

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 \$ 649,303,668	including grants of \$ 2,035,814)	(Revenue \$ 799,005,626)
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	649,303,668
-----------	---------------------------------------	-------------

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	10 Yes	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d Yes	
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 Yes	
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? If "Yes," complete Schedule H	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
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? If "Yes," complete Schedule I, Parts I and II	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? If "Yes," complete Schedule I, Parts I and III	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? If "Yes," complete Schedule J	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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a	24a	No
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part 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? If "Yes," complete Schedule L, Part 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? If "Yes," complete Schedule L, Part II	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? If "Yes," complete Schedule L, Part III	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? If "Yes," complete Schedule L, Part IV b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV	28a 28b 28c	No Yes No
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M	29	No
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	30	No
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	31	No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32	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? If "Yes," complete Schedule R, Part I	33	Yes
34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1	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)? If "Yes," complete Schedule R, Part V, line 2	35b	Yes
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	36	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? If "Yes," complete Schedule R, Part VI	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	1a	628
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	6,835
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	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)?	4a	No
b	If "Yes," enter the name of the foreign country ► _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c	
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d	
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h	
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8	
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b	
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

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

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	8	
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	4	
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	Yes
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	No
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	
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	No
b	Other officers or key employees of the organization.	15b	No
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.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records: **►**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 ▶ 596

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
NATIONAL JEWISH HEALTH 1400 JACKSON STREET DENVER, CO 80206	MEDICAL SERVICES	6,385,082
MIDTOWN INPATIENT MEDICINE LLC 535 16TH STREET DENVER, CO 802024228	HOSPITALIST SERVICES	6,225,792
COLORADO PATHOLOGY CONSULTANTS PO BOX 840274 DALLAS, TX 752840274	PATHOLOGY SERVICES	4,144,051
HUDSPETH & ASSOCIATES INC 4775 S SANTA FE CIRCLE ENGLEWOOD, CO 80110	CONSTRUCTION SERVICES	3,734,568
SAUNDERS EXPRESS LLC 6950 SOUTH JORDAN ROAD CENTENNIAL, CO 80112	CONSTRUCTION SERVICES	3,437,776

Form 990 (2016)

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	1,682,806				
	e Government grants (contributions)	1e	1,238,462				
	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			2,921,268			
	Program Service Revenue			Business Code			
2a NET PATIENT SERVICE REVENUE			621110	794,588,161	794,227,553	360,608	
b COLORADO LUTHERAN HOME			623990	1,398,434	1,398,434		
c MEDICAL DIRECTOR FEES			621110	217,688	217,688		
d _____							
e _____							
f All other program service revenue							
g Total. Add lines 2a-2f				796,204,283			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		8,308,610			8,308,610	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6a Gross rents	(i) Real	(ii) Personal				
		1,718,481					
		b Less rental expenses	1,124,031				
		c Rental income or (loss)	594,450				
	d Net rental income or (loss)		594,450		175,321	419,129	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			522,673				
		b Less cost or other basis and sales expenses	539,319				
		c Gain or (loss)	-16,646				
	d Net gain or (loss)		-16,646			-16,646	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18		a				
	b Less direct expenses		b				
	c Net income or (loss) from fundraising events						
	9a Gross income from gaming activities See Part IV, line 19		a				
	b Less direct expenses		b				
	c Net income or (loss) from gaming activities						
	10a Gross sales of inventory, less returns and allowances		a				
		393,970					
b Less cost of goods sold		b					
		193,894					
c Net income or (loss) from sales of inventory				200,076		200,076	
Miscellaneous Revenue		Business Code					
11a CAFETERIA		624210		2,769,052	2,769,052		
b MEDICAL DIRECTORS' FEES		624210		330,000		330,000	
c VENDING MACHINE INCOME		624210		32,291	32,291		
d All other revenue							
e Total. Add lines 11a-11d				3,131,343			
12 Total revenue. See Instructions				811,343,384	798,645,018	865,929	
						8,911,169	

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.	1,485,547	1,485,547		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	493,006	493,006		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	57,261	57,261		
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	5,420,251	5,027,994	392,257	
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.	285,057,351	264,428,092	20,629,259	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	12,679,511	11,830,214	849,297	
9 Other employee benefits.	39,128,790	36,946,518	2,182,272	
10 Payroll taxes.	19,368,973	18,179,731	1,189,242	
11 Fees for services (non-employees):				
a Management.				
b Legal.	282	282		
c Accounting.	3,864	3,864		
d Lobbying.	11,424		11,424	
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	63,957,040	61,064,834	2,892,206	
12 Advertising and promotion.	4,773,448	2,512,591	2,260,857	
13 Office expenses.	2,630,591	2,402,294	228,297	
14 Information technology.	41,792,172		41,792,172	
15 Royalties.				
16 Occupancy.	15,705,784	15,385,202	320,582	
17 Travel.	904,873	606,607	298,266	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	1,304,404	1,153,403	151,001	
20 Interest.	9,444,209	9,443,297	912	
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	29,854,076	29,854,076		
23 Insurance.	5,553,426	5,524,231	29,195	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
a MEDICAL SUPPLIES	112,499,804	111,314,791	1,185,013	
b MEDICAL PROVIDER TAXES	31,322,026	31,322,026		
c BAD DEBT	22,917,313	22,917,313		
d BILLING & COLLECTION -	19,953,728		19,953,728	
e All other expenses	50,989,114	17,350,494	33,638,620	
25 Total functional expenses. Add lines 1 through 24e.	777,308,268	649,303,668	128,004,600	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		24,932	1	573,497
	2	Savings and temporary cash investments		287,000	2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		83,761,097	4	81,030,543
	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		1,146,838	7	1,794,139
	8	Inventories for sale or use		12,056,939	8	12,946,264
	9	Prepaid expenses and deferred charges		7,831,827	9	6,821,114
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D.	10a	1,032,391,847		
	b	Less: accumulated depreciation	10b	609,582,431		
				412,062,320	10c	422,809,416
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11		32,603	12	0
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets		941,040	14	941,040
15	Other assets. See Part IV, line 11		277,795,083	15	82,594,283	
16	Total assets. Add lines 1 through 15 (must equal line 34)		795,939,679	16	609,510,296	
Liabilities	17	Accounts payable and accrued expenses		58,198,446	17	56,145,352
	18	Grants payable			18	
	19	Deferred revenue			19	117,903
	20	Tax-exempt bond liabilities		1,601,494	20	1,601,494
	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		2,305,422	23	2,243,478
	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.		245,675,850	25	237,369,050
	26	Total liabilities. Add lines 17 through 25		307,781,212	26	297,477,277
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		488,158,467	27	312,033,019
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		488,158,467	33	312,033,019
34	Total liabilities and net assets/fund balances		795,939,679	34	609,510,296	

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	811,343,384
2	Total expenses (must equal Part IX, column (A), line 25)	2	777,308,268
3	Revenue less expenses Subtract line 2 from line 1	3	34,035,116
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	488,158,467
5	Net unrealized gains (losses) on investments	5	766
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	-210,161,330
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	312,033,019

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: 84-1103606

Name: SCL HEALTH - FRONT RANGE INC

Form 990 (2016)

Form 990, Part III, Line 4a:

SEE SCHEDULE O

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors			
(A)	(B)	(C)	(D)
1. Name of the officer, director, trustee, key employee, highest compensated employee, or independent contractor	2. Title	3. Compensation for services rendered to the organization	4. Compensation for services rendered to the organization
		(a) Salary or fee	(b) Other compensation
		(c) Total compensation	(d) Compensation for services rendered to the organization

(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			
STEPHEN COBB MD MEMBER-RESIGNED FROM SCL HEALTH 4/25/16	1 00 50 00	X						0	238,342	81,035
LORI FOX BECAME CHAIR SEPTEMBER 2016	2 00 0 00	X		X				0	0	0
FAYE HUMMEL RN MEMBER	1 00 0 00	X						0	0	0
LYDIA JUMONVILLE TREASURER	2 00 50 00	X		X				0	1,012,271	238,836
KEVIN MILLER MD MEMBER	50 00 1 00	X						778,152	0	39,897
MICHAEL SALEM MD MEMBER	1 00 0 00	X						0	0	0
RICHARD ALLEN SCHIERBURG MD MEMBER	1 00 0 00	X						0	0	0
MICHAEL SLUBOWSKI MEMBER	1 00 50 00	X						0	1,951,205	38,596
MICHAEL TAYLOR VICE CHAIR	2 00 50 00	X		X				0	849,356	156,505
MARLA WILLIAMS CHAIR RESIGNED SEPTEMBER 2016	2 00 0 00	X		X				0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										(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
(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)										
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former					
ELIZABETH CARVER SECRETARY	2 00 50 00			X					0	295,936	36,337	
J GRANT WICKLUND PRESIDENT-CEO LMC	50 00 2 00			X					0	555,162	263,703	
DAVID HAMM PRESIDENT - CEO GSMC	50 00 0 00			X					0	530,418	208,359	
JAMES DOYLE VP FINANCE SERVICES	2 00 50 00			X					0	249,231	59,738	
JOHN HIGGINS VICE PRESIDENT AND CFO GSMC	50 00 0 00			X					0	229,420	62,000	
ANDREA BURCH VP CHIEF NURSING OFFICER LMC	50 00 0 00				X				0	177,628	10,905	
SCOTT DAY VP HUMAN RESOURCES LMC	50 00 0 00				X				0	231,225	54,161	
BETH FORSYTH CHIEF OPERATING OFFICER-GSMC	50 00 0 00				X				0	307,851	63,936	
CHRISTINA JOHNSON VP OPERATIONS LMC	50 00 0 00				X				0	442,546	70,580	
SUSAN KERSCHEN VP-CHIEF NURSING OFFICER GSMC	50 00 0 00				X				0	261,457	60,909	

