOD CENTERS TO HOST BLOOD DRIVES PROVIDE SPACE, STAFF AND MATERIALS EACH COMMUNITY HOSPITAL PARTICIPATES IN A ROTATING SCHEDULE FOR THE DRIVES - HOSTED A SENIOR HEALTH FAIR, OFFERING VARIOUS HEALTH SCREENINGS INCLUDING BLOOD PRESSURE, BONE DENSITY, MEDICATION REVIEW, BODY MASS INDEX, AND OTHERS - GENERAL WELLNESS AND PREVENTION - EVENT SPONSOR AND HOST FOR THE HOME RUN AGAINST DRUGS PROGRAM WHICH PARTNERS WITH (5) LOCAL ELEMENTARY SCHOOLS PROGRAM ADDRESSES PRESCRIPTION DRUGS, MARIJUANA, AND OVER-THE-COUNTER DRUG USE - SAFETY-PALOOSA - EVENT SPONSOR AND HOST FOR A BROAD SERVING COMMUNITY EVENT THAT PROVIDES MATERIALS, EDUCATION AND EXPERT INTERACTION AROUND EVIDENCE BASED INJURY PREVENTION INTERVENTIONS (E G BABY'S FIRST RIDE, SEAT BELT CAR FITTINGS, SAFE DISPOSAL OF PRESCRIPTION DRUGS, BIKE SAFETY, AND OTHERS)- WESTYFEST - JEFFERSON COUNTY COMMUNITY HEALTH AND WELLNESS EVENT FOR FAMILIES THAT DRAWS ATTENDANCE FROM MULTIPLE COUNTIES PARTNER TO OFFER FREE HEALTH IMPROVEMENT RESOURCES FOR CHILDHOOD OBESITY PREVENTION, MENTAL HEALTH FIRST AID CLASSES, CHRONIC DISEASE SELF-MANAGEMENT, AND SOCIAL SERVICES RESOURCE MATERIALS</p> |

| 990 Schedule H, Supplemental Information | |
|--|-------------|
| Form and Line Reference | Explanation |
| PART VI, LINE 6 | |

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

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

| Section A. Hospital Facilities | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER—24 hours | ER—other | Other (Describe) | Facility reporting group |
|---|---|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>2</u> | | | | | | | | | | | |
| 1 | SCL HEALTH WESTMINSTER LLC 6500 WEST 104TH AVENUE SUITE 100 WESTMINSTER, CO 80020 WWW.SCLHEALTHCOMMUNITY.ORG/WESTMINSTER 01A413 | X | X | | | | | X | | | A |
| 2 | SCL HEALTH SOUTHWEST LLC 8515 W COAL MINE AVENUE LITTLETON, CO 80123 WWW.SCLHEALTHCOMMUNITY.ORG/SOUTHWEST 01U326 | X | X | | | | | X | | | A |

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

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

| Form and Line Reference | Explanation |
|-------------------------|----------------------------|
| PART V, SECTION B | FACILITY REPORTING GROUP A |

| | |
|---|--|
| Form 990 Part V Section C Supplemental Information for Part V, Section B. | |
| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility. | |
| Form and Line Reference | Explanation |
| FACILITY REPORTING GROUP A CONSISTS OF | - FACILITY 1 SCL HEALTH WESTMINSTER, LLC, - FACILITY 2 SCL HEALTH SOUTHWEST, LLC |

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

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

| Form and Line Reference | Explanation |
|---------------------------|---|
| PART V, SECTION B, LINE 2 | SCL HEALTH WESTMINSTER COMMUNITY HOSPITAL WAS PLACED INTO SERVICE IN NOVEMBER 2015 SCL HEALTH SOUTHWEST COMMUNITY HOSPITAL WAS PLACED INTO SERVICE IN JUNE 2016 THE HOSPITALS ARE OWNED THROUGH A JOINT VENTURE, SCL HEALTH - EMERUS, LLC |

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

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

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

| Name and address | Type of Facility (describe) |
|--|-------------------------------|
| 1 1 - DENVER WEST ENDOSCOPY CENTER LLC 382 S ARTHUR AVENUE LOUISVILLE, CO 80027 | OUTPATIENT ENDOSCOPY SERVICES |
| 1 2 - LUTHERAN CAMPUS ASC LLC 3455 LUTHERAN PKWY STE 150 WHEATRIDGE, CO 80033 | OUTPATIENT SURGERY |
| 2 3 - NORTHGLENN ENDOSCOPY CENTER LLC 11900 GRANT STREET NORTHGLENN, CO 80233 | ENDOSCOPY SERVICES |
| 3 4 - TOUCHSTONE MEDICAL IMAGING - AURORA 3055 SOUTH PARKER RD BLDG A STE 103 AURORA, CO 80014 | RADIOLOGY SERVICES |
| 4 5 - TOUCHSTONE MEDICAL IMAGING - DRY CREEK 125 INVERNESS DR EAST STE 140 ENGLEWOOD, CO 80112 | RADIOLOGY SERVICES |
| 5 6 - TOUCHSTONE MEDICAL IMAGING - HIGHLINE 26 WEST DRY CREEK CIR STE 160 LITTLETON, CO 80120 | RADIOLOGY SERVICES |
| 6 7 - TOUCHSTONE MEDICAL IMAGING - LAFAYETTE 390 EMPIRE ROAD STE 102 LAFAYETTE, CO 80026 | RADIOLOGY SERVICES |
| 7 8 - TOUCHSTONE MEDICAL IMAGING - LAKEWOOD 14062 DENVER WEST PKWY BLDG 52 STE 180 LAKEWOOD, CO 80401 | RADIOLOGY SERVICES |
| 8 9 - TOUCHSTONE MEDICAL IMAGING - THORNTON 12021 PENNSYLVANIA ST STE 106 THORNTON, CO 80241 | RADIOLOGY SERVICES |
| 9 10 - TOUCHSTONE MEDICAL IMAGING MAMMOGRAPHY AND BONE 3455 N LUTHERAN PKWY 110 WHEAT RIDGE, CO 80033 | RADIOLOGY SERVICES |
| 10 11 - TOUCHSTONE MEDICAL IMAGING - UPTOWN 1007 E COLFAX AVE DENVER, CO 80218 | RADIOLOGY SERVICES |
| 11 12 - TOUCHSTONE MEDICAL IMAGING - WHEAT RIDGE 7615 WEST 38TH AVENUE STE B115 WHEAT RIDGE, CO 80033 | RADIOLOGY SERVICES |
| 12 13 - SCL FRONT RANGE HOME HEALTH LLC 3980 QUEBEC STREET SUITE 100 DENVER, CO 80207 | HOME HEALTH |
| 13 14 - ROCKY MOUNTAIN CLINIC FAM PRAC & INT MED 435 S CRYSTAL ST STE 300 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 14 15 - ROCKY MTN CLINIC FAM PRAC & INT MED - BE 400 S CLARK ST BUTTE, MT 597012328 | OUTPATIENT PHYSICIAN CLINIC |

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

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

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

| Name and address | Type of Facility (describe) |
|--|-----------------------------|
| 16 16 - ROCKY MOUNTAIN CLINIC NEUROLOGY 435 S CRYSTAL ST STE 300 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 1 17 - ST JAMES CARDIAC & THORACIC SURG- CVTS 435 S CRYSTAL ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 2 18 - ST JAMES CARDIAC & THORACIC SURG - SURGI 400 W PORPHYRY ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 3 19 - ST JAMES CARDIAC INTERPRETATIONS 400 S CLARK ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 4 20 - ST JAMES CARDIOLOGY 435 S CRYSTAL ST STE 220 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 5 21 - ST JAMES EMERGENCY PHYSICIANS 400 S CLARK ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 6 22 - ST JAMES HEALTHCARE REHAB - BOULDER 214 S MAIN BOULDER, MT 59632 | OUTPATIENT PHYSICIAN CLINIC |
| 7 23 - ST JAMES HEALTHCARE REHAB - WHITEHALL 309 EAST LEGION WHITEHALL, MT 59759 | OUTPATIENT PHYSICIAN CLINIC |
| 8 24 - ST JAMES OBSTETRICS & GYNECOLOGY 305 W PORPHYRY STE 200 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 9 25 - ST JAMES RADIATION ONCOLOGY 400 S CLARK ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 10 26 - ST JAMES SUMMIT LAB 435 S CIRYSTAL ST STE 300 BUTTE, MT 597011506 | OUTPATIENT PHYSICIAN CLINIC |
| 11 27 - ST JAMES UROLOGY 305 W PORPHYRY STE 100 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 12 28 - ST JAMES WMMH OUTREACH 106 W BROADWAY ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 13 29 - ST VINCENT HEALTH CENTER CCBDC 1233 N 30TH ST BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 14 30 - SVP - ABSAROKEE FAMILY MEDICINE 55 N MONTANA ABSAROKEE, MT 590010425 | OUTPATIENT PHYSICIAN CLINIC |

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) |
|---|-----------------------------|
| 31 31 - SVP - BEHAVIORAL HEALTH 2900 12TH AVE N STE 280W BILLINGS, MT 591017516 | OUTPATIENT PHYSICIAN CLINIC |
| 1 32 - SVP - BIG HORN BASIN REG CANCER CTR 1025 9TH ST CODY, WY 824143441 | OUTPATIENT PHYSICIAN CLINIC |
| 2 33 - SVP - BROADWATER FAMILY MEDICINE 2019 BROADWATER AVE BILLINGS, MT 591024810 | OUTPATIENT PHYSICIAN CLINIC |
| 3 34 - SVP - BROADWATER WALK-IN CLINIC 2019 BROADWATER AVE BILLINGS, MT 591024810 | OUTPATIENT PHYSICIAN CLINIC |
| 4 35 - SVP - CODY FAMILY MEDICINE 720 LINDSAY LN STE A CODY, WY 824144103 | OUTPATIENT PHYSICIAN CLINIC |
| 5 36 - SVP - DERMATOLOGY 2900 12TH AVE N STE 265W BILLINGS, MT 591017513 | OUTPATIENT PHYSICIAN CLINIC |
| 6 37 - SVP - DIABETES CENTER 2900 12TH AVE N STE 160W BILLINGS, MT 591017588 | OUTPATIENT PHYSICIAN CLINIC |
| 7 38 - SVP - FORTIN PED SPEC CLINIC - CARDIO 2600 WILSON ST MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |
| 8 39 - SVP - FORTIN PED SPEC CLINIC - CARDIO - 935 HIGHLAND PARK BLVD STE 2200 BOZEMAN, MT 59718 | OUTPATIENT PHYSICIAN CLINIC |
| 9 40 - SVP - FORTIN PED SPEC CLINIC - CARDIO BU 435 S CRYSTAL ST STE 300 BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 10 41 - SVP - FORTIN PED SPEC CLINIC - FORTIN PE 1232 N 30TH STE 300 BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 11 42 - SVP - FORTIN PED SPEC CLINIC - FORTIN PE 1232 N 30TH STE 200 BILLINGS, MT 591010128 | OUTPATIENT PHYSICIAN CLINIC |
| 12 43 - SVP - FORTIN PED SPEC CLINIC - GI BOZEMA 935 HIGHLAND PARK BLVD STE 2200 BOZEMAN, MT 59718 | OUTPATIENT PHYSICIAN CLINIC |
| 13 44 - SVP - FORTIN PED SPEC CLINIC - MILES CIT 2600 WILSON ST MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |
| 14 45 - SVP - FORTIN PED SPEC CLINIC - ONC BOZEM 935 HIGHLAND PARK BLVD STE 2200 BOZEMAN, MT 59718 | OUTPATIENT PHYSICIAN CLINIC |