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			
THOMAS MYDLER CHIEF MEDICAL OFFICER GSMC	50 00 0 00				X			0	367,116	76,480
BRIAN WITWER MD PHYSICIAN	50 00 0 00					X		960,297	0	41,673
JASON SHOFNOS MD PHYSICIAN	50 00 0 00					X		838,686	0	40,463
JAMES THOMPSON MD PHYSICIAN	50 00 0 00					X		812,422	0	35,293
ROBERT REPLOGLE MD PHYSICIAN	50 00 0 00					X		803,230	0	18,222
BASHEAL AGRAWAL MD PHYSICIAN	50 00 0 00					X		791,623	0	42,771
ROBERT LADENBURGER FORMER OFFICER	0 00 0 00						X	0	323,001	6,893
ROSLAND MCLEOD FORMER OFFICER	0 00 50 00						X	0	570,645	168,979
KAREN SCREMIN FORMER OFFICER	0 00 50 00						X	0	342,779	54,820
AMY PACEY FORMER KEY EMPLOYEE	0 00 50 00						X	0	229,794	41,397

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			
GERALDINE TOWNDROW FORMER KEY EMPLOYEE	0 00 50 00						X	0	402,244	22,315

SCHEDULE A
(Form 990 or
990EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
SCL HEALTH - FRONT RANGE INC

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**

Employer identification number

84-1103606

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

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

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

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) 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 ▶ <input type="checkbox"/>						

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>	1	
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <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>	2	
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>	3a	
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>	3b	
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>	3c	
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>	4a	
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>	4b	
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <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>	4c	
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>	5a	
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>	6	
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	7	
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>	8	
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>	9a	
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>	9b	
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>	9c	
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>	10a	
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>	10b	

Part IV Supporting Organizations (continued)

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

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		
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		
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		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
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>		
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		

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

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

OMB No 1545-0047

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 SCL HEALTH - FRONT RANGE INC	Employer identification number 84-1103606
--	---

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		11,424
j	Total Add lines 1c through 1i			11,424
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).	2a	
a	Current year	2b	
b	Carryover from last year	2c	
c	Total	3	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	4	
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?	5	
5	Taxable amount of lobbying and political expenditures (see instructions)		

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	SCHEDULE C, PART II-B, QUESTION 1I LOBBYING EXPENDITURES LOBBYING EXPENDITURES INCLUDES THE PORTIONS OF VARIOUS MEMBERSHIP DUES THAT ARE DESIGNATED AS LOBBYING EXPENSE BY THOSE ORGANIZATIONS IN WHICH SCL HEALTH - FRONT RANGE, INC. OR ITS ENTITIES ARE MEMBERS

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493310023477	
<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>
Name of the organization SCL HEALTH - FRONT RANGE INC				Employer identification number 84-1103606	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(a) Donor advised funds		(b) Funds and other accounts	
1	Total number at end of year				
2	Aggregate value of contributions to (during year)				
3	Aggregate value of grants from (during year)				
4	Aggregate value at end of year				
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space</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					
				Held at the End of the Year	
a Total number of conservation easements				2a	
b Total acreage restricted by conservation easements				2b	
c Number of conservation easements on a certified historic structure included in (a)				2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register				2d	
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►					
4 Number of states where property subject to conservation easement is located ►					
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <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 <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					
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.					
1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items					
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items					
(i) Revenue included on Form 990, Part VIII, line 1				► \$	
(ii) Assets included in Form 990, Part X				► \$	
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items					
a Revenue included on Form 990, Part VIII, line 1				► \$	
b Assets included in Form 990, Part X				► \$	
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	6,329,102	6,884,823	6,612,331	510	510
b Contributions	3,500		177,166	6,611,821	
c Net investment earnings, gains, and losses	250,818	98,225	95,326		
d Grants or scholarships					
e Other expenditures for facilities and programs	335,359	653,946			
f Administrative expenses					
g End of year balance	6,248,061	6,329,102	6,884,823	6,612,331	510

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

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

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		24,640,041		24,640,041
b Buildings		568,144,629	271,363,435	296,781,194
c Leasehold improvements		45,513,535	34,731,361	10,782,174
d Equipment		368,033,722	303,487,635	64,546,087
e Other		26,059,920		26,059,920
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				422,809,416

Part VII

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

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

Part VIII

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

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

Part IX

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

(a) Description	(b) Book value
(1) INTERCOMPANY RECEIVABLES	80,736,160
(2) PHARMACY - RECEIVABLES	737,740
(3) RENT RECEIVABLES	11,525
(4) OTHER RECEIVABLES	704,767
(5) MEDICARE RECEIVABLE	404,091
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15) ▶	82,594,283

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	
LESSEE DEPOSITS	72,948
CAPITALIZED LEASE OBLIGATIONS	51,326
LIABILITY-MITIGATION	2,349,776
NOTE PAYABLE TO SCLHS	234,895,000
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25) ▶	237,369,050

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: 84-1103606
Name: SCL HEALTH - FRONT RANGE INC

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	THE SCL HEALTH - FRONT RANGE, INC , ENDOWMENT FUNDS ARE HELD AND ADMINISTERED BY THE RELATED ORGANIZATION LUTHERAN MEDICAL CENTER FOUNDATION THE ENDOWMENT FUNDS CONSIST OF 1) THE HEALTH EDUCATION ENDOWMENT FUND THE PURPOSE IS TO SUPPORT HEALTH EDUCATION IN THE COMMUNITY DISTRIBUTIONS ARE LIMITED BY BOARD ACTION TO THREE PERCENT OF ANNUAL VALUE 2) THE FRIENDS OF HOSPICE ENDOWMENT FUND THE PURPOSE IS LIMITED TO PROGRAMS AT LUTHERAN HOSPICE DISTRIBUTIONS ARE LIMITED TO THREE PERCENT OF ANNUAL VALUE 3) THE VOLUNTEER ENDOWMENT FUND THE PURPOSE IS TO SUPPORT PROGRAMS AND ACTIVITIES OF THE VOLUNTEERS AT LUTHERAN MEDICAL CENTER DISTRIBUTIONS FROM THE FUND CAN ONLY BE MADE IF THE FUND BALANCE IS GREATER THAN \$1 MILLION 4) THE CLH ENDOWMENT FUND THE PURPOSE IS TO SUPPORT COLORADO LUTHERAN HOME DISTRIBUTIONS FROM THE FUND CAN ONLY BE MADE IF THE FUND BALANCE IS GREATER THAN \$1 MILLION ACCOUNTS FOR ENDOWMENT FUNDS WERE INVESTED, ALLOWING INCOME AND PRINCIPAL TO GROW OVER TIME

**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
SCL HEALTH - FRONT RANGE INC

Employer identification number

84-1103606

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
(1) SUB-SAHARAN AFRICA	0	0	GRANT	HOSPITAL & MEDICAL CENTER	57,261
(2)					
(3)					
(4)					
(5)					
3a Sub-total	0	0			57,261
b Total from continuation sheets to Part I	0	0			0
c Totals (add lines 3a and 3b)	0	0			57,261

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)
(1)		SUB-SAHARAN AFRICA	SUPPORT SELIAN LUTHERAN HOSPITAL AND ITS SISTER HOSPITAL ARUSHA LUTHERAN MEDICAL CENTER IN TANZANIA	46,000	WIRE TRANSFER	11,261	MEDICAL AIR COMPRESSOR	BOOK
(2)								
(3)								
(4)								

- 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.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

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
PART 1, LINE 2	SCL HEALTH - FRONT RANGE, INC (SCLHFR) PROVIDES ASSISTANCE TO ONLY ONE ORGANIZATION OUTSIDE THE U S SCLHFR OBTAINED AN INITIAL NEEDS ASSESSMENT REPORT FROM THE ORGANIZATION, WHICH ALSO OUTLINED THE COMMITMENT OF SCLHFR TO PROVIDE SUPPORT TO THE ORGANIZATION BASED ON AN INITIAL SITE VISIT SCLHFR MAINTAINS REGULAR CONTACT WITH THE ORGANIZATION, SENDS A TEAM OF CLINICIANS FOR SITE VISITS TO THE ORGANIZATION EVERY YEAR AND REVIEWS THE ORGANIZATION'S ANNUAL REPORT

SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization

SCL HEALTH - FRONT RANGE INC

Employer identification number

84-1103606

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	Yes	
1b	If "Yes," was it a written policy?	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 free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	Yes	
	<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b	Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	Yes	
	<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c	If the organization 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"?	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	Yes	
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?		No
6a	Did the organization prepare a community benefit report during the tax year?	Yes	
b	If "Yes," did the organization make it available to the public?	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)			4,611,810		4,611,810	0 610 %
b Medicaid (from Worksheet 3, column a)			141,278,584	96,727,755	44,550,829	5 910 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			366,023	258,720	107,303	0 010 %
d Total Financial Assistance and Means-Tested Government Programs			146,256,417	96,986,475	49,269,942	6 530 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			426,045	43,455	382,590	0 050 %
f Health professions education (from Worksheet 5)			2,106,767	48,144	2,058,623	0 270 %
g Subsidized health services (from Worksheet 6)			22,458,948	16,866,394	5,592,554	0 740 %
h Research (from Worksheet 7)			53,172		53,172	0 010 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			1,344,989		1,344,989	0 180 %
j Total. Other Benefits			26,389,921	16,957,993	9,431,928	1 250 %
k Total. Add lines 7d and 7j			172,646,338	113,944,468	58,701,870	7 780 %

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			230		230	0 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			5,680		5,680	0 %
8 Workforce development						
9 Other						
10 Total			5,910		5,910	0 %

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	22,917,313	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	222,634,557
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	312,082,377
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-89,447,820
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 E PLUS PET IMAGING X LP	RADIOLOGY SERVICES	42 860 %	0 %	57 140 %
2 EKG INTERPRETATION SERVICE	EKG INTERPRETATION	86 850 %	0 %	13 150 %
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

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)
 GOOD SAMARITAN MEDICAL CENTER LLC

Name of hospital facility or letter of facility reporting group _____

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

1

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
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	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b Yes	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b <input checked="" type="checkbox"/> Other website (list url) <u>HTTP //WWW BOULDERCOUNTYHEALTHCOMPASS ORG/</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>	10	
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>SEE PART V, SECTION C</u>	10 Yes	
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)

GOOD SAMARITAN MEDICAL CENTER LLC

Name of hospital facility or letter of facility reporting group

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	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 400 000000000000 %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input checked="" 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 checked="" 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) SEE PART V, SECTION C		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C		
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**

GOOD SAMARITAN MEDICAL CENTER LLC

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 checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	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)**

GOOD SAMARITAN MEDICAL CENTER LLC

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

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)
LUTHERAN MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

2

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C) _____		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C) _____		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>SEE PART V, SECTION C</u>	10	Yes
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)

LUTHERAN MEDICAL CENTER																																																																																								
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 400 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 checked="" 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 checked="" 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 checked="" 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) SEE PART V, SECTION C</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) SEE PART V, SECTION C</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) SEE PART V, SECTION C</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 400 000000000000 %			b <input type="checkbox"/> Income level other than FPG (describe in Section C)			c <input checked="" type="checkbox"/> Asset level			d <input checked="" type="checkbox"/> Medical indigency			e <input type="checkbox"/> Insurance status			f <input checked="" 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 checked="" 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) SEE PART V, SECTION C			b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			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 400 000000000000 %																																																																																								
b <input type="checkbox"/> Income level other than FPG (describe in Section C)																																																																																								
c <input checked="" type="checkbox"/> Asset level																																																																																								
d <input checked="" type="checkbox"/> Medical indigency																																																																																								
e <input type="checkbox"/> Insurance status																																																																																								
f <input checked="" 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 checked="" 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) SEE PART V, SECTION C																																																																																								
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C																																																																																								
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C																																																																																								
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**

LUTHERAN MEDICAL CENTER

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 checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made			

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	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)**

LUTHERAN MEDICAL CENTER

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? 90

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	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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	
PART II, COMMUNITY BUILDING ACTIVITIES	<p>GOOD SAMARITAN MEDICAL CENTER (GSMC) CONTINUES TO BE INTENTIONAL IN BUILDING COMMUNITY RELATIONSHIPS WITH LOCAL ORGANIZATIONS TO ADDRESS THE HEALTH OF OUR COMMUNITY THIS IS ADDRESSED THROUGH COMMITMENT TO ADDRESS THE MENTAL HEALTH NEEDS AND IMPROVE ACCESS TO HEALTH CARE BY PARTICIPATING ON SEVERAL BOARDS TO INCLUDE MENTAL HEALTH PARTNERS AND WORKING WITH THE SISTER CARMEN CENTER GSMC PARTICIPATES IN COMMUNITY WORK GROUPS, SUCH AS MENTAL HEALTH TASK FORCE AND BOULDER COUNTY PUBLIC HEALTH IMPROVEMENT PROCESS (PHIP) STEERING COMMITTEE, TO ENSURE THE SOCIAL DETERMINANTS OF HEALTH ARE BEING ADDRESSED LUTHERAN MEDICAL CENTER COMMUNITY BUILDING ACTIVITIES ARE DEFINED AS THOSE THAT ENHANCE THE EXISTING EFFORTS TO FILL GAPS OF COMMUNITY NEED WITH SPECIFIC ATTENTION TO PROGRAMS THAT SUPPORT THOSE IN THE COMMUNITY LIVING AT OR BELOW POVERTY IN ADDITION TO THE COMMUNITY BUILDING ACTIVITIES OUTLINED BY THE CHIP AS DESCRIBED ABOVE, THE ADMINISTRATIVE LEADERSHIP TEAM AT LUTHERAN MEDICAL CENTER AND ITS ASSOCIATES ROUTINELY PERFORMED CIVIC ACTIVITIES IN WHICH THE SOCIAL AND PHYSICAL HEALTH OF THE COMMUNITY WAS ADVOCATED AS A PRIORITY OF THE HOSPITAL IN 2016, THIS INCLUDED VARIOUS DONATION DRIVES FOR CLOTHING AND OTHER SUPPLIES, SUPPORT FOR LOCAL CHARITY ORGANIZATIONS INCLUDING HABITAT FOR HUMANITY FINANCIAL SUPPORT FOR YOUNG AMERITOWNE AND LOCAL STEM PROGRAMS CONTRIBUTES TO DEVELOPMENT OF THE FUTURE WORKFORCE MAJOR SPONSORSHIP OF LOCAL SAFETY NET CLINICS PROVIDES ACCESS TO NEEDED HEALTHCARE SERVICES OTHERWISE NOT AVAILABLE FOR THOSE LIVING AT OR BELOW POVERTY PART III, LINE 1 THE ORGANIZATION REPORTS BAD DEBT IN ACCORDANCE WITH HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA) STATEMENT NO 15 TO THE EXTENT THAT HFMA 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 OF FINANCIAL ASSISTANCE POLICY UPON ADMISSION AND DISCHARGE. IN ADDITION, THE PATIENTS RECEIVE INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY WITH THEIR PATIENT BILLS. 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 UPON ADMISSION AND PRIOR TO DISCHARGE. NOTICES ABOUT THE FINANCIAL ASSISTANCE POLICY ARE DISPLAYED THROUGHOUT 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>COLLECTIVELY WITH ITS 234 LICENSED BEDS, GOOD SAMARITAN MEDICAL CENTER (GSMC) HAS SERVED ITS COMMUNITY BY PROVIDING COMPREHENSIVE MEDICAL SERVICES INCLUDING CARDIOLOGY, ONCOLOGY, ORTHOPEDIC, WOMEN AND FAMILY, EMERGENCY AND TRAUMA, NEONATAL INTENSIVE CARE, NEUROLOGY, NEUROSURGERY, OB/GYN, GENERAL SURGICAL AND MEDICAL, PRIMARY CARE, INTERNAL MEDICINE, BEHAVIORAL HEALTH, SENIOR EMERGENCY DEPARTMENT CARE, PALLIATIVE & HOSPICE CARE AND INTEGRATIVE HEALTH SERVICES COMMUNITY ACTIVITIES INCLUDE A VARIETY OF CLASSES ON WEIGHT MANAGEMENT AND SUPPORT GROUPS FOR CANCER PATIENTS, COMMUNITY HEALTH AND SAFETY CLINICS, SKIN CANCER SCREENINGS, BREAST CANCER SURVIVORSHIP PROGRAMS, CLASSES FOR PROSPECTIVE PARENTS AND DIABETES MANAGEMENT CLASSES, TO NAME A FEW THE HEALTH & HEALING CENTER CONDUCTS HEART HEALTH SCREENINGS IN THE COMMUNITY INCLUDING CHOLESTEROL TESTING AND BLOOD PRESSURE SCREENINGS SEVERAL TIMES THROUGHOUT THE YEAR GSMC ALSO PROMOTES HEALTH AND WELLNESS FOR OUR EMPLOYEES THROUGH OUR WELLNESS INCENTIVE PROGRAM WE ALSO PROVIDE PRESENTATIONS TO COMMUNITY GROUPS ON SUBJECTS SUCH AS BALANCE, EXERCISE AND STRETCHING WE HAVE PARTNERED WITH SUCH ORGANIZATIONS AS THE LAFAYETTE SENIOR CENTER, THE LAFAYETTE RECREATION CENTER, BOULDER COUNTY HEALTH AND HUMAN SERVICES AS WELL AS BROOMFIELD COUNTY HEALTH AND HUMAN SERVICES TO PROVIDE SERVICES TO OUR COMMUNITY GSMC ALSO PROVIDES HEALTH SCREENINGS FOR EMPLOYEES OF BOULDER VALLEY SCHOOL DISTRICT AND SCREENINGS AT EVENTS SEVERAL TIMES THROUGHOUT THE YEAR TO RESIDENTS OF BROOMFIELD, LAFAYETTE AND OTHERS IN THE SURROUNDING AREAS WE ARE AN IMPORTANT PART OF OUR COMMUNITY AND SERVE IN MANY WAYS, FROM DELIVERING CORE HEALTH CARE TO PREVENTIVE CARE TO SUPPORT OF OTHER CIVIC GROUPS IN 2016, GSMC PROVIDED COMMUNITY BENEFIT TO INCLUDE TRADITIONAL CHARITY CARE AND THE UNPAID COST OF MEDICAID OUR BOARD OF DIRECTORS REPRESENTS MEDICAL AND BUSINESS PROFESSIONALS, AND ALL PROVIDE HOURS OF SERVICE IN SUPPORT OF OUR HOSPITAL THEY ARE DEEPLY INVOLVED IN OUR COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS, BUILDING PROGRAMS AND SERVICES, AND COMMUNITY OUTREACH TO ENSURE THAT PEOPLE KNOW ABOUT SERVICES AVAILABLE TO THEM THROUGH OUR HOSPITAL WHEN GSMC HAS EXCESS REVENUE OVER OPERATING EXPENSES, WE USE THOSE FUNDS TO OBTAIN CURRENT HEALTH CARE TECHNOLOGIES AND EQUIPMENT, IMPROVE PATIENT CARE, PROVIDE MEDICAL TRAINING EDUCATION AND RESEARCH, AND TO EXPAND ACCESS TO CARE THESE INVESTMENTS ENSURE WE'LL BE HERE TO CARE FOR FUTURE GENERATIONS LUTHERAN MEDICAL CENTER HAS A MULTITUDE OF PROGRAMS IN PLACE THROUGH ITS CANCER CENTER, NEUROVASCULAR CENTER, TRAUMA CENTER AND THROUGH COMMUNITY OUTREACH A VARIETY OF CLASSES ARE OFFERED ON WEIGHT MANAGEMENT AND HEALTHY LIFESTYLE SUPPORT GROUPS FOR CANCER PATIENTS ARE OFFERED LMC ALSO ROUTINELY OFFERS COMMUNITY HEALTH EDUCATION, SKIN CANCER SCREENINGS, BREAST CANCER SURVIVORSHIP PROGRAMS, CLASSES FOR PROSPECTIVE PARENTS AND DIABETES MANAGEMENT CLASSES, TO NAME A FEW LMC PARTNERS WITH SAFETY CLINICS SUCH AS METRO COMMUNITY PROVIDER NETWORK LMC ALSO RECOGNIZES THE ESSENTIAL NEED TO ENHANCE AND IMPROVE MEDICAL OUTCOMES, QUALITY AND SERVICES THE OBJECTIVES OF THE PROGRAM ARE TO BE A HIGHLY RELIABLE ORGANIZATION, OFFER HIGH QUALITY, PROVIDE SAFETY FOR PATIENTS AND STAFF AND BE COST EFFECTIVE THE QUALITY INDICATORS ARE IN ALIGNMENT WITH MAJOR PUBLICLY COMPARABLE DATABASES INCLUDING THE COLORADO HEALTH AND HOSPITAL ASSOCIATION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES</p>