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) |
|--|-----------------------------|
| 46 46 - SVP - FORTIN PED SPEC CLINIC - ONC G FAL 1300 28TH ST S STE 4 GREAT FALLS, MT 59405 | OUTPATIENT PHYSICIAN CLINIC |
| 1 47 - SVP - FORTIN PED SPEC CLINIC - PED BOZEM 120 N 19TH ST BOZEMAN, MT 59718 | OUTPATIENT PHYSICIAN CLINIC |
| 2 48 - SVP - FORTIN PED SPEC CLINIC - PED BUTTE 435 S CRYSTAL ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 3 49 - SVP - FORTIN PED SPEC CLINIC - PED G FAL 1300 28TH ST S STE 4 GREAT FALLS, MT 59405 | OUTPATIENT PHYSICIAN CLINIC |
| 4 50 - SVP - FORTIN PED SPEC CLINIC - PED GI 1232 N 30TH STE 200 BILLINGS, MT 591010128 | OUTPATIENT PHYSICIAN CLINIC |
| 5 51 - SVP - FORTIN PED SPEC CLINIC - PED GI BU 435 S CRYSTAL ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 6 52 - SVP - FORTIN PED SPEC CLINIC - PED GI G 1300 28TH ST S STE 4 GREAT FALLS, MT 59405 | OUTPATIENT PHYSICIAN CLINIC |
| 7 53 - SVP - FORTIN PED SPEC CLINIC - PED GI HE 3330 PTARMIGAN LN HELENA, MT 59602 | OUTPATIENT PHYSICIAN CLINIC |
| 8 54 - SVP - FORTIN PED SPEC CLINIC - PED HELEN 3330 PTARMIGAN LN HELENA, MT 59602 | OUTPATIENT PHYSICIAN CLINIC |
| 9 55 - SVP - FORTIN PED SPEC CLINIC PED CARDIO 707 SHERIDAN AVE CODY, WY 82414 | OUTPATIENT PHYSICIAN CLINIC |
| 10 56 - SVP - GASTROENTEROLOGY 1144 N BROADWAY STE C BILLINGS, MT 591010110 | OUTPATIENT PHYSICIAN CLINIC |
| 11 57 - SVP - HARDIN FAMILY MEDICINE 16 N MILES STE 101 HARDIN, MT 590342356 | OUTPATIENT PHYSICIAN CLINIC |
| 12 59 - SVP - HEART & VASCULAR CTR - CODY 720 LINDSEY LANE STE A CODY, WY 824144103 | OUTPATIENT PHYSICIAN CLINIC |
| 13 60 - SVP - HEART & VASCULAR CTR - GLASGO 621 3RD ST SOUTH GLASGOW, MT 592301111 | OUTPATIENT PHYSICIAN CLINIC |
| 14 61 - SVP - HEART & VASCULAR CTR - MILES CITY 2600 WILSON ST MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |

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) |
|---|-----------------------------|
| 61 62 - SVP - HEART & VASCULAR CTR - VASCULAR 2900 12TH AVE N STE 400E BILLINGS, MT 591017504 | OUTPATIENT PHYSICIAN CLINIC |
| 1 63 - SVP - HEIGHTS FAMILY MEDICINE 32 WICKS LN BILLINGS, MT 591053810 | OUTPATIENT PHYSICIAN CLINIC |
| 2 64 - SVP - INTERNAL MEDICINE ASSOCIATES 2900 12TH AVE N STE 310W BILLINGS, MT 591017588 | OUTPATIENT PHYSICIAN CLINIC |
| 3 65 - SVP - LAUREL FAMILY MEDICINE 1035 1ST AVE LAUREL, MT 590442119 | OUTPATIENT PHYSICIAN CLINIC |
| 4 66 - SVP - LONG TERM CARE 1101 N 27TH ST STE 101 BILLINGS, MT 591010100 | OUTPATIENT PHYSICIAN CLINIC |
| 5 67 - SVP - MATERNAL FETAL MED - FETAL MED 2900 12TH AVE N STE 130W BILLINGS, MT 591017504 | OUTPATIENT PHYSICIAN CLINIC |
| 6 68 - SVP - MATERNAL FETAL MED - GREAT PLAINS 1700 11TH ST W WILLISTON, ND 58801 | OUTPATIENT PHYSICIAN CLINIC |
| 7 69 - SVP - MIDWIFERY & WOMEN'S HEALTH 2900 12TH AVE N STE 245W BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 8 70 - SVP - MONTANA HEART 2900 12TH AVE N STE 204E BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 9 71 - SVP - MONTANA HEART - ABSAROKEE 55 N MONTANA ABSAROKEE, MT 590016331 | OUTPATIENT PHYSICIAN CLINIC |
| 10 72 - SVP - MONTANA HEART - CODY 720 LINDSAY LANE STE A CODY, WY 824144103 | OUTPATIENT PHYSICIAN CLINIC |
| 11 73 - SVP - MONTANA HEART - HARDIN 16 N MILES AVE STE 101 HARDIN, MT 590342356 | OUTPATIENT PHYSICIAN CLINIC |
| 12 74 - SVP - MONTANA HEART - LAUREL 1035 1ST AVE LAUREL, MT 590442120 | OUTPATIENT PHYSICIAN CLINIC |
| 13 75 - SVP - MONTANA HEART - MTN VIEW 10 ROBINSON LANE RED LODGE, MT 590689010 | OUTPATIENT PHYSICIAN CLINIC |
| 14 76 - SVP - MOUNTAIN VIEW FAMILY MEDICINE 10 ROBINSON LN RED LODGE, MT 590680070 | OUTPATIENT PHYSICIAN CLINIC |

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) |
|--|-----------------------------|
| 76 77 - SVP - NEPHROLOGY 2900 12TH AVE STE 160W BILLINGS, MT 591017508 | OUTPATIENT PHYSICIAN CLINIC |
| 1 78 - SVP - NEPHROLOGY - CODY 720 LINDSAY LN STE A CODY, WY 824144103 | OUTPATIENT PHYSICIAN CLINIC |
| 2 79 - SVP - NEPHROLOGY - LEWISTON 310 WENDELL AVE STE 5 LEWISTOWN, MT 59457 | OUTPATIENT PHYSICIAN CLINIC |
| 3 80 - SVP - NEPHROLOGY - MILES CITY 2600 WILSON ST MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |
| 4 81 - SVP - NEPHROLOGY - WORLAND 1106 BIG HORN AVE WORLAND, WY 824012803 | OUTPATIENT PHYSICIAN CLINIC |
| 5 82 - SVP - NEUROSURGERY 1041 N 29TH ST BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 6 83 - SVP - NORTH SHILOH FAMILY MEDICINE 2223 MISSION WAY BILLINGS, MT 591020160 | OUTPATIENT PHYSICIAN CLINIC |
| 7 84 - SVP - OCCUPATIONAL HEALTH 2019 BROADWATER AVE BILLINGS, MT 591024810 | OUTPATIENT PHYSICIAN CLINIC |
| 8 85 - SVP - OP NEURO CLINIC & MS CTR - BOZEMAN 650 FERGUSON STE 1 BOZEMAN, MT 59715 | OUTPATIENT PHYSICIAN CLINIC |
| 9 86 - SVP - OP NEURO CLINIC & MS CTR - BUTTE 435 S CRYSTAL ST BUTTE, MT 59701 | OUTPATIENT PHYSICIAN CLINIC |
| 10 87 - SVP - OP NEURO CLINIC & MS CTR - CODY 720 LINDSAY LN CODY, WY 82414 | OUTPATIENT PHYSICIAN CLINIC |
| 11 88 - SVP - OP NEURO CLINIC & MS CTR - FM GLAS 621 3RD STREET SOUTH GLASGOW, MT 59230 | OUTPATIENT PHYSICIAN CLINIC |
| 12 89 - SVP - OP NEURO CLINIC & MS CTR - GI FM G 621 3RD ST S GLASGOW, MT 59230 | OUTPATIENT PHYSICIAN CLINIC |
| 13 90 - SVP - OP NEURO CLINIC & MS CTR - HELENA 2550 BROADWAY HELENA, MT 59602 | OUTPATIENT PHYSICIAN CLINIC |
| 14 91 - SVP - OP NEURO CLINIC & MS CTR - LEWISTO 310 WENDELL STE 5 LEWISTOWN, MT 59457 | OUTPATIENT PHYSICIAN CLINIC |

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) |
|--|-----------------------------|
| 91 92 - SVP - OP NEURO CLINIC & MS CTR - MILES C 2600 WILSON ST MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |
| 1 93 - SVP - OP NEURO CLINIC & MS CTR - MILES C 2600 WILSON MILES CITY, MT 59301 | OUTPATIENT PHYSICIAN CLINIC |
| 2 94 - SVP - OP NEURO CLINIC & MS CTR - NEURO 1041 N 29TH ST BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 3 95 - SVP - OP NEURO CLINIC & MS CTR - NEURO G 621 3RD ST S GLASGOW, MT 59230 | OUTPATIENT PHYSICIAN CLINIC |
| 4 96 - SVP - OP NEURO CLINIC & MS CTR - NSGY BO 650 FERGUSON STE 1 BOZEMAN, MT 59715 | OUTPATIENT PHYSICIAN CLINIC |
| 5 97 - SVP - OP NEURO CLINIC & MS CTR - NSGY SI 216 14TH AVE SW SIDNEY, MT 59270 | OUTPATIENT PHYSICIAN CLINIC |
| 6 98 - SVP - OP NEURO CLINIC & MS CTR - OP NEUR 1041 N 29TH ST BILLINGS, MT 59101 | OUTPATIENT PHYSICIAN CLINIC |
| 7 99 - SVP - OP NEURO CLINIC & MS CTR - SIDNEY 216 14TH AVE SW SIDNEY, MT 59270 | OUTPATIENT PHYSICIAN CLINIC |
| 8 100 - SVP - OP NEURO CLINIC & MS CTR - SNSGY W 1213 15TH AVENUE WEST WILLISTON, ND 58801 | OUTPATIENT PHYSICIAN CLINIC |
| 9 101 - SVP - OP NEURO CLINIC & MS CTR - WILLIST 1213 15TH AVE W WILLISTON, ND 58801 | OUTPATIENT PHYSICIAN CLINIC |
| 10 102 - SVP - PAIN CENTER 2900 12TH AVE N STE 335W BILLINGS, MT 591017506 | OUTPATIENT PHYSICIAN CLINIC |
| 11 103 - SVP - PHYSIATRY & INFECTIOUS DISEASE 2900 12TH AVE N STE 201E BILLINGS, MT 591010136 | OUTPATIENT PHYSICIAN CLINIC |
| 12 104 - SVP - SLEEP & RESPIRATORY 2900 12TH AVE N STE 300 E BILLINGS, MT 591010127 | OUTPATIENT PHYSICIAN CLINIC |
| 13 105 - SVP - WEIGHT MANAGEMENT 2900 12TH AVE N STE 160W BILLINGS, MT 591017588 | OUTPATIENT PHYSICIAN CLINIC |
| 14 106 - SVP - WEST GRAND FAMILY MEDICINE 2750 GRAND AVE BILLINGS, MT 591022629 | OUTPATIENT PHYSICIAN CLINIC |

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Employer identification number
23-7379161

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed

| (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|--|---------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| | | | | | | | |

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 5

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

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

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of non-cash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of non-cash assistance |
|-------------------------------------|--------------------------|--------------------------|-----------------------------------|---|--|
| (1) SECONDARY EDUCATION SCHOLARSHIP | 27 | 70,280 | | | |
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |

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

| Return Reference | Explanation |
|------------------|---|
| PART I, LINE 2 | SCLHS' MISSION DEPARTMENT REQUIRES WRITTEN STATEMENTS THREE TIMES A YEAR REGARDING THE PROGRESS AND STATUS OF THE GRANT |

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH 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 |
|--|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| INTEGRITY HEALTH 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 | 47-4520350 | 501(C)(3) | 5,000,000 | | | | SUPPORT MISSION |
| MOUNT SAINT VINCENT HOME 4159 LOWELL BOULEVARD DENVER, CO 80211 | 84-0405260 | 501(C)(3) | 627,849 | | | | SUPPORT MISSION |

| 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 |
| MARIAN CLINIC 1001 SW GARFIELD AVE TOPEKA, KS 66604 | 48-1046905 | 501(C)(3) | 92,411 | | | | SUPPORT MISSION |
| CARITAS CLINICS 818 NORTH 7TH STREET LEAVENWORTH, KS 66048 | 48-1009910 | 501(C)(3) | 64,929 | | | | SUPPORT MISSION |

| 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 |
| LUTHERAN MEDICAL CENTER FOUNDATION 8300 WEST 38TH AVENUE WHEAT RIDGE, CO 80033 | 20-8846152 | 501(C)(3) | 56,000 | | | | SUPPORT MISSION |

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 SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM INC | Employer identification number 23-7379161 |
|---|--|

Part I

Questions Regarding Compensation

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

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 |
|---------------------|-------------|
| See Additional Data | |

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Part III, Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART I, LINE 1A | TAX INDEMNIFICATION AND GROSS-UP PAYMENTS THE ORGANIZATION AND RELATED ORGANIZATIONS ALLOW FOR CERTAIN TAX INDEMNIFICATION AND GROSS-UP PAYMENTS IN THE INSTANCES OF RELOCATION THESE AMOUNTS ARE TREATED AS TAXABLE COMPENSATION THE INDIVIDUALS THAT RECEIVED TAX GROSS-UP PAYMENTS IN 2016 WERE MICHAEL TAYLOR - \$2,141, KERRY KOHNEN - \$1,477 |

Part III, Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART I, LINE 1B | TAX INDEMNIFICATION AND GROSS-UP PAYMENTS - WRITTEN POLICY THE ORGANIZATION AND RELATED ORGANIZATIONS DO NOT HAVE A FORMAL WRITTEN POLICY FOR TAX INDEMNIFICATION AND GROSS-UP PAYMENTS HOWEVER, BEFORE ANY TAX INDEMNIFICATION AND GROSS-UP PAYMENTS ARE MADE, PROPER APPROVAL FROM THE EMPLOYEE'S MANAGER IS REQUIRED IN ADDITION, APPROVAL IS ALSO REQUIRED FROM HUMAN RESOURCES |

Part III, Supplemental Information

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 3 | COMPENSATION OF THE ORGANIZATION'S CEO/EXECUTIVE DIRECTOR COMPENSATION FOR THE OFFICERS AND SENIOR MANAGEMENT IS MANAGED BY THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) BOARD COMPENSATION COMMITTEE (COMMITTEE) ON BEHALF OF SCL HEALTH AND ALL OF ITS AFFILIATES THE COMMITTEE REVIEWS AND APPROVES COMPENSATION ARRANGEMENTS OF THE OFFICERS AND SENIOR MANAGEMENT AND MAKES RECOMMENDATIONS TO SCL HEALTH'S BOARD FOR APPROVAL OF ANY CHANGES TO COMPENSATION FOR THE OFFICERS AND SENIOR MANAGEMENT THE COMMITTEE'S REVIEW IS CONDUCTED IN A MANNER THAT IS INTENDED TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER THE INTERMEDIATE SANCTIONS RULES OF INTERNAL REVENUE CODE SECTION 4958 THE COMMITTEE CONDUCTS THE REVIEW WITH THE ASSISTANCE OF AN EXPERIENCED AND INDEPENDENT COMPENSATION CONSULTING FIRM THAT HAS DEEP NATIONAL EXPERTISE IN HEALTH SYSTEMS' EXECUTIVE COMPENSATION PROGRAMS AND LEVELS THE COMMITTEE OBTAINS AND RELIES UPON CURRENT, COMPARABLE MARKET DATA FOR PEER ORGANIZATIONS PRIOR TO MAKING COMPENSATION RELATED DECISIONS THE INFORMATION REVIEWED INCLUDES COMPENSATION LEVELS PAID BY SIMILARLY SITUATED ORGANIZATIONS FOR FUNCTIONALLY COMPARABLE POSITIONS, THE AVAILABILITY OF SIMILAR SERVICES IN THE GEOGRAPHIC AREA SERVED BY SCL HEALTH AND CURRENT COMPENSATION SURVEYS COMPILED BY AN INDEPENDENT FIRM CONSISTENT WITH THE PAY PHILOSOPHY SET BY SCL HEALTH'S BOARD, THE COMMITTEE EMPHASIZES THE IMPORTANCE OF ENSURING TOTAL REMUNERATION IS REASONABLE AND APPROPRIATE WHEN REVIEWING AND MAKING RECOMMENDATIONS WITH RESPECT TO COMPENSATION PACKAGES FOR THE OFFICERS AND SENIOR MANAGEMENT AS PART OF THE REVIEW PROCESS, SCL HEALTH USES THE FOLLOWING IN ESTABLISHING THE COMPENSATION OF OFFICERS AND SENIOR MANAGEMENT 1) COMPENSATION COMMITTEE 2) INDEPENDENT COMPENSATION CONSULTANT 3) FORM 990 OF OTHER ORGANIZATIONS 4) WRITTEN EMPLOYMENT CONTRACTS 5) COMPENSATION SURVEYS AND STUDIES 6) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE THE ITEMS LISTED ABOVE SUPPORT THE COMPENSATION COMMITTEE'S EFFORTS TO ENSURE THAT THE LEVEL OF COMPENSATION PROVIDED TO ITS OFFICERS AND SENIOR MANAGEMENT IS REASONABLE, APPROPRIATE AND CONSISTENT WITH THE PAY PHILOSOPHY SET BY THE BOARD |