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

Additional Data

Software ID:
Software Version:
EIN: 84-1103606
Name: SCL HEALTH - FRONT RANGE 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? 2											
Name, address, primary website address, and state license number											
1	GOOD SAMARITAN MEDICAL CENTER 200 EXEMPLA CIRCLE LAFAYETTE, CO 80026 FOR WEBSITE SEE SCHEDULE "O" 011529	X	X					X			
2	LUTHERAN MEDICAL CENTER 8300 W 38TH AVENUE WHEAT RIDGE, CO 80211 FOR WEBSITE SEE SCHEDULE "O" 010440	X	X					X			

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
GOOD SAMARITAN MEDICAL CENTER, LLC	
LUTHERAN MEDICAL CENTER	PART V, SECTION B, LINE 5 LUTHERAN MEDICAL CENTER, A COMMUNITY-BASED, ACUTE-CARE HOSPITAL LOCATED IN WHEAT RIDGE, COLORADO, IS COMMITTED TO IMPROVING THE HEALTH OF ITS COMMUNITY IN SO DOING, LUTHERAN WORKED CLOSELY WITH COMMUNITY PARTNERS TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN 2015 THE GOAL FOR THE CHNA WAS TO DETERMINE CURRENT AND PROJECTED FUTURE HEALTH CARE NEEDS IN THE LUTHERAN PRIMARY COMMITMENT AREA AND TO IDENTIFY GAPS IN SERVICES TO IMPROVE THE HEALTH OF JEFFERSON COUNTY RESIDENTS THE CHNA FEATURES EXTENSIVE BACKGROUND RESEARCH, INCLUDING DEMOGRAPHIC ANALYSIS AND LITERATURE REVIEW THE ASSESSMENT TEAM SOUGHT INPUT AND ENGAGEMENT FROM COMMUNITY MEMBERS, COMMUNITY ORGANIZATIONS, BUSINESS LEADERS, NON-PROFIT PARTNERS REPRESENTING THE MEDICALLY UNDERSERVED, AS WELL AS INTERNAL STAKEHOLDERS AT LUTHERAN MEDICAL CENTER THESE PARTNERS ACTIVELY PARTICIPATED IN THE QUALITATIVE REVIEW AND ASSESSMENT PRIORITIZATION COMPONENTS OF THE CHNA PARTNERS INCLUDED BUT WERE NOT LIMITED TO JEFFERSON COUNTY PUBLIC HEALTH, METRO COMMUNITY PROVIDER NETWORK, MEDICAL STAFF AT LUTHERAN MEDICAL CENTER, WEST CHAMBER SERVING JEFFERSON COUNTY'S YOUTH LEADERSHIP JEFFERSON COUNTY, MUNICIPALITIES, AREA NON-PROFITS, AND CIVIC, COMMUNITY, AND BUSINESS LEADERS KEY FINDINGS HAVE IDENTIFIED GAPS AND UNMET NEEDS FOR HEALTHCARE IN THE SERVICE AREA AND WILL INFORM RECOMMENDATIONS AND STRATEGIC IMPLEMENTATIONS FOR THE LUTHERAN SERVICE DELIVERY MODEL TO FILL THE GAPS KEY FINDINGS FOR THIS CHNA ARE (1) ACCESS TO HEALTHCARE, (2) CHRONIC DISEASE MANAGEMENT, (3) BEHAVIORAL HEALTH, AND (4) OBESITY
GOOD SAMARITAN MEDICAL CENTER, LLC	PART V, SECTION B, LINE 6A N/A
LUTHERAN MEDICAL CENTER	PART V, SECTION B, LINE 6A N/A
GOOD SAMARITAN MEDICAL CENTER, LLC	PART V, SECTION B, LINE 6B ORGANIZATIONS THAT PARTICIPATED WITH GOOD SAMARITAN MEDICAL CENTER FOR COMPLETION OF THE COMMUNITY HEALTH NEEDS ASSESSMENT INCLUDED * BOULDER COUNTY PUBLIC HEALTH, BOULDER, COLORADO* BROOMFIELD PUBLIC HEALTH AND ENVIRONMENT, BROOMFIELD, COLORADO* PROFESSIONAL RESEARCH CONSULTANTS, INC , OMAHA, NEBRASKA* COMMUNITY HEALTH PARTNERS, INC , COLORADO SPRINGS, COLORADO