Part III, Supplemental Information

| Return Reference | Explanation |
|--------------------|--|
| PART I, LINES 4A-B | <p>SCHEDULE J, PART I, LINE 4A THE ORGANIZATION AND RELATED ORGANIZATIONS PERIODICALLY INCUR SEVERANCE PAYMENTS TO FORMER EMPLOYEES THE INDIVIDUALS AND THE AMOUNTS PAID FOR SEVERANCE IN 2016 WERE ROBERT LADENBURGER - \$318,682, THOMAS PETERSON - \$100,522 SCHEDULE J, PART I, LINE 4B PAYMENTS FROM NONQUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN THE ORGANIZATION PROVIDES NONQUALIFIED DEFERRED COMPENSATION PLANS (NQDC) KNOWN AS SUPPLEMENTAL EXECUTIVE RETIREMENT PROGRAM (SERP) FOR EXECUTIVES (SENIOR MANAGEMENT) TO COMPENSATE FOR REGULATORY IMPOSED LIMITATIONS IN QUALIFIED RETIREMENT PLANS AND TO PROVIDE A BENEFIT CONSISTENT WITH OTHER NOT FOR PROFIT HEALTH SYSTEMS THESE PLANS ENABLE THE EXECUTIVE TO EARN BENEFITS DURING EACH YEAR THAT THEY PARTICIPATE IN 2014, IN AN EFFORT TO REDUCE LONG-TERM COST AND HAVE GREATER CONTROL OVER FINANCIAL RISK, THE SERP WAS CONVERTED FROM A DEFINED BENEFIT (DB) TO A DEFINED CONTRIBUTION (DC) DESIGN CERTAIN MEMBERS OF SENIOR MANAGEMENT WHOSE BENEFITS WERE CONVERTED FROM DB TO DC WOULD HAVE BEEN DISPROPORTIONATELY AND NEGATIVELY AFFECTED BY THE CHANGE, SO THE COMMITTEE DETERMINED IT WOULD BE APPROPRIATE TO GRANT "TRANSITION CREDITS" IN ORDER TO MITIGATE THE NEGATIVE IMPACT OF THE CHANGE ON THEIR RETIREMENT BENEFITS THIS IS A COMMON APPROACH EMPLOYED BY OTHER ORGANIZATIONS UNDERGOING A SIMILAR TRANSITION THE TRANSITION CREDITS VEST IN ACCORDANCE WITH THE TERMS OF THE DC SERP (I E , AFTER THREE YEARS) AND ARE PAID TO THE EXECUTIVE UPON VESTING NQDC SERP PLANS PRIOR TO 2014 PRIOR TO 2014, THE ORGANIZATION'S NQDC SERP PLAN PROVIDED A BENEFIT TO ELIGIBLE PARTICIPANTS BASED ON A PERCENTAGE OF THEIR BASE COMPENSATION THE VESTING PERIOD IS 5 YEARS OR WHEN THE PARTICIPANT IS AGE 65 OR OLDER THERE WERE NO CONTRIBUTIONS TO THIS PLAN AFTER DECEMBER 31, 2013 THE ORGANIZATION HAS DETERMINED THAT THESE BENEFITS SHOULD BE SUBJECT TO TAXATION AS THE AMOUNTS ARE VESTED RATHER THAN WHEN THEY ARE RECEIVED AS A RESULT, THE TOTAL NONQUALIFIED RETIREMENT PLAN BENEFITS, WHICH WERE VESTED IN THE CURRENT YEAR, ARE CONSIDERED TAXABLE AND THUS WERE TAXED TO THE PARTICIPANTS FOR SOME OF THE PARTICIPANTS, AN AMOUNT EQUAL TO THE PARTICIPANT'S EXPECTED INCOME TAX LIABILITY WAS WITHDRAWN FROM THE PARTICIPANT'S ACCOUNT AND REMITTED TO THE FEDERAL AND STATE GOVERNMENTS AS WITHHOLDING ON THE TAXABLE BENEFIT NO CASH PAYMENT IS MADE DIRECTLY TO THE PARTICIPANT AND THE REMAINING BENEFIT AMOUNT STAYS IN THE RETIREMENT PLAN THE AMOUNTS WITHDRAWN FROM THE PLAN FOR TAXES IN 2016 WERE LYDIA JUMONVILLE - \$86,105, STEVEN CHYUNG - \$37,071, MARK WILKINSON - \$24,970, STEVE LOVELESS - \$36,382 FOR AMOUNTS CONTRIBUTED TO THE NQDC SERP PLAN PRIOR TO 2014, VESTED AMOUNTS ARE PAYABLE UPON THE END OF EMPLOYMENT THE VESTED AMOUNTS WITHDRAWN INCLUDE AMOUNTS PREVIOUSLY TAXED TO THE RECIPIENT AND AMOUNTS TAXABLE TO THE RECIPIENT IN THE CURRENT YEAR THE TAXABLE AMOUNTS ARE INCLUDED ON THE RECIPIENT'S W-2 ANY DISTRIBUTIONS FROM THIS PLAN ARE REPORTED BELOW NQDC SERP PLANS STARTING IN 2014 STARTING IN 2014, THE ORGANIZATION'S NQDC SERP PLAN PROVIDED A BENEFIT TO ELIGIBLE PARTICIPANTS BASED ON A PERCENTAGE OF THEIR BASE COMPENSATION THE VESTING PERIOD IS ROLLING 3 YEARS OR WHEN THE PARTICIPANT IS AGE 65 OR OLDER THERE WERE NO CONTRIBUTIONS TO THIS PLAN BEFORE JANUARY 1, 2014 ANY DISTRIBUTIONS FROM THIS PLAN ARE REPORTED BELOW STARTING IN 2014, FOR CONTRIBUTIONS TO THE NQDC SERP PLAN, CERTAIN PARTICIPANTS ARE VESTED OR BECAME VESTED IN THE PLAN DURING 2016 VESTED AMOUNTS ARE PAYABLE TO THE RECIPIENT THE VESTED AMOUNTS ARE TAXABLE TO THE RECIPIENT IN THE CURRENT YEAR THE TAXABLE AMOUNTS ARE INCLUDED ON THE RECIPIENT'S W-2 THE AMOUNTS WITHDRAWN FROM THE NQDC SERP PLANS IN 2016 WERE MICHAEL SLUBOWSKI - \$566,716, WILLIAM ANDERSON - \$77,197, DAVID PECORARO - \$90,679, GERALDINE TOWNDROW - \$34,500, THOMAS PETERSON - \$114,483 IN ACCORDANCE WITH THE REQUIREMENTS OF SCHEDULE J, DEFERRED COMPENSATION EARNED OVER THE VESTING PERIOD IS REPORTED IN COLUMN C AND ANY AMOUNTS VESTED/PAID FROM A DEFERRED COMPENSATION PLAN ARE REPORTED IN COLUMN B(III) THUS, THE SAME AMOUNT WOULD BE REPORTED TWICE (FIRST WHEN IT ACCRUED DURING THE VESTING PERIOD AND AGAIN WHEN IT IS VESTED/PAID) THIS RESULTS IN THE APPEARANCE OF CERTAIN EXECUTIVES RECEIVING MORE THAN THEY ARE ACTUALLY PAID FROM THE DEFERRED COMPENSATION PLANS COLUMN F IS INTENDED TO RECONCILE THIS DUPLICATION (BY REPORTING AMOUNTS INCLUDED IN COLUMN B(III) THAT HAD BEEN REPORTED AS DEFERRED COMPENSATION ON A SCHEDULE J FOR A PREVIOUS YEAR) HOWEVER, THE SIGNIFICANCE OF THE AMOUNTS LISTED IN COLUMN F IS OFTEN OVERLOOKED AND GIVEN THE COMPLEXITY OF THE SCHEDULE J REPORTING REQUIREMENTS, THE AMOUNTS SHOWN ARE EASILY MISUNDERSTOOD TO DETERMINE TOTAL AMOUNT EARNED (RATHER THAN THE AMOUNT VESTED/PAID OUT) DURING THE YEAR, SUBTRACT THE AMOUNT IN COLUMN F FROM COLUMN E</p> |

Part III, Supplemental Information

| Return Reference | Explanation |
|------------------|---|
| PART I, LINE 7 | OTHER NON-FIXED PAYMENTS THE AT RISK COMPENSATION PLAN WAS ESTABLISHED TO ENABLE THE HEALTH CARE SYSTEM AND ITS CARE SITES TO ATTRACT AND ENGAGE QUALIFIED LEADERS AND TO PROVIDE SUCH LEADERS WITH AN ADDITIONAL PERFORMANCE COMPENSATION OPPORTUNITY TO PROMOTE AND FURTHER ITS CHARITABLE MISSION, VISION STRATEGIC PRIORITIES AND KEY INITIATIVES THE PLAN OPERATES ON A CALENDAR-YEAR BASIS AND IS FUNDED EACH YEAR BY MEETING THRESHOLD LEVELS OF OPERATING INCOME TARGET AWARD AMOUNTS ARE A PERCENTAGE OF LEADERS' BASE PAY AS DETERMINED BY THEIR SPECIFIC ROLE AT THE HEALTH CARE SYSTEM ACTUAL AWARDS ARE PAID OUT BASED ON ATTAINMENT OF BOARD APPROVED GOALS, INCLUDING OPERATING INCOME, STEWARDSHIP, PATIENT EXPERIENCE, EMPLOYEE SAFETY AND COMMUNITY BENEFIT/MISSION TARGETS AWARDS ARE BASED ON THE BOARD'S DETERMINATION ON HOW WELL THE HEALTH CARE SYSTEM PERFORMS RELATIVE TO THE PLAN'S STATED PERFORMANCE STANDARDS AND THE WEIGHT GIVEN TO EACH OF THE PERFORMANCE MEASURES AS DEFINED FOR THAT PLAN YEAR THE AT RISK COMPENSATION PLANS ARE BASED ON A COMBINATION OF PERFORMANCE MEASURES PERFORMANCE MEASURES INCLUDE OPERATING INCOME, STEWARDSHIP, PATIENT EXPERIENCE, EMPLOYEE SAFETY AND COMMUNITY BENEFIT/MISSION TARGETS THE AT RISK COMPENSATION PLAN SHALL BE INTERPRETED, APPLIED AND ADMINISTERED AT ALL TIMES IN ACCORDANCE WITH CODE SECTION 409A AND GUIDANCE ISSUED THEREUNDER THE HEALTH CARE SYSTEM RESERVES THE RIGHT TO AMEND OR TERMINATE THIS PLAN AT ANY TIME FOR ANY REASON |

Part III, Supplemental Information

| Return Reference | Explanation |
|--|--|
| ADDITIONAL OFFICER AND BOARD DISCLOSURES | THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) AND RELATED TAX EXEMPT ORGANIZATIONS CONSISTS OF NINE HOSPITALS, NINE FOUNDATIONS, TWO SAFETY-NET CLINICS, ONE CHILDREN'S MENTAL HEALTH CENTER AND MORE THAN 190 AMBULATORY SERVICE CENTERS IN THREE STATES SCLHS AND RELATED TAX EXEMPT ORGANIZATIONS ADHERE TO GOVERNANCE EXCELLENCE STANDARDS INCLUDING TRANSPARENCY AND ACCOUNTABILITY IN KEEPING WITH SCLHS' CORE VALUE OF STEWARDSHIP, NO BOARD MEMBER SERVING ON THE BOARD OF DIRECTORS (BOARD) IS COMPENSATED FOR THAT SERVICE SCLHS' BOARD COMPENSATION COMMITTEE (COMMITTEE) HAS RETAINED THE SERVICES OF AN INDEPENDENT COMPENSATION ADVISOR THE COMPENSATION ADVISOR IS RESPONSIBLE FOR ADVISING THE COMMITTEE ON ALL MATTERS RELATING TO EXECUTIVE COMPENSATION INCLUDING SUPPORTING THE COMMITTEE'S EFFORTS TO ENSURE THAT THE LEVEL OF COMPENSATION PROVIDED OFFICERS AND SENIOR MANAGEMENT IS REASONABLE, APPROPRIATE AND CONSISTENT WITH THE PAY PHILOSOPHY SET BY THE BOARD THE SISTERS WHO SERVE AS OFFICERS AND/OR BOARD MEMBERS ARE MEMBERS OF THE SISTERS OF CHARITY OF LEAVENWORTH (A RELIGIOUS ORDER OF WOMEN) THE SISTERS HAVE TAKEN VOWS OF POVERTY AND RECEIVE NO COMPENSATION, EXPENSE ACCOUNT ALLOWANCE, OR CONTRIBUTIONS TO BENEFIT PLANS FOR THEIR SERVICES TO THE HEALTH CARE SYSTEM HOWEVER, A PAYMENT IS MADE DIRECTLY TO THE SISTERS OF CHARITY OF LEAVENWORTH FOR THE SERVICES OF THOSE WHO PERFORM PROFESSIONAL, ADMINISTRATIVE, AND OTHER SUCH SERVICES |

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 | | | | |
| 1MICHAEL SLUBOWSKI SYSTEM PRESIDENT AND CEO | (i) | 1,132,496 | 220,576 | 598,133 | 19,080 | 19,516 | 1,989,801 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 1LYDIA JUMONVILLE TREASURER & CFO/EVP | (i) | 706,515 | 97,092 | 208,664 | 220,478 | 18,358 | 1,251,107 | 190,203 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 2ROSLAND MCLEOD SECRETARY/SVP CHIEF LEGAL OFFICER | (i) | 476,267 | 76,875 | 17,503 | 141,090 | 27,889 | 739,624 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 3MICHAEL TAYLOR CHIEF OPERATING OFF-HOSP OPS | (i) | 700,141 | 112,079 | 37,136 | 129,931 | 26,574 | 1,005,861 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 4WILLIAM ANDERSON SVP-CHIEF HUMAN RESOURCES OFCR | (i) | 367,647 | 61,436 | 120,370 | 18,240 | 21,586 | 589,279 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 5STEVEN CHYUNG CHIEF STEWARDSHP & TRNFMTN OFC | (i) | 365,105 | 61,181 | 102,752 | 66,652 | 29,836 | 625,526 | 85,581 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 6SHAWN DUFFORD SVP CHIEF MEDICAL OFFICER SYS | (i) | 476,834 | 65,891 | 14,838 | 87,580 | 21,814 | 666,957 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 7TAJQUAH HUDSON SVP-CHIEF STRAT-BUS DEV OFCR | (i) | 445,804 | 71,036 | 17,695 | 137,057 | 6,817 | 678,409 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 8KERRY KOHNEN SVP PAYER & POP HEALTH STRAT | (i) | 269,667 | 0 | 47,374 | 0 | 201 | 317,242 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 9WILLIAM PACK VP FINANCE OPERATIONS 1/1-5/6 | (i) | 147,546 | 42,624 | 2,218 | 56,393 | 10,011 | 258,792 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 10DAVID PECORARO SVP-CHIEF INFORMATION OFFICER | (i) | 417,839 | 68,142 | 113,581 | 19,080 | 18,210 | 636,852 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 11DAVID PRINGLE SVP MISSION INTEGRATION | (i) | 285,518 | 47,097 | 46,105 | 49,930 | 18,415 | 447,065 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 12KAREN SCREMIN VP FINANCE OPERATIONS | (i) | 312,819 | 28,524 | 1,436 | 45,080 | 9,740 | 397,599 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 13TROY SPRING VP REVENUE CYCLE | (i) | 249,373 | 23,773 | 2,964 | 32,629 | 28,777 | 337,516 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 14GERALDINE TOWNDROW SVP CHIEF NURSING OFFICER SYS | (i) | 307,717 | 40,664 | 53,863 | 14,617 | 7,698 | 424,559 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 15MARK WILKINSON VP TREASURER | (i) | 266,163 | 30,586 | 58,747 | 44,119 | 9,532 | 409,147 | 57,309 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 16CHRISTINE WOOLSEY SVP AND CHIEF COMM-MKTG OFCR | (i) | 319,297 | 51,614 | 13,520 | 82,402 | 15,417 | 482,250 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 17J GRANT WICKLUND PRESIDENT-CEO LMC | (i) | 451,185 | 74,595 | 29,382 | 241,737 | 21,966 | 818,865 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 18WILLIAM ANDERSON MEDICAL DIRECTOR | (i) | 686,101 | 27,160 | 11,138 | 16,430 | 25,605 | 766,434 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |
| 19DAVID HAMM PRESIDENT-CEO EGSM | (i) | 428,582 | 71,471 | 30,365 | 189,399 | 18,960 | 738,777 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | - 0 | - 0 | 0 |

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 | | | | |
| 21STEVE LOVELESS PRESIDENT CEO SVH-MT REG | (i) | 461,919 | 71,543 | 94,782 | 75,503 | 21,607 | 725,354 | 80,560 |
| | (ii) | 0 | 0 | 0 | 0 | -0 | -0 | 0 |
| 1THOMAS PETERSON CHIEF SAFETY OFFICER 1/1-9/9 | (i) | 229,046 | 36,417 | 247,934 | 14,095 | 20,923 | 548,415 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | -0 | -0 | 0 |
| 2ROBERT LADENBURGER FORMER KEY EMPLOYEE | (i) | 0 | 0 | 323,002 | 0 | 6,893 | 329,895 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | -0 | -0 | 0 |

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Supplemental Information on Tax Exempt Bonds

► Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
► Attach to Form 990.

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

OMB No 1545-0047

2016

Open to Public Inspection

Employer identification number
23-7379161

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 COLORADO HEALTH FACILITIES AUTHORITY | 84-0752932 | 19648AST3 | 05-20-2010 | 605,460,143 | 3/24/98,11/13/02,7/18/02 REFI+HOSP FA | | X | | X | | X |
| B MONTANA FACILITY FINANCE AUTHORITY | 81-0302402 | 61204KHV6 | 05-20-2010 | 217,535,868 | 3/24/98 & 5/25/00 REFI+HOSP FAC | | X | | X | | X |
| C KANSAS DEVELOPMENT FINANCE AUTHORITY | 48-1066589 | 48542K5N5 | 05-20-2010 | 202,625,401 | 3/24/98 & 5/25/00 REFI+HOSP FAC | X | | | X | | X |
| D COLORADO HEALTH FACILITIES AUTHORITY | 84-0752932 | NONEAVAIL | 06-15-2011 | 62,620,000 | 7/18/02 & 2/4/09 REFI | | X | | X | | X |

Part II

Proceeds

| | | | | | A | | B | | C | | D | |
|----|--|--|--|--|-------------|----|-------------|----|-------------|----|------------|----|
| 1 | Amount of bonds retired | | | | 74,170,000 | | 32,180,000 | | 29,745,000 | | 5,105,000 | |
| 2 | Amount of bonds legally defeased | | | | | | | | 135,375,000 | | | |
| 3 | Total proceeds of issue | | | | 605,500,535 | | 217,665,906 | | 202,625,401 | | 62,620,000 | |
| 4 | Gross proceeds in reserve funds | | | | | | | | | | | |
| 5 | Capitalized interest from proceeds | | | | | | | | | | | |
| 6 | Proceeds in refunding escrows | | | | | | | | | | | |
| 7 | Issuance costs from proceeds | | | | 6,836,215 | | 2,529,281 | | 2,488,006 | | 420,000 | |
| 8 | Credit enhancement from proceeds | | | | | | | | | | | |
| 9 | Working capital expenditures from proceeds | | | | | | | | | | | |
| 10 | Capital expenditures from proceeds | | | | 310,650,923 | | 94,781,550 | | 77,008,019 | | | |
| 11 | Other spent proceeds | | | | 288,013,397 | | 120,355,075 | | 123,129,376 | | 62,200,000 | |
| 12 | Other unspent proceeds | | | | | | | | | | | |
| 13 | Year of substantial completion | | | | 2010 | | 2010 | | 2010 | | 2011 | |
| | | | | | Yes | No | Yes | No | Yes | No | Yes | No |
| 14 | Were the bonds issued as part of a current refunding issue? | | | | X | | X | | X | | X | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | | | X | | | X | | X | | X |
| 16 | Has the final allocation of proceeds been made? | | | | X | | X | | X | | X | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | | | | X | | X | | X | | X | |

Part III

Private Business Use

| | | A | | B | | C | | D | |
|---|--|-----|----|-----|----|-----|----|-----|----|
| | | Yes | No | 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 | | X | | X |
| 2 | Are there any lease arrangements that may result in private business use of bond-financed property? | X | | X | | 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 | | 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 | | X | | X | |
| c Are there any research agreements that may result in private business use of bond-financed property? | | X | | X | | 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? | | | | | | | | |
| 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 ▶ | | | 1 300 % | | | | | |
| 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 ▶ | | | 0 100 % | | | | | |
| 6 Total of lines 4 and 5 | | | 1 400 % | | | | | |
| 7 Does the bond issue meet the private security or payment test? . . . | | X | | X | 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 | X | | | X |
| b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . | | | | | 64 520 % | | | |
| c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? | | | | | X | | | |
| 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 | | 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 | | X | | X |
| 2 If "No" to line 1, did the following apply? | | | | | | | | |
| a Rebate not due yet? | | X | | X | | X | | X |
| b Exception to rebate? | | X | | X | | X | | X |
| c No rebate due? | X | | X | | 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? | | X | | X | | X | X | |
| 4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | X | | X | | X | | X |
| b Name of provider | | | | | | | | |
| c Term of hedge | | | | | | | | |
| d Was the hedge superintegrated? | | | | | | | | |
| e Was the hedge terminated? | | | | | | | | |

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 | | 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 | | X | | X |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | X | | X | | 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 | | X | | X | |

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

| Return Reference | Explanation |
|------------------|--|
| PART IV, LINE 2C | REBATE COMPLETION DATES A - COLORADO HEALTH FACILITIES AUTHORITY 2010 - 5/20/16 B - MONTANA FACILITY FINANCE AUTHORITY 2010 - 5/20/16 C - KANSAS DEVELOPMENT FINANCE AUTHORITY 2010 - 5/20/16 D - COLORADO HEALTH FACILITIES AUTHORITY 2011 - 6/15/16 A - COLORADO HEALTH FACILITIES AUTHORITY 2013 - 11/12/16 B - KANSAS DEVELOPMENT FINANCE AUTHORITY 2013 - 5/20/16 |

| Return Reference | Explanation |
|---------------------------------------|--|
| PART I COLUMN (E) & PART II LINE 3 | ANY DIFFERENCE BETWEEN ISSUES PRICE REPORTED ON PART I, COLUMN (E) AND TOTAL PROCEEDS REPORTED ON PART II, LINE 3 IS DUE TO INVESTMENT EARNINGS |

| Return Reference | Explanation |
|-------------------|--|
| PART III, LINE 8B | PROVIDENCE MEDICAL CENTER (KANSAS CITY, KS) AND SAINT JOHN HOSPITAL (LEAVENWORTH, KS) WERE SOLD APRIL 2013 AND REMEDIAL ACTIONS (REISSUANCE AND REDEMPTION) WERE TAKEN WITH RESPECT TO THE OUTSTANDING BONDS |

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public
Inspection

Employer identification number
23-7379161

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 COLORADO HEALTH FACILITY AUTHORITY | 84-0752932 | 19648AN84 | 11-12-2013 | 302,719,375 | CONSTRUCT HOSPITAL FACILITY | | X | | X | | X |
| B KANSAS DEVELOPMENT FINANCE AUTHORITY | 48-1066589 | 48542K5N5 | 04-01-2013 | 32,775,000 | REISSUANCE OF KANSAS 2010 | X | | | X | | X |
| C COLORADO HEALTH FACILITY AUTHORITY | 84-0752932 | 19648A5S0 | 05-12-2016 | 221,970,000 | CONSTRUCT HOSPITAL FACILITY | | X | | X | | X |

Part II

Proceeds

| | | A | | B | | C | | D | |
|----|--|-------------|----|------------|----|-------------|----|-----|----|
| 1 | Amount of bonds retired | | | 3,170,000 | | | | | |
| 2 | Amount of bonds legally defeased | | | 7,805,000 | | | | | |
| 3 | Total proceeds of issue | 302,719,375 | | 32,775,000 | | 221,976,622 | | | |
| 4 | Gross proceeds in reserve funds | | | | | | | | |
| 5 | Capitalized interest from proceeds | | | | | | | | |
| 6 | Proceeds in refunding escrows | | | | | | | | |
| 7 | Issuance costs from proceeds | 3,005,563 | | | | 1,908,538 | | | |
| 8 | Credit enhancement from proceeds | | | | | | | | |
| 9 | Working capital expenditures from proceeds | | | | | | | | |
| 10 | Capital expenditures from proceeds | 299,713,812 | | | | 219,956,622 | | | |
| 11 | Other spent proceeds | | | 32,775,000 | | | | | |
| 12 | Other unspent proceeds | | | | | 111,462 | | | |
| 13 | Year of substantial completion | 2013 | | 2013 | | 2016 | | | |
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 14 | Were the bonds issued as part of a current refunding issue? | | X | | X | | X | | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | X | | X | | X | | |
| 16 | Has the final allocation of proceeds been made? | X | | X | | | X | | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | X | | | |

Part III

Private Business Use

| | | A | | B | | C | | D | |
|---|--|-----|----|-----|----|-----|----|-----|----|
| | | Yes | No | 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 | | X | | |
| 2 | Are there any lease arrangements that may result in private business use of bond-financed property? | X | | 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 | | 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 | | X | | | |
| c Are there any research agreements that may result in private business use of bond-financed property? | | X | | 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? | | | | | | | | |
| 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 ▶ | | | | | | | | |
| 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 | | | | | | | | |
| 7 Does the bond issue meet the private security or payment test? . . . | | X | | 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 | | 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 | | 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 | | X | | |
| 2 If "No" to line 1, did the following apply? | | | | | | | | |
| a Rebate not due yet? | | X | | X | X | | | |
| b Exception to rebate? | | X | | X | | X | | |
| c No rebate due? | X | | 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? | | X | | X | X | | | |
| 4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | X | | X | | X | | |
| b Name of provider | | | | | | | | |
| c Term of hedge | | | | | | | | |
| d Was the hedge superintegrated? | | | | | | | | |
| e Was the hedge terminated? | | | | | | | | |

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 | | 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 | | X | | |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | X | | 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 | | X | | | |

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

SCHEDULE O
(Form 990 or 990-EZ)Department of the Treasury
Internal Revenue ServiceName of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC**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

2016**Open to Public
Inspection****Employer identification number**

23-7379161

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION A, LINE 6 | THE MEMBERS OF SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) SHALL BE THE MEMBERS OF LEAVEN MINISTRIES THE MEMBERS OF LEAVEN MINISTRIES SHALL SERVE AS MEMBERS OF SCLHS DURING THEIR TERMS OF OFFICE AS MEMBERS OF LEAVEN MINISTRIES |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION A, LINE 7A | THE PRESIDENT/CHIEF EXECUTIVE OFFICER OF THE CORPORATION AND THE CHAIR OF LEAVEN MINISTRIES, OR HIS/HER DESIGNEE, SHALL BE EX-OFFICIO MEMBERS OF THE BOARD WITH FULL VOTING RIGHTS THE CHAIR OF LEAVEN MINISTRIES SHALL APPOINT AN ADDITIONAL MEMBER OF THE CORPORATION TO SERVE ON THE BOARD OF DIRECTORS OF THE CORPORATION THE BOARD OF DIRECTORS SHALL ENSURE THE PRESENCE OF REPRESENTATIVES NOMINATED BY THE PARTICIPATING ENTITIES ON THIS BOARD AND ON THE BOARD OF ANY CORPORATION OF WHICH THIS CORPORATION IS A CONTROLLING MEMBER EXCEPT FOR EX-OFFICIO MEMBERS OF THE BOARD OF DIRECTORS, THE MEMBERS SHALL APPOINT DIRECTORS AT THE ANNUAL MEETING OF THE MEMBERS A SLATE OF NAMES PROPOSED BY A NOMINATING COMMITTEE OF THE BOARD OF DIRECTORS FOR APPOINTMENT AS DIRECTORS SHALL BE SUBMITTED TO THE MEMBERS BY THE CHAIRPERSON OF THE BOARD, PROVIDED, HOWEVER, THAT THE MEMBERS MAY APPOINT INDIVIDUALS AS DIRECTORS WHO HAVE NOT BEEN NOMINATED BY THE NOMINATING COMMITTEE |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7B | <p>THE MEMBERS OF THE CORPORATION SHALL BE THE MEMBERS OF LEAVEN MINISTRIES THE MEMBERS OF LEAVEN MINISTRIES SHALL SERVE AS MEMBERS OF THE CORPORATION DURING THEIR TERM OF OFFICE AS MEMBERS OF LEAVEN MINISTRIES IN ADDITION TO ALL MATTERS REQUIRED BY LAW OR BY THE ARTICLES OF INCORPORATION OR OTHER PROVISIONS OF THESE BYLAWS WHICH ARE REQUIRED TO BE PERFORMED BY THE MEMBERS, THE MEMBERS SHALL HAVE THE SOLE PREROGATIVE TO ACT UPON ANY OF THE FOLLOWING MATTERS AND, IF ANY ACTION WITH RESPECT TO ANY OF THE FOLLOWING IS INITIATED BY A BODY OTHER THAN THE MEMBERS, IT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED BY AN AFFIRMATIVE VOTE OF THE MEMBERS TO ESTABLISH/APPROVE THE MISSION/PHILOSOPHY OF THIS CORPORATION AND ANY CORPORATION OF WHICH THIS CORPORATION IS THE CONTROLLING MEMBER, TO ADOPT, AMEND OR REPEAL THE ARTICLES OF INCORPORATION OR BYLAWS OF THIS CORPORATION AND THE ARTICLES AND BYLAWS OF ANY CORPORATION OF WHICH THIS CORPORATION IS THE CONTROLLING MEMBER, TO FIX THE NUMBER OF DIRECTORS OF THIS CORPORATION AND APPOINT THE CORPORATION'S BOARD OF DIRECTORS, AFTER RECEIVING RECOMMENDATIONS FROM THE BOARD, PROVIDED THAT THE MEMBERS' APPOINTMENT AUTHORITY SHALL NOT BE LIMITED TO THE NOMINATIONS RECEIVED, TO REMOVE, WITH OR WITHOUT CAUSE, AFTER CONSULTATION WITH THE BOARD OF DIRECTORS, ANY MEMBER OF THE BOARD OF THIS CORPORATION, TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, AFTER CONSULTATION WITH THE BOARD OF DIRECTORS, THE PRESIDENT/CHIEF EXECUTIVE OFFICER OF THIS CORPORATION, TO APPROVE FOR THIS CORPORATION, OR FOR ANY CORPORATION OF WHICH THIS CORPORATION IS THE CONTROLLING MEMBER, THE INCURRENCE OF INDEBTEDNESS OR THE SALE, TRANSFER, ASSIGNMENT, OR ENCUMBERING OF THE ASSETS, PURSUANT TO POLICIES ESTABLISHED FROM TIME TO TIME BY THE MEMBERS OF THIS CORPORATION, TO APPROVE THE MERGER, DISSOLUTION OR CORPORATE RESTRUCTURING OF THIS CORPORATION OR ANY CORPORATION OF WHICH THIS CORPORATION IS THE CONTROLLING MEMBER</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION B, LINE 11B | THE FORM 990 IS PREPARED BY THE TAX DEPARTMENT THE FORM 990 IS REVIEWED BY SENIOR MANAGEMENT A COPY OF THE FORM 990 IS PROVIDED TO THE BOARD OF DIRECTORS PRIOR TO THE FILING OF THE FORM 990 WITH THE INTERNAL REVENUE SERVICE ANY QUESTIONS ARE ADDRESSED TO THE TAX DIRECTOR OF SCLHS PRIOR TO FILING THE FORM 990 WITH THE INTERNAL REVENUE SERVICE THE FORM 990 WAS ALSO REVIEWED BY AN OUTSIDE ACCOUNTING FIRM |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>MONITORING AND ENFORCEMENT OF COMPLIANCE WITH CONFLICT OF INTEREST POLICY SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES ITS CONFLICT OF INTEREST POLICY BY PROVIDING EDUCATION AND TRAINING FOR ITS EMPLOYEES, STAFF, OFFICERS AND DIRECTORS PERSONS CONSIDERED TO BE IN AN INFLUENTIAL POSITION, SUCH AS BOARD MEMBERS, OFFICERS, PHYSICIANS, EXECUTIVES AND MANAGERS ARE ALL REQUIRED TO COMPLETE A CONFLICT OF INTEREST STATEMENT ON AN ANNUAL BASIS TO DISCLOSE ANY POTENTIAL CONFLICT ISSUES THESE STATEMENTS ARE CAREFULLY REVIEWED BY THE SCL HEALTH INTEGRITY AND COMPLIANCE DEPARTMENT AND APPROPRIATE LEADERSHIP A REPORT IS PROVIDED TO SCLHS' PRESIDENT/CEO AND THE BOARD OF DIRECTORS THE BUSINESS AND AFFAIRS OF SCL HEALTH WILL AT ALL TIMES BE CONDUCTED IN A MANNER THAT IS SOLELY IN THE BEST INTERESTS OF SCL HEALTH AND NOT BE INFLUENCED BY CONFLICTING INTERESTS OF PERSONS RESPONSIBLE FOR ADMINISTERING THOSE AFFAIRS THE EXISTENCE OF ANY CONFLICTS OF INTEREST WILL BE DISCLOSED AND THE PROCEDURES SET FORTH HEREIN WILL BE FOLLOWED CERTAIN TRANSACTIONS SUGGESTIVE OF A CONFLICT OF INTEREST ARE PROHIBITED ANY PERSON IN A POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER SCL HEALTH IS CONSIDERED AN INTERESTED PERSON THIS TERM INCLUDES, BUT IS NOT LIMITED TO THE FOLLOWING - BOARD MEMBERS, BOARD COMMITTEE MEMBERS, OFFICERS AND DIRECTORS, - SENIOR LEADERS AND EXECUTIVES (CEO, PRESIDENT, SVP, VP, EXECUTIVE DIRECTORS), - EMPLOYED PHYSICIANS AND PHYSICIANS IN MEDICAL STAFF LEADERSHIP ROLES (E.G., DEPARTMENT CHAIRS, MEMBERS OF MEDICAL STAFF COMMITTEES), - MEDICAL DIRECTORS OF CLINICAL PROGRAMS THAT ASSESS, REVIEW, RECOMMEND OR REQUEST PURCHASE OF ANY SPECIFIC PHARMACEUTICAL PRODUCTS, MEDICAL DEVICES, SUPPLIES AND/OR EQUIPMENT, - DEPARTMENT DIRECTORS AND MANAGERS, AND - OTHER SELECT INDIVIDUALS IDENTIFIED BY LEADERSHIP WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, SUPPLY CHAIN AND FINANCE UPON BECOMING AN INTERESTED PERSON AND ON AN ANNUAL BASIS, INTERESTED PERSONS ARE REQUIRED TO DISCLOSE ANY RELATIONSHIPS THAT CONSTITUTE OR MIGHT LEAD TO A CONFLICT OF INTEREST BY COMPLETING THE CURRENT CONFLICT OF INTEREST AND GIFT DISCLOSURE STATEMENT ("STATEMENT") AS APPROVED BY THE CHIEF INTEGRITY AND COMPLIANCE OFFICER THE CHIEF INTEGRITY AND COMPLIANCE OFFICER WILL OVERSEE THE REVIEW OF THE STATEMENTS AND THE RESOLUTION OF ANY IDENTIFIED CONFLICTS OF INTEREST AND ALERT THE SCL HEALTH CEO AND/OR THE CHAIR OF THE SCL HEALTH BOARD OF DIRECTORS TO ANY ITEMS OF CONCERN WHEN AN INTERESTED PERSON BECOMES AWARE OF A CONFLICT OF INTEREST WHICH HAS NOT BEEN DISCLOSED ON A STATEMENT, HE OR SHE SHALL CONTACT THE LOCAL COMPLIANCE AND PRIVACY OFFICER OR THE CHIEF INTEGRITY AND COMPLIANCE OFFICER, OBTAIN A STATEMENT FORM, COMPLETE AND RETURN IT TO THE SCL HEALTH INTEGRITY AND COMPLIANCE DEPARTMENT WHENEVER AN INTERESTED PERSON BECOMES AWARE THAT AN ARRANGEMENT WITH RESPECT TO WHICH HE OR SHE HAS A CONFLICT OF INTEREST IS BEING CO</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>NSIDERED, THE INTERESTED PERSON MUST DISCLOSE ALL MATERIAL FACTS CONCERNING THE EXISTENCE AND NATURE OF THE CONFLICT OF INTEREST TO HIS OR HER SUPERVISOR (IF AN EMPLOYEE OTHER THAN THE ORGANIZATIONS SCL HEALTH CEO) OR TO THE APPLICABLE BOARD OR COMMITTEE CHAIR (IF THE S CL HEALTH CEO OR A BOARD OR COMMITTEE MEMBER), EVEN IF THE CONFLICT OF INTEREST HAS BEEN P REVIOUSLY DISCLOSED WITH REGARD TO EMPLOYEES OTHER THAN THE SCL HEALTH CEO, THE INTERESTE D PERSON'S SUPERVISOR WILL DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS WITH REGARD TO THE SCL HEALTH CEO AND BOARD OR COMMITTEE MEMBERS, THE REMAINING MEMBERS OF THE BOARD OR COMMITTEE WILL DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS PERSON(S) RESPONSIBLE FOR THE DETERMINATION SHOULD OBTAIN FURTHER GUIDANCE FROM THE SCL HEALTH INTEGRITY AND COMPLIANCE OR LEGAL DEPARTMENTS UPON MAKING HIS OR HER DISCLOSURE, THE INTERESTED PERSON WILL LE AVE THE MEETING OR OTHERWISE REMOVE HIM OR HERSELF FROM THE DELIBERATIONS OR OTHER DECISIO N-MAKING PROCESS UNTIL SUCH TIME AS A DETERMINATION IS REACHED IF A DETERMINATION HAS BEE N MADE THAT NO CONFLICT OF INTEREST EXISTS, THE INTERESTED PERSON MAY BE PRESENT AND PARTI CIPATE IN THE DELIBERATION REGARDING THE TRANSACTION OR ARRANGEMENT HOWEVER, IF AN INTERE STED PERSON HAS BEEN DETERMINED TO HAVE A CONFLICT OF INTEREST, HE OR SHE MAY NOT PARTICIP ATE IN THE DELIBERATION OR DECISION REGARDING THE TRANSACTION OR ARRANGEMENT, BE PRESENT D URING THE DELIBERATION OR DECISION-MAKING, OR BE ALLOWED TO MAKE A PRESENTATION PRIOR TO T HE DELIBERATION AND DECISION-MAKING ACTIVITIES WHEN AN INTERESTED PERSON HAS A CONFLICT O F INTEREST, THE DECISION-MAKER/DECISION-MAKING BODY CONSIDERING THE TRANSACTION OR ARRANGE MENT WILL TAKE REASONABLE MEASURES, PRIOR TO APPROVING OR ENTERING INTO THE TRANSACTION OR ARRANGEMENT, TO ENSURE THAT THE PROPOSAL IS IN SCL HEALTH'S BEST INTERESTS THE PROPOSED TRANSACTION OR ARRANGEMENT MAY PROCEED IF THE DECISION-MAKER/DECISION-MAKING BODY, AFTER H AVING BEEN FULLY INFORMED OF THE MATERIAL FACTS ESTABLISHING THE CONFLICT OF INTEREST, DET ERMINES THAT THE TRANSACTION OR ARRANGEMENT IS IN SCL HEALTH'S BEST INTERESTS AND IS FAIR AND REASONABLE A MAJORITY VOTE OF THE DISINTERESTED DECISION-MAKERS IS REQUIRED WHEN A DE TERMINATION IS MADE BY A BOARD, COMMITTEE OR OTHER DECISION-MAKING BODY MANAGEMENT OF POT ENTIAL CONFLICTS IS DONE BY THE CHIEF INTEGRITY AND COMPLIANCE OFFICER AND/OR CARE SITE CO MPLIANCE AND PRIVACY OFFICERS AND REPORTED ANNUALLY TO THE CARE SITE LEADERSHIP COMMITTEES AND/OR EXECUTIVE INTEGRITY AND COMPLIANCE COMMITTEE, THE AUDIT COMMITTEE, ORGANIZATIONAL INTEGRITY AND COMPLIANCE COMMITTEE OF THE SCL HEALTH BOARD OF DIRECTORS ANY REPORTED CONF LICTS OR POTENTIAL CONFLICTS WILL ALSO BE REPORTED TO AND REVIEWED BY THE SCL HEALTH TAX D IRECTOR FOR COMPLIANCE WITH THE FORM 990 TAX RETURN</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION B, LINE 15 | <p>SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) PROCESS FOR DETERMINING COMPENSATION FOR THE OFFICERS AND SENIOR MANAGEMENT IS THE RESPONSIBILITY OF THE COMPENSATION COMMITTEE COMPENSATION FOR THE OFFICERS AND SENIOR MANAGEMENT IS MANAGED BY THE SCL HEALTH BOARD COMPENSATION COMMITTEE (COMMITTEE) ON BEHALF OF SCL HEALTH AND ALL OF ITS AFFILIATES THE COMMITTEE REVIEWS AND APPROVES COMPENSATION ARRANGEMENTS OF THE OFFICERS AND SENIOR MANAGEMENT AND MAKES RECOMMENDATIONS TO SCL HEALTH'S BOARD FOR APPROVAL OF ANY CHANGES TO COMPENSATION FOR THE OFFICERS AND SENIOR MANAGEMENT THE COMMITTEE'S REVIEW IS CONDUCTED IN A MANNER THAT IS INTENDED TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER THE INTERMEDIATE SANCTIONS RULES OF INTERNAL REVENUE CODE SECTION 4958 THE COMMITTEE CONDUCTS THE REVIEW WITH THE ASSISTANCE OF AN EXPERIENCED AND INDEPENDENT COMPENSATION CONSULTING FIRM THAT HAS DEEP NATIONAL EXPERTISE IN HEALTH SYSTEMS' EXECUTIVE COMPENSATION PROGRAMS AND LEVELS THE COMMITTEE OBTAINS AND RELIES UPON CURRENT, COMPARABLE MARKET DATA FOR PEER ORGANIZATIONS PRIOR TO MAKING COMPENSATION RELATED DECISIONS THE INFORMATION REVIEWED INCLUDES COMPENSATION LEVELS PAID BY SIMILARLY SITUATED ORGANIZATIONS FOR FUNCTIONALLY COMPARABLE POSITIONS, THE AVAILABILITY OF SIMILAR SERVICES IN THE GEOGRAPHIC AREA SERVED BY SCL HEALTH AND CURRENT COMPENSATION SURVEYS COMPILED BY AN INDEPENDENT FIRM CONSISTENT WITH THE PAY PHILOSOPHY SET BY SCL HEALTH'S BOARD, THE COMMITTEE EMPHASIZES THE IMPORTANCE OF ENSURING TOTAL REMUNERATION IS REASONABLE AND APPROPRIATE WHEN REVIEWING AND MAKING RECOMMENDATIONS WITH RESPECT TO COMPENSATION PACKAGES FOR THE OFFICERS AND SENIOR MANAGEMENT AS PART OF THE REVIEW PROCESS, SCL HEALTH USES THE FOLLOWING IN ESTABLISHING THE COMPENSATION OF OFFICERS AND SENIOR MANAGEMENT 1) COMPENSATION COMMITTEE 2) INDEPENDENT COMPENSATION CONSULTANT 3) FORM 990 OF OTHER ORGANIZATIONS 4) WRITTEN EMPLOYMENT CONTRACTS 5) COMPENSATION SURVEYS AND STUDIES 6) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE THE ITEMS LISTED ABOVE SUPPORT THE COMPENSATION COMMITTEE'S EFFORTS TO ENSURE THAT THE LEVEL OF COMPENSATION PROVIDED TO ITS OFFICERS AND SENIOR MANAGEMENT IS REASONABLE, APPROPRIATE AND CONSISTENT WITH THE PAY PHILOSOPHY SET BY THE BOARD</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION C, LINE 19 | THE ORGANIZATION MAKES ITS CONFLICT OF INTEREST POLICY, FINANCIAL STATEMENTS, AND GOVERNING DOCUMENTS AVAILABLE UPON REQUEST |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990, PART XI, LINE 9 | CHANGE IN SELF INSURED LIABILITY 1,577,654 EQUITY TRANSFER - FUND NEGATIVE CASH BALANCES IN PHYSICIAN CLINICS 72,900,000 EQUITY TRANSFER - INTEREST EXPENSE IN EXCESS OF INTEREST INCOME 99,091,862 EQUITY TRANSFER - MARIAN CLINIC 649,000 EQUITY TRANSFER - MOUNT SAINT VINCENT HOME 3,800,000 EQUITY TRANSFER - REFUNDING OF KANSAS 2010 BOND ISSUE 163,662,319 EQUITY TRANSFER - REFUNDING OF KANSAS 2012 BOND ISSUE 32,467,007 EQUITY TRANSFER - SYSTEM ACQUISITION COST 280,000,000 EQUITY TRANSFER - UNRECOGNIZED LOSSES NOT EXPENSED TO PENSION PLAN 14,670,430 EQUITY TRANSFER - UNRECOVERED COST OF SYSTEM OFFICE FIXED ASSETS 20,558,442 FAS 157 CREDIT RISK ADJUSTMENT -46,756 FAS 158 UNRECOGNIZED FROZEN DB PLAN -2,317,242 LEAVEN INSURANCE DIVIDEND 15,500,000 |

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As Filed Data -

DLN: 93493310019757

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Employer identification number
23-7379161

Part I Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| See Additional Data Table | | | | | |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Part II Identification of Related Tax-Exempt Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| See Additional Data Table | | | | | | | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
| | | | | | | Yes | No |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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

See Additional Data Table

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

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

See Additional Data Table

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

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

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

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

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

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

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

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

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

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

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

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

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

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

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

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

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

Yes

No

1a

Yes

1b

Yes

1c

Yes

1d

Yes

1e

No

1f

Yes

1g

No

1h

No

1i

No

1j

No

1k

No

1l

Yes

1m

No

1n

No

1o

No

1p

No

1q

No

1r

No

1s

Yes

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

See Additional Data Table

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

Schedule R (Form 990) 2016

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

[illegible]

Part VII **Supplemental Information**

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

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

Additional Data

Software ID:
Software Version:
EIN: 23-7379161
Name: SISTERS OF CHARITY OF LEAVENWORTH HEALTH
SYSTEM INC

Form 990, Schedule R, Part I - Identification of Disregarded Entities

| (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) SCL HEALTH MEDICAL GROUP - MONTANA LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 47-1888400 | PHYSICIAN SERVICES | MT | 0 | 0 | SCLHS |
| (1) SCL HEALTH MEDICAL GROUP - BILLINGS LLC 1233 NORTH 30TH STREET BILLINGS, MT 59101 46-4056262 | PHYSICIAN SERVICES | MT | 54,519,851 | 16,439,581 | SCL HEALTH MEDICAL GROUP - MONTANA LLC |
| (2) ST JAMES HEALTHCARE PHYSICIAN BILLING LLC 400 SOUTH CLARK STREET BUTTE, MT 59701 27-3193107 | PHYSICIAN SERVICES | MT | 6,390,530 | 1,624,994 | SCL HEALTH MEDICAL GROUP - MONTANA LLC |
| (3) SCL HEALTH MEDICAL GROUP - MILES CITY LLC 2600 WILSON STREET MILES CITY, MT 59301 46-4056338 | PHYSICIAN SERVICES | MT | 0 | 0 | SCL HEALTH MEDICAL GROUP - MONTANA LLC |
| (4) SCL HEALTH PARTNERS LLC 8300 WEST 38TH AVENUE WHEAT RIDGE, CO 80033 02-0749530 | HEALTHCARE SERVICES | CO | -6,231,535 | 14,969,805 | SCLHS |
| (5) SCL HOME HEALTH SOLUTIONS LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 46-2418729 | HOME CARE | DE | 0 | 0 | SCL HEALTH PARTNERS LLC |
| (6) SCL FRONT RANGE HOME HEALTH LLC 3980 QUEBEC STREET SUITE 100 DENVER, CO 80207 84-1195134 | HOME HEALTH SERVICES | CO | 3,810,338 | 1,498,098 | SCL HOME HEALTH SOLUTIONS LLC |
| (7) SCL HEALTH PSO LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 47-3534856 | PHYSICIAN SERVICES | CO | 0 | 0 | SCLHS |
| (8) 1227 LOWER LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 81-0811084 | REAL ESTATE INVESTMENT | CO | 0 | 0 | SCLHS |
| (9) 1227 UPPER LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 81-0906413 | REAL ESTATE INVESTMENT | CO | 0 | 0 | SCLHS |

| Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations | | | | | | | |
|--|--|--|----------------------------|---|---|---|----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
| | | | | | | Yes | No |
| (1) 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 47-4520350 | SUPPORTING ORGANIZATION | CO | 501(C)(3) | LINE 12C, III-FI | SCLHS | Yes | |
| (1) 1600 PRAIRIE CENTER PARKWAY BRIGHTON, CO 80601 84-0482695 | HOSPITAL SERVICES | CO | 501(C)(3) | LINE 3 | INTEGRITY HEALTH | Yes | |
| (2) 1600 PRAIRIE CENTER PARKWAY BRIGHTON, CO 80601 74-2255936 | SUPPORTING ORGANIZATION | CO | 501(C)(3) | LINE 12A, I | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | Yes | |
| (3) 4159 LOWELL BOULEVARD DENVER, CO 80211 84-0405260 | RESIDENT CARE | CO | 501(C)(3) | LINE 10 | SCLHS | Yes | |
| (4) 500 ELDORADO BLVD SUITE 4300 DENVER, CO 80211 47-1194849 | MANAGEMENT OF RELATED TAX EXEMPT HOSPITALS AND HEALTHCARE SERVICES | CO | 501(C)(3) | LINE 12A, I | SCLHS | Yes | |
| (5) 1375 EAST 19TH AVENUE DENVER, CO 80218 84-0417134 | HOSPITAL SERVICES | CO | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (6) 1375 EAST 19TH AVENUE DENVER, CO 80218 84-0735096 | SUPPORT RELATED TAX EXEMPT ORGANIZATIONS | CO | 501(C)(3) | LINE 10 | SAINT JOSEPH HOSPITAL INC | Yes | |
| (7) 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 84-1103606 | HOSPITAL SERVICES | CO | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (8) 200 EXEMPLA CIRCLE LAFAYETTE, CO 80026 84-1649162 | SUPPORT RELATED TAX EXEMPT ORGANIZATIONS | CO | 501(C)(3) | LINE 7 | SCL HEALTH-FRONT RANGE INC | Yes | |
| (9) 8300 WEST 38TH AVENUE WHEAT RIDGE, CO 80033 20-8846152 | SUPPORT RELATED TAX EXEMPT ORGANIZATIONS | CO | 501(C)(3) | LINE 7 | SCL HEALTH-FRONT RANGE INC | Yes | |
| (10) 2635 NORTH 7TH STREET GRAND JUNCTION, CO 81501 84-0425720 | HOSPITAL SERVICES | CO | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (11) 2635 NORTH 7TH STREET GRAND JUNCTION, CO 81501 23-7001007 | SUPPORTING ORGANIZATION | CO | 501(C)(3) | LINE 12A, I | ST MARYS HOSPITAL & MEDICAL CENTER INC | Yes | |
| (12) 818 NORTH 7TH STREET LEAVENWORTH, KS 66048 48-1009910 | CLINIC SERVICES | KS | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (13) 3164 EAST 6TH AVENUE TOPEKA, KS 66607 48-1046905 | CLINIC SERVICES | KS | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (14) 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 48-0547719 | HOSPITAL SERVICES | KS | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (15) 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 48-1092520 | SUPPORTING ORGANIZATION | KS | 501(C)(3) | LINE 12A, I | ST FRANCIS HEALTH CENTER INC | Yes | |
| (16) 2600 WILSON STREET MILES CITY, MT 59301 81-0231792 | HOSPITAL SERVICES | MT | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (17) 2600 WILSON STREET MILES CITY, MT 59301 20-2270238 | SUPPORTING ORGANIZATION | MT | 501(C)(3) | LINE 12A, I | HOLY ROSARY HEALTHCARE | Yes | |
| (18) 400 SOUTH CLARK STREET BUTTE, MT 59701 81-0231785 | HOSPITAL SERVICES | MT | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (19) 400 SOUTH CLARK STREET BUTTE, MT 59701 65-1202190 | SUPPORTING ORGANIZATION | MT | 501(C)(3) | LINE 12A, I | ST JAMES HEALTHCARE | Yes | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c) (3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|--|---|--|-------------------------------|---|-------------------------------------|--|----|
| | | | | | | Yes | No |
| (21) 1233 NORTH 30TH STREET BILLINGS, MT 59101 81-0232124 | HOSPITAL SERVICES | MT | 501(C)(3) | LINE 3 | SCLHS | Yes | |
| (1) 1106 NORTH 30TH STREET BILLINGS, MT 59101 81-0468034 | SUPPORT RELATED TAX EXEMPT ORGANIZATIONS | MT | 501(C)(3) | LINE 7 | ST VINCENT HEALTHCARE | Yes | |

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

[illegible]

| Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust | | | | | | | | | |
|--|-------------------------|---|--|--|---------------------------------|---------------------------------------|-------------------------|---|-----|
| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) | (i) | |
| | | | | | | | Percentage ownership | Section 512 (b)(13) controlled entity? | Yes |
| (1) APEX SURGICAL PARTNERS INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 47-3268324 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | 1,383,177 | 243,311 | 100 000 % | Yes | |
| (1) EAGLE RIDGE MEDICAL INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 46-2387681 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | 2,157,609 | 208,308 | 100 000 % | Yes | |
| (2) HIGH PLAINS HEART AND VASCULAR CENTER INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-2038197 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | 2,407,106 | 401,355 | 100 000 % | Yes | |
| (3) INTEGRATIVE INTERNAL MEDICINE AND MEDICAL ACUPUNCTURE INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-4433325 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | 899,601 | 129,737 | 100 000 % | Yes | |
| (4) MOUNTAIN VIEW ORTHOPEDICS INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-5382523 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | 3,458,320 | 336,119 | 100 000 % | Yes | |
| (5) PVMC MEDICAL TEAM INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 47-3988808 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | | | 100 000 % | Yes | |
| (6) PVMC PHYSICIAN SERVICES INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 94-3458548 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | | | 100 000 % | Yes | |
| (7) PLATTE VALLEY MEDICAL TEAM INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 84-1110470 | MEDICAL SERVICES | CO | BRIGHTON COMMUNITY HOSPITAL ASSOCIATION | C | | 19,948 | 100 000 % | Yes | |
| (8) CARITAS INC AND SUBSIDIARIES 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 48-0941069 | HEALTHCARE | KS | SCLHS | C | 10,204,481 | 23,943,964 | 100 000 % | Yes | |
| (9) ST FRANCIS ACCOUNTABLE HEALTH NETWORK INC 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 46-2874128 | HEALTHCARE | KS | ST FRANCIS HEALTH CENTER INC | C | 165,793 | | 100 000 % | Yes | |
| (10) LEAVEN INSURANCE COMPANY LTD 23 LIME TREE BAY AVENUE WEST BAY R GRAND CAYMAN KY1-1102 CJ 98-0370522 | INSURANCE | CJ | SCLHS | C | 13,642,706 | 59,511,687 | 100 000 % | Yes | |

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

| | (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|------|---|---------------------------------|------------------------|--|
| (1) | ST MARY'S HOSPITAL & MEDICAL CENTER INC | A | 786,285 | FMV |
| (1) | ST JAMES HEALTHCARE | A | 301,160 | FMV |
| (2) | SCL HEALTH-FRONT RANGE INC | A | 9,446,828 | FMV |
| (3) | SAINT JOSEPH HOSPITAL INC | A | 12,052,910 | FMV |
| (4) | CARITAS CLINICS INC | B | 64,929 | FMV |
| (5) | MARIAN CLINIC INC | B | 92,411 | FMV |
| (6) | MOUNT ST VINCENT HOME INC | B | 627,849 | FMV |
| (7) | LUTHERAN MEDICAL CENTER FOUNDATION | B | 56,000 | FMV |
| (8) | INTEGRITY HEALTH | B | 5,000,000 | FMV |
| (9) | LEAVEN INSURANCE COMPANY LTD | C | 109,720 | FMV |
| (10) | ST VINCENT HEALTHCARE FOUNDATION | C | 1,967,503 | FMV |
| (11) | SAINT JOSEPH HOSPITAL INC | D | 3,251,196 | FMV |
| (12) | SCL HEALTH-FRONT RANGE INC | D | 10,870,000 | FMV |
| (13) | ST JAMES HEALTHCARE | D | 2,212,945 | FMV |
| (14) | ST MARY'S HOSPITAL & MEDICAL CENTER INC | D | 5,421,418 | FMV |
| (15) | LEAVEN INSURANCE COMPANY LTD | F | 15,500,000 | FMV |
| (16) | ST FRANCIS HEALTH CENTER INC | L | 46,334,735 | FMV |
| (17) | ST VINCENT HEALTHCARE | L | 49,548,985 | FMV |
| (18) | HOLY ROSARY HEALTHCARE | L | 7,395,034 | FMV |
| (19) | ST JAMES HEALTHCARE | L | 14,424,023 | FMV |
| (20) | ST MARY'S HOSPITAL & MEDICAL CENTER INC | L | 52,711,786 | FMV |
| (21) | SAINT JOSEPH HOSPITAL INC | L | 65,279,444 | FMV |
| (22) | SCL HEALTH-FRONT RANGE INC | L | 96,368,531 | FMV |
| (23) | ST JAMES HEALTHCARE | S | 2,212,945 | CASH |
| (24) | ST MARY'S HOSPITAL & MEDICAL CENTER INC | S | 5,421,418 | CASH |

| 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 |
| (26) SAINT JOSEPH HOSPITAL INC | S | 3,251,196 | CASH |
| (1) SCL HEALTH-FRONT RANGE INC | S | 10,870,000 | CASH |