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
LUTHERAN MEDICAL CENTER	
GOOD SAMARITAN MEDICAL CENTER, LLC	<p>PART V, SECTION B, LINE 11 IN 2015 GOOD SAMARITAN MEDICAL CENTER (GSMC) ENGAGED PROFESSIONAL RESEARCH CONSULTANTS, INC (PRC) TO CONDUCT A CHNA CONCERNING THE HEALTH STATUS OF THE HOSPITAL'S COMMUNITY BOULDER COUNTY PUBLIC HEALTH (BCPH) AND BROOMFIELD COUNTY PUBLIC HEALTH WERE ENGAGED TO PROVIDE HEALTH DATA USED IN THE SURVEY COMMUNITY LEADERS AND HEALTHCARE LEADERS IN BOULDER AND BROOMFIELD COUNTIES WERE SURVEYED TO DETERMINE THE TOP HEALTH NEEDS THE TOP HEALTH NEEDS IDENTIFIED BY SURVEY PARTICIPANTS WERE * OLDER ADULTS & AGING* MENTAL HEALTH* CANCER* SUBSTANCE ABUSE, INCLUDING TOBACCO* EXERCISE, NUTRITION & WEIGHT* HEART DISEASE & STROKE* DIABETES* IMMUNIZATIONS & INFECTIOUS DISEASES* ORAL HEALTH* ACCESS TO HEALTH SERVICES* RESPIRATORY DISEASES* MATERNAL, FETAL & INFANT HEALTHA TASK FORCE OF KEY COMMUNITY HEALTHCARE LEADERS, PUBLIC HEALTH OFFICIALS, AND INTERNAL SENIOR HOSPITAL LEADERS MET TO RANK AND PRIORITIZE THE 12HEALTH NEEDS THE SCOPE AND SEVERITY OF HEALTH ISSUES WERE EVALUATED ASWELL AS GOOD SAMARITAN MEDICAL CENTER'S ABILITY TO IMPACT THE IDENTIFIED HEALTH ISSUES THE FINAL SELECTION OF THE TWO TOP HEALTH NEEDS GSMC WILL ADDRESS DURING 2016-2018 INCLUDE 1 MENTAL HEALTH2 ACCESS TO HEALTH SERVICESGIVEN THE LIMITED FINANCIAL RESOURCES, AS WELL AS THE LIMITED STAFF, THE STRATEGIC DECISION WAS MADE TO FOCUS ON TWO TOP HEALTH NEEDS THE ABILITY TO MAKE A SIGNIFICANT IMPACT WILL BE GREATLY IMPROVED BY NARRATING THE FOCUS TO TWO TOP HEALTH NEEDS THE ACTIONS GSMC INTENDS TO TAKE TO ADDRESS THE TOP HEALTH NEEDS INCLUDE * EVALUATE THE FEASIBILITY OF DEVELOPING BEHAVIORAL HEALTH SERVICES VIA TELEHEALTH FOR BOULDER AND BROOMFIELD COUNTIES THIS IS A BOLD, CREATIVE CHALLENGE THAT CAN IMPROVE ACCESS TO HEALTH CARE AND IMPROVE THE WAY BEHAVIORAL HEALTH SERVICES ARE PROVIDED * WE WILL EVALUATE THE OPPORTUNITIES TO DEVELOP OR ENHANCEBEHAVIORAL HEALTH "NAVIGATORS" TO ASSIST IN MATCHING INDIVIDUALS WITH THEAPPROPRIATE MENTAL HEALTH RESOURCES THIS SERVICE WILL ALSO SERVE AS A"CONNECTOR" TO ALL THE FRAGMENTED SERVICES NOW AVAILABLE IN THE COMMUNITY * CONTINUE TO PARTNER WITH COMMUNITY MENTAL HEALTH PROVIDERS AND SCL PHYSICIANS, TO EMBED BEHAVIORAL HEALTH SERVICES INTO PRIMARY CARE CLINICS *EXTEND PILOT PROJECT WHICH ALLOWED GSMC TO SUPPORT A SOCIAL WORKER ANDNURSE PRACTITIONER WHO PROVIDE INTERVENTIONS, MONITORING AND DRUGADMINISTRATION IN PRIMARY CARE CLINICS * PROVIDE SERVICES TO ALL AGES OF PATIENTS, INCLUDING CHILDREN AGE 14AND UNDER * DURING 2016, 2,102 PATIENT ENCOUNTERS WERE DOCUMENTED BY EMBEDDING BEHAVIORAL HEALTH SERVICE INTO PRIMARY CARE CLINICS * HIGH PRIMARY CARE PROVIDER SATISFACTION DUE TO THE SUCCESS OF THE PILOT, PLANS TO PLACE BEHAVIORAL HEALTH SERVICES IN ADDITIONAL SCL PHYSICIAN CLINICS IN THE GSMC SERVICE AREA ARE BEING DEVELOPED * PROVIDE ONGOING IN-KIND DONATIONS TO COMMUNITY ORGANIZATIONS THAT SERVE THOSE AFFECTED BY MENTAL HEALTH ISSUES MOUNT SAINT VINCENT HOME, IMAGINE!FOUNDATION, MENTAL HEALTH PARTNERS, BAL SWAN CHILDREN'S CENTER, DEVEREUXCLEO WALLACE, MENTAL HEALTH CENTER OF BOULDER AND BROOMFIELD COUNTIES,FOOTHILLS BEHAVIORAL HEALTH PARTNERS, AND SENIOR REACH - A COLLABORATIONWITH JEFFERSON CENTER FOR MENTAL HEALTH, THE SENIORS' RESOURCE CENTER ANDMENTAL HEALTH PARTNERS * PARTNER WITH LOCAL COMMUNITY ORGANIZATIONS TO INCREASE ACCESS TO HEALTH SERVICES THROUGH OPEN ENROLLMENT ASSISTANCE EVENTS AND SERVICES AND TRANSPORTATION TO HEALTH CARE SERVICES * SEVERAL HOSPITAL STAFF MEMBERS SERVE ON BOARDS AND OR COMMUNITYCOMMITTEES THAT FOCUS ON MENTAL HEALTH ISSUES INCLUDING BOARD MEMBERSHIPFOR MENTAL HEALTH PARTNERS AND MOUNT SAINT VINCENT HOME IN ADDITION TO MENTAL HEALTH AND ACCESS TO HEALTH SERVICES, THE HOSPITAL SUPPORTS OTHER AREAS OF NEED IN THE COMMUNITY INCLUDING SUPPORT OF ORGANIZATIONS THAT ADDRESS FOOD INSECURITY, ORAL HEALTH NEEDS FOR BOTH ADULTS AND CHILDREN, CANCER CARE ASSISTANCE, AND CHILDREN SAFETY PROGRAMS AMONG OTHERS THE REMAINDER OF NEEDS IDENTIFIED IN THE CHNA ARE IMPORTANT TO GSMC, BUT DUE TO LIMITED RESOURCES AT THE HOSPITAL LEVEL, AND THE AVAILABILITY OF COMMUNITY ORGANIZATIONS WHO ARE ALREADY ADDRESSING NEEDS, GSMC CONTINUES TO COLLABORATE WITH COMMUNITY ORGANIZATIONS TO ENSURE ALL NEEDS AND HEALTH INDICATORS ARE BEING ADDRESSED</p>
LUTHERAN MEDICAL CENTER	<p>PART V, SECTION B, LINE 11 THROUGH THE 2015 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), LUTHERAN MEDICAL CENTER (LMC) IDENTIFIED THE FOLLOWING TOP PRIORITY FOCUS AREAS FOR INCLUSION IN THE 2016-2018 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) ACCESS TO HEALTHCARETHE AIM FOR ADDRESSING ACCESS INCLUDE EFFORTS TO PROVIDE COMMUNITY-BASED EVENTS AND ACTIVITIES THAT BRING HEALTHCARE TO FAMILIES AND CHILDREN WHERE THEY LIVE IN OUR PRIMARY SERVICE AREA THE PRIMARY STRATEGY FOR ADDRESSING THIS SIGNIFICANT HEALTH NEED IS TO PARTNER WITH THE JEFFERSON COUNTY PUBLIC HEALTH DEPARTMENT (JAPED) TO IMPROVE ACCESS BY REMOVING BARRIERS AND CREATING CONNECTIVITY TO APPROPRIATE HEALTH SERVICES AND COMMUNITY RESOURCES THIS WILL BE ACCOMPLISHED THROUGH THE DEVELOPMENT OF A 340B PHARMACEUTICAL PLAN, INCREASED ACCESS FOR PATIENTS TO SERVICES THAT SUPPORT CHRONIC DISEASE MANAGEMENT INCLUDING PAIN MANAGEMENT, DIABETES MANAGEMENT AND EDUCATION, CARDIOVASCULAR PROGRAMS, AND CANCER SERVICES IN ADDITION, LMC PLANS TO PARTNER WITH SAFETY NET CLINIC PARTNERS IN OUR PRIMARY SERVICE AREA INCLUDING METRO COMMUNITY PROVIDER NETWORK (MCPC), BRIDGES TO CARE, AND THE SENIOR RESOURCE CENTER IN ORDER TO ACHIEVE HIGHER LEVELS OF CARE ALIGNMENT THROUGH A PATIENT NAVIGATOR PROGRAM BARRIERS TO ACCESS WILL BE IDENTIFIED THROUGH ADDITIONAL PARTNERSHIPS THAT PROMOTE PREVENTATIVE CARE INCLUDING ACCESS TO VIRTUAL HEALTH PROGRAMS PREVENTATIVE CARE AND BEHAVIORAL HEALTHTHE AIMS FOR ADDRESSING PREVENTATIVE CARE AND BEHAVIORAL HEALTH ARE TO INTEGRATE SERVICES AND BUILD NETWORKS WHICH ALLOW PRIMARY CARE PROVIDERS TO DIRECT THEIR PATIENTS TO APPROPRIATE RESOURCES AND SERVICES THE PRIMARY STRATEGY FOR ADDRESSING THESE SIGNIFICANT HEALTH NEEDS IS TO COLLABORATE WITH THE JAPED TO CREATE A COMPREHENSIVE COUNTY-WIDE PLAN TO CONNECT PATIENTS TO SERVICES ACROSS THE CONTINUUM OF PREVENTATIVE CARE, INCLUDING BEHAVIORAL HEALTH THIS WILL BE ACCOMPLISHED THROUGH AN ASSESSMENT AND INVENTORY OF COMMUNITY RESOURCES TO LINK PATIENTS WITH SERVICES THAT TEACH THEM HOW TO BETTER MANAGE THEIR INDIVIDUAL CONDITIONS (E G MCPC, BRIDGES TO CARE, ETC) IN ADDITION, LMC WILL DEVELOP AND PROVIDE EDUCATIONAL OPPORTUNITIES FOR CANCER, CARDIOVASCULAR, AND OTHER SERVICES TO PROVIDE IMPORTANT PREVENTATIVE CARE AND BEHAVIORAL HEALTH MESSAGES SUCH AS WARNING SIGNS OF CHRONIC OR ACUTE CONDITIONS (E G STROKE, DIABETES, ETC) FINALLY, ACCESS TO BEHAVIORAL HEALTH SERVICES WILL BE SUPPLEMENTED BY PROGRAMS AIMED AT REDUCING THE STIGMA OF BEHAVIORAL HEALTH THEREBY ENCOURAGING INDIVIDUALS TO SEEK TREATMENT FOR BEHAVIORAL HEALTH CONDITIONS OBESITYTHE AIMS FOR ADDRESSING THIS SIGNIFICANT HEALTH NEED INCLUDE PROGRAMS AND SERVICES THAT PROMOTE PHYSICAL ACTIVITY AND HEALTHY EATING THIS WILL BE ACCOMPLISHED THROUGH COLLABORATION WITH JAPED AROUND INITIATIVES SUCH AS HEALTHY BEVERAGE CONSUMPTION, ACCESS TO HEALTHY FOOD, AND PHYSICAL ACTIVITY EDUCATION AND PROGRAMS KEY GOALS FOR THIS AIM INCLUDE LINKING INDIVIDUALS TO WELLNESS RESOURCES INCLUDING FREE AND LOW-COST FITNESS AND HEALTH CLASSES, SUPPORT GROUPS, AND COUNSELING INCLUDING WEIGHT LOSS PROGRAMS IN ADDITION, LMC WILL CONTINUE PARTICIPATION IN THE COLORADO HEALTH HOSPITAL COMPACT ADDITIONAL ATTENTION WILL BE GIVEN TO THE CULTURAL RELEVANCE OF MATERIALS TO ENSURE THAT TARGET POPULATIONS MOST AT RISK FOR OBESITY AND DECREASED PHYSICAL ACTIVITY ARE ABLE TO READILY ACCESS PROGRAMS AND SERVICES INITIATIVES THAT ENCOURAGE AND SUPPORT BREASTFEEDING WILL ALSO CONTINUE HEALTH PRIORITIES NOT ADDRESSED BY THE CURRENT CHIPLUTHERAN MEDICAL CENTER (LMC) RECOGNIZES THAT THE OTHER HEALTH NEEDS AND INDICATORS IDENTIFIED IN THE 2015 LMC COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS ARE IMPORTANT FOR THE HOSPITAL AND THE COMMUNITIES IT SERVES NUMEROUS OTHER ORGANIZATIONS ARE CONCURRENTLY ADDRESSING MANY OF THESE REMAINING NEEDS THEREFORE, DUE TO LIMITED EXPERTISE AND RESOURCES AT THE INDIVIDUAL HOSPITAL LEVEL LMC HAS NARROWED ITS TOP PRIORITIES TO THE FOCUS AREAS LISTED ABOVE LMC WILL, HOWEVER, CONTINUE TO BUILD PARTNERSHIPS WITH OTHER COMMUNITY AGENCIES IN OUR PRIMARY SERVICE AREA IN ORDER TO EXPAND OUR FOOTPRINT AS FAR AS POSSIBLE INTO ALL RELEVANT HEALTH PRIORITY AREAS WITHOUT CONCURRENTLY OVERTAXING AVAILABLE RESOURCES IN OUR IDENTIFIED PRIORITY AREAS GOOD SAMARITAN MEDICAL CENTER, LLCPART V, SECTION B, LINE 16A, FINANCIAL ASSISTANCE POLICY WEBSITE https://www.sclhealth.org/locations/good-samaritan-hospital/patients-visitors/billing-and-insurance/financial-assistance/lutheran-medical-centerPART V, SECTION B, LINE 16A, FINANCIAL ASSISTANCE POLICY WEBSITE https://www.sclhealth.org/locations/lutheran-medical-center/patients-visitors/billing-and-insurance/financial-assistance/good-samaritan-medical-centerPART V, SECTION B, LINE 16B, FINANCIAL ASSISTANCE APPLICATION WEBSITE https://www.sclhealth.org/locations/good-samaritan-hospital/patients-visitors/billing-and-insurance/financial-assistance/lutheran-medical-centerPART V, SECTION B, LINE 16B, FINANCIAL ASSISTANCE APPLICATION WEBSITE https://www.sclhealth.org/locations/lutheran-medical-center/patients-visitors/billing-and-insurance/financial-assistance/good-samaritan-medical-centerPART V, SECTION B, LINE 16C, FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY https://www.sclhealth.org/locations/good-samaritan-medical-center/patients-visitors/billing-and-insurance/financial-assistance/lutheran-medical-centerPART V, SECTION B, LINE 16C, FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY https://www.sclhealth.org/locations/lutheran-medical-center/patients-visitors/billing-and-insurance/financial-assistance/good-samaritan-medical-center</p>

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 - CCC AT GOOD SAMARITAN HOSPITAL 300 EXEMPLA CIR LAFAYETTE, CO 80026	PHYSICIAN CLINIC
1 2 - GOOD SAMARITAN PULMONARYCRITICAL CARE 200 EXEMPLA CIR LAFAYETTE, CO 80026	PHYSICIAN CLINIC
2 3 - LMC BRIDGES CHIROPRACTIC SERVICES 8098 W 38TH AVE WHEAT RIDGE, CO 800336114	PHYSICIAN CLINIC
3 4 - LMC ORTHOPEDIC HOSPITALISTS 3455 LUTHERAN PKWY WHEAT RIDGE, CO 800336034	PHYSICIAN CLINIC
4 5 - LMC - SPINE CENTER - PHYSIATRY 1687 COLE BLVD SUITE 150 LAKEWOOD, CO 804013322	PHYSICIAN CLINIC
5 6 - LMC - SPINE CENTER - PSYCHOLOGY 1687 COLE BLVDSTE 150 LAKEWOOD, CO 804013322	PHYSICIAN CLINIC
6 7 - LMC - SPINE CENTER - SPINE CARE 1687 COLE BLVDSTE 150 LAKEWOOD, CO 804013322	PHYSICIAN CLINIC
7 8 - LMC MEDICAL ONCOLOGY 8300 W 38TH AVEDOOR 16 WHEAT RIDGE, CO 800336005	PHYSICIAN CLINIC
8 9 - LMC PALLIATIVE CARE 3210 LUTHERAN PKWY WHEAT RIDGE, CO 800336019	PHYSICIAN CLINIC
9 10 - LUTHERAN PERINATOLOGY - MATERNAL 3655 N LUTHERAN PKWYSTE 408 WHEAT RIDGE, CO 800336012	PHYSICIAN CLINIC
10 11 - SCLP STAPLETON FAMILY OSM&PT 2803 ROSLYN ST DENVER, CO 802382624	PHYSICIAN CLINIC
11 12 - SCLP ASSOCIATE HEALTH CENTER 500 ELDORADO BLVDBLDG 4 STE 4250 BROOMFIELD, CO 800213408	PHYSICIAN CLINIC
12 13 - SCLP BELMAR FAMILY MEDICINE 325 S TELLER ST STE 250 LAKEWOOD, CO 802267429	PHYSICIAN CLINIC
13 14 - SCLP BLUESTONE ADVANCED SURGERY 300 EXEMPLA CIR STE 400 LAFAYETTE, CO 800263396	PHYSICIAN CLINIC
14 15 - SCLP BROOMFIELD FAMILY OM&PT 12169 SHERIDAN BLVD BROOMFIELD, CO 800202459	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 - SCLP COMPLETE FAMILY MEDICINE 8758 WOLFF CTSTE 200 WESTMINSTER, CO 800316904	PHYSICIAN CLINIC
1 17 - SCLP COMPREHENSIVE BREAST CARE 1960 N OGDEN ST STE 230 DENVER, CO 802183671	PHYSICIAN CLINIC
2 18 - SCLP COSMETIC & PLASTIC SURGERY 6500 W 104TH AVE STE 240 WESTMINSTER, CO 800204189	PHYSICIAN CLINIC
3 19 - SCLP CV SURGERY 3555 LUTHERAN PARKWAY STE 380 WHEAT RIDGE, CO 800336023	PHYSICIAN CLINIC
4 20 - SCLP DENVER MEDICAL ASSOCIATES 1960 OGDEN ST STE 120 DENVER, CO 802183667	PHYSICIAN CLINIC
5 21 - SCLP DENVER SPORTS MEDICINE 1960 OGDEN ST STE 30 DENVER, CO 802183667	PHYSICIAN CLINIC
6 22 - SCLP ENDOCRINE SERVICES & DIABETES 3555 LUTHERAN PKWY STE 180 WHEAT RIDGE, CO 800336000	PHYSICIAN CLINIC
7 23 - SCLP ESSENTIAL WOMEN'S CARE 1960 OGDEN ST STE 230 DENVER, CO 802183668	PHYSICIAN CLINIC
8 24 - SCLP FAMILY OF LAFAYETTE 3550 LUTHERAN PKWY G-20 WHEAT RIDGE, CO 800336016	PHYSICIAN CLINIC
9 25 - SCLP FIRESTONE FAMILY & OCCUPATIONAL 8350 COLORADO BLVD STE 160 FIRESTONE, CO 805046803	PHYSICIAN CLINIC
10 26 - SCLP FOOT & ANKLE CLINIC 9351 GRANT STREET SUITE 490 THORNTON, CO 802294365	PHYSICIAN CLINIC
11 27 - SCLP FRONT RANGE CARDIAC & THORACIC 1960 OGDEN ST STE 540 DENVER, CO 802183671	PHYSICIAN CLINIC
12 28 - SCLP GOOD SAMARITAN DIABETES & ENDOCRINE 300 EXEMPLA CIR STE 380 LAFAYETTE, CO 800263395	PHYSICIAN CLINIC
13 29 - SCLP GREEN MOUNTAIN FAMILY OM&PT 12792 C-1 W ALAMEDA PKWY LAKEWOOD, CO 802282850	PHYSICIAN CLINIC
14 30 - SCLP GREEN MOUNTAIN MEDICAL CENTER 12790-A W ALAMEDA PKWY LAKEWOOD, CO 802282850	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 - SCLP GYNECOLOGIC ONCOLOGY MIDTOWN 1960 OGDEN ST STE 520A DENVER, CO 802183671	PHYSICIAN CLINIC
1 32 - SCLP GYNECOLOGIC ONCOLOGY NORTH 300 EXEMPLA CIRSTE 400A LAFAYETTE, CO 800263396	PHYSICIAN CLINIC
2 33 - SCLP HEART INSITUTE OF COLORADO 1960 OGDEN ST STE 540 DENVER, CO 80218	PHYSICIAN CLINIC
3 34 - SCLP HEART INSITUTE OF COLORADO - NORTH 8300 ALCOTT ST STE 300 WESTMINSTER, CO 800314030	PHYSICIAN CLINIC
4 35 - SCLP HEART INSTITUTE OF COLORADO - GSMC 300 EXEMPLA CIR STE 310 LAFAYETTE, CO 800263394	PHYSICIAN CLINIC
5 36 - SCLP HEART INSTITUTE OF COLORADO - LMC 28000 MEADOW DR EVERGREEN, CO 804392116	PHYSICIAN CLINIC
6 37 - SCLP HEART INSTITUTE OF COLORADO - LMC 3655 LUTHERAN PKWY STE 201 WHEAT RIDGE, CO 800336010	PHYSICIAN CLINIC
7 38 - SCLP HEART INSTITUTE OF COLORADO - SJH 1960 OGDEN ST STE 110 DENVER, CO 802183667	PHYSICIAN CLINIC
8 39 - SCLP LAFAYETTE FAMILY PEDIATRIC 2600 CAMPUS DR STE A LAFAYETTE, CO 800263358	PHYSICIAN CLINIC
9 40 - SCLP LAFAYETTE INTERNAL & SPORTS MEDICIN 300 EXEMPLA CIR 300 LAFAYETTE, CO 800263394	PHYSICIAN CLINIC
10 41 - SCLP LARKRIDGE FAMILY OMPT 16570 WASHINGTON ST THORNTON, CO 800238964	PHYSICIAN CLINIC
11 42 - SCLP LARKRIDGE PHYSICAL THERAPY 16571 WASHINGTON ST THORNTON, CO 800238964	PHYSICIAN CLINIC
12 43 - SCLP LMC DIABETES EDUCATION CENTER 3555 LUTHERAN PKWY STE 180 WHEAT RIDGE, CO 800336000	PHYSICIAN CLINIC
13 44 - SCLP LMC-WHEAT RIDGE REHAB CTR - MTN STA 1960 OGDEN ST STE 520 DENVER, CO 80218	PHYSICIAN CLINIC
14 45 - SCLP LMC-WHEAT RIDGE REHAB CTR - WHEAT R 9830 I-70 FRONTAGE ROAD S WHEAT RIDGE, CO 800331724	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 - SCLP LUTHERAN HEMATOLOGY & ONCOLOGY 3550 LUTHERAN PKWY STE 100-A WHEAT RIDGE, CO 800336013	PHYSICIAN CLINIC
1 47 - SCLP MOUNTAIN STATES UROGYNECOLOGY - DEN 1960 OGDEN ST STE 520 DENVER, CO 802183671	PHYSICIAN CLINIC
2 48 - SCLP MOUNTAIN STATES UROGYNECOLOGY - LAF 300 EXEMPLA CIR STE 360 LAFAYETTE, CO 800263392	PHYSICIAN CLINIC
3 49 - SCLP NEUROSCIENCES NEUROLOGY SERVICES 300 EXEMPLA CIR STE 300 LAFAYETTE, CO 800263394	PHYSICIAN CLINIC
4 50 - SCLP NORTHWEST MEDICAL CENTER 12169 SHERIDAN BLVD BROOMFIELD, CO 800202459	PHYSICIAN CLINIC
5 51 - SCLP OASIS FAMILY MEDICINE 360 S GARFIELD STE 500 DENVER, CO 802093136	PHYSICIAN CLINIC
6 52 - SCLP QUAIL CREEK FAMILY MEDICINE 2055 WEST 136TH AVE UNIT B118 BROOMFIELD, CO 800239308	PHYSICIAN CLINIC
7 53 - SCLP ROCKY MOUNTAIN CARDIOVASCULAR ASSOC 355 UNION BLVD STE 200 LAKEWOOD, CO 802281500	PHYSICIAN CLINIC
8 54 - SCLP SJ SURGICAL SPECIALISTS FACULTY 1960 OGDEN ST STE 530 DENVER, CO 802183671	PHYSICIAN CLINIC
9 55 - SCLP ST JOSEPH DIABETES & ENDOCRINE 1960 OGDEN ST STE 120A DENVER, CO 802183667	PHYSICIAN CLINIC
10 56 - SCLP STAPLETON OB-GYN OBESTESTRICS & GYN 2823 ROSLYN ST DENVER, CO 802382624	PHYSICIAN CLINIC
11 57 - SCLP STAPLETON REHABILITATION 2807 ROSLYN ST DENVER, CO 802382624	PHYSICIAN CLINIC
12 58 - SCLP SURGICAL SPECIALISTS 1960 OGDEN ST STE 530 DENVER, CO 802183671	PHYSICIAN CLINIC
13 59 - SCLP THORNTON MEDICAL CENTER FAMILY MEDI 1181 E 120TH AVE UNIT A THORNTON, CO 802335729	PHYSICIAN CLINIC
14 60 - SCLP UNION FAMILY & INTERNAL MEDICINE 355 UNION BLVD STE 200 LAKEWOOD, CO 802281500	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 61 - SCLP WELLMORE FAMILY MEDICINE 7777 W 38TH AVE WHEAT RIDGE, CO 800336170	PHYSICIAN CLINIC
1 62 - SCLP WHEAT RIDGE OMPT 9830 I-70 FRONTAGE ROAD S WHEAT RIDGE, CO 800331724	PHYSICIAN CLINIC
2 63 - ST MARY'S CARDIOVASCULAR & THORACIC SURG 2643 PATTERSON RD STE 403 GRAND JUNCTION, CO 815061937	PHYSICIAN CLINIC
3 64 - ST MARY'S CENTER FOR BRAIN & SPINE - COR 20 S MARKET ST CORTEZ, CO 81321	PHYSICIAN CLINIC
4 65 - ST MARY'S CENTER FOR BRAIN & SPINE - CRA 785 RUSSELL ST CRAIG, CO 81625	PHYSICIAN CLINIC
5 66 - ST MARY'S CENTER FOR BRAIN & SPINE - GJ 750 WELLINGTON AVE STE 3A GRAND JUNCTION, CO 815016124	PHYSICIAN CLINIC
6 67 - ST MARY'S CENTER FOR BRAIN & SPINE - MON 224 S NEVADA MONTROSE, CO 81401	PHYSICIAN CLINIC
7 68 - ST MARY'S ENDOCRINOLOGY - GRAND JUNCTION 2643 PATTERSON RD STE 401 GRAND JUNCTION, CO 815061937	PHYSICIAN CLINIC
8 69 - ST MARY'S ENDOCRINOLOGY - RIFLE 51 AIRPORT RD RIFLE, CO 81650	PHYSICIAN CLINIC
9 70 - ST MARY'S INFECTIOUS DISEASE 2643 PATTERSON RD STE 401 GRAND JUNCTION, CO 815061937	PHYSICIAN CLINIC
10 71 - ST MARY'S LUNG & SLEEP CENTER - CRAIG 750 HOSPITAL LOOP CRAIG, CO 816258750	PHYSICIAN CLINIC
11 72 - ST MARY'S LUNG & SLEEP CENTER - GRAND JU 1050 WELLINGTON AVE GRAND JUNCTION, CO 815018121	PHYSICIAN CLINIC
12 73 - ST MARY'S LUNG & SLEEP CENTER - MOAB 450 W WILLIAMS WAY MOAB, UT 845322065	PHYSICIAN CLINIC
13 74 - ST MARY'S MATERNAL FETAL MEDICINE - GJ 2643 PATTERSON RD STE 406 GRAND JUNCTION, CO 815061937	PHYSICIAN CLINIC
14 75 - ST MARY'S MATERNAL FETAL MEDICINE - GUNN 711 N TAYLOR ST GUNNISON, CO 812302243	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 76 - ST MARY'S NEUROLOGY CLINIC - BASALT 350 MARKET AVE STE 316 BASALT, CO 816217405	PHYSICIAN CLINIC
1 77 - ST MARY'S NEUROLOGY CLINIC - CORTEZ 20 S MARKET ST CORTEZ, CO 81321	PHYSICIAN CLINIC
2 78 - ST MARY'S NEUROLOGY CLINIC - CRAIG 785 RUSSELL ST CRAIG, CO 81625	PHYSICIAN CLINIC
3 79 - ST MARY'S NEUROLOGY CLINIC - DURANGO 450 S CAMINO DEL RIOHWY 550 DURANGO, CO 813016856	PHYSICIAN CLINIC
4 80 - ST MARY'S NEUROLOGY CLINIC - GRAND JUNCT 750 WELLINGTON AVE STE 3C GRAND JUNCTION, CO 815016124	PHYSICIAN CLINIC
5 81 - ST MARY'S NEUROLOGY CLINIC - GUNNISON 711 N TAYLOR ST GUNNISON, CO 812302243	PHYSICIAN CLINIC
6 82 - ST MARY'S NEUROLOGY CLINIC - MOAB 476 WEST WILLIAM WAY MOAB, UT 84532	PHYSICIAN CLINIC
7 83 - ST MARY'S OCCUPATIONAL MEDICINE 2686 PATTERSON RD GRAND JUNCTION, CO 815068817	PHYSICIAN CLINIC
8 84 - ST MARY'S PEDIATRIC SPECIALTY CLINIC 2643 PATTERSON RD STE 603 GRAND JUNCTION, CO 815061937	PHYSICIAN CLINIC
9 85 - ST MARY'S PHYSICAL AND REHABILITATION CL 2686 PATTERSON RD GRAND JUNCTION, CO 815068817	PHYSICIAN CLINIC
10 86 - ST MARY'S RHEUMATOLOGY 1050 WELLINGTON AVE GRAND JUNCTION, CO 81501	PHYSICIAN CLINIC
11 87 - WEST PINES BEHAVIORAL HEALTH - MMACS 3400 LUTHERAN PKWY WHEAT RIDGE, CO 800336035	PHYSICIAN CLINIC
12 88 - WEST PINES BEHAVIORAL HEALTH - PHYSICIAN 3400 LUTHERAN PKWY WHEAT RIDGE, CO 800336035	PHYSICIAN CLINIC
13 89 - WEST PINES BEHAVIORAL HEALTH - TMS 3400 LUTHERAN PKWY WHEAT RIDGE, CO 800336035	PHYSICIAN CLINIC
14 90 - SCL PHYSICIANS - RMPC LLC 500 ELDORADO BLVD BLDG 4 STE 4300 BROOMFIELD, CO 80026	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
SCL HEALTH - FRONT RANGE INC

Employer identification number
84-1103606

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 10

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

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) FREE PRESCRIPTION DRUGS FOR INDIGENT PATIENTS	173		486,466	COST	FREE PRESCRIPTION DRUGS FOR INDIGENT PATIENTS
(2) POST-ACUTE HOME HEALTH CARE FOR INDIGENT PATIENTS	10		4,540	COST	POST-ACUTE HOME HEALTH CARE TO SAFELY DISCHARGE THOSE WHO HAVE LITTLE TO NO RESOURCES
(3) 5K RUN SPONSORSHIP ASSISTANCE	600	2,000			
(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	THE ORGANIZATION KEEPS RECORDS TO SUPPORT THE AMOUNTS PROVIDED OR REASON FOR SUCH SUPPORT. ELIGIBILITY FOR FUNDING IS DETERMINED ON AN INDIVIDUAL BASIS, CONSIDERING THE USE OF THE FUNDS AND HOW THE USE RELATES TO THE ORGANIZATION'S MISSION.

Additional Data

Software ID:
Software Version:
EIN: 84-1103606
Name: SCL HEALTH - FRONT RANGE 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
GOOD SAMARITAN MEDICAL CENTER FOUNDATION 200 EXEMPLA CIRCLE LAFAYETTE, CO 80026	84-1649162	501 (C) (3)	506,702				PROGRAM SUPPORT
METRO COMMUNITY PROVIDER NETWORK 3701 S BROADWAY ENGLWOOD, CO 80113	84-2477108	501 (C) (3)	50,000				SUPPORT FOR ESTES STREET CLINIC

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)	329,833				PROGRAM SUPPORT
PROJECT CURE INTERNATIONAL HEADQUARTERS 10377 E GEDDES AVENUE CENTENNIAL, CO 80112	31-0804358	501 (C) (3)		438,044	BOOK	SURGICAL SUPPLES	PROGRAM SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MENDING FACES 422 HUMBOLT STREET DENVER, CO 80218	27-2151804	501 (C) (3)	7,500				PROGRAM SUPPORT
ROCKY MOUNTAIN STROKE 5666 SOUTH BANNOCK STREET LITTLETON, CO 80120	84-1216307	501 (C) (3)	20,000				PROGRAM SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CLINICA CAMPESINA FAMILY HEALTH SERVICES 1345 PLAZA COURT NORTH NO 1A LAFAYETTE, CO 80026	84-0743432	501 (C) (3)	12,500				PROGRAM SUPPORT
SISTER CARMEN COMMUNITY CENTER 655 ASPEN RIDGE DR LAFAYETTE, CO 80026	84-0820308	501 (C) (3)	7,500				PROGRAM SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TRUE COMMUNITY CARE 2594 TRAIL RIDGE DRIVE LAFAYETTE, CO 80020	84-0748577	501 (C) (3)	5,300				HOSPICE CARE

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
SCL HEALTH - FRONT RANGE INC

Employer identification number
84-1103606

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: 84-1103606
Name: SCL HEALTH - FRONT RANGE 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

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 THE ORGANIZATION'S OFFICERS AND SENIOR MANAGEMENT ARE PAID BY A RELATED ORGANIZATION, SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) 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

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINES 4A-B	<p>SCHEDULE J, PART I, LINE 4A SEVERANCE PAYMENTS 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 SCHEDULE J, PART I, LINE 4B PAYMENTS FROM SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN A RELATED 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 RELATED 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 RELATED 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 BENFIT AMOUNT STAYS IN THE RETIREMENT PLAN THE AMOUNTS WITHDRAWN FROM THE PLAN FOR TAXES IN 2016 WERE LYDIA JUMONVILLE - \$86,105 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 RELATED 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, AND GERALDINE TOWNDROW - \$34,500 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	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
SCHEDULE J - 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				
1STEPHEN COBB MD MEMBER-RESIGNED FROM SCL HEALTH 4/25	(i)	0	0	0	0	0	0	0
	(ii)	192,070	44,737	1,535	72,456	-	-	0
						8,579	319,377	
1LYDIA JUMONVILLE TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	706,515	97,092	208,664	220,478	-	-	190,203
						18,358	1,251,107	
2KEVIN MILLER MDMEMBER	(i)	684,373	69,386	24,393	19,080	20,817	818,049	0
	(ii)	0	0	0	0	-	-	0
						0	0	
3MICHAEL SLUBOWSKI MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	1,132,496	220,576	598,133	19,080	-	-	0
						19,516	1,989,801	
4MICHAEL TAYLOR VICE CHAIR	(i)	0	0	0	0	0	0	0
	(ii)	700,141	112,079	37,136	129,931	-	-	0
						26,574	1,005,861	
5ELIZABETH CARVER SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	268,135	23,425	4,376	15,392	-	-	0
						20,945	332,273	
6J GRANT WICKLUND PRESIDENT-CEO LMC	(i)	0	0	0	0	0	0	0
	(ii)	451,185	74,595	29,382	241,737	-	-	0
						21,966	818,865	
7DAVID HAMM PRESIDENT - CEO GSMC	(i)	0	0	0	0	0	0	0
	(ii)	428,582	71,471	30,365	189,399	-	-	0
						18,960	738,777	
8JAMES DOYLE VP FINANCE SERVICES	(i)	0	0	0	0	0	0	0
	(ii)	215,501	23,192	10,538	37,633	-	-	0
						22,105	308,969	
9JOHN HIGGINS VICE PRESIDENT AND CFO GSMC	(i)	0	0	0	0	0	0	0
	(ii)	202,064	24,138	3,218	36,003	-	-	0
						25,997	291,420	
10ANDREA BURCH VP CHIEF NURSING OFFICER LMC	(i)	0	0	0	0	0	0	0
	(ii)	169,762	7,468	398	10,905	-	-	0
						0	188,533	
11SCOTT DAY VP HUMAN RESOURCES LMC	(i)	0	0	0	0	0	0	0
	(ii)	195,888	23,071	12,266	33,199	-	-	0
						20,962	285,386	
12BETH FORSYTH CHIEF OPERATING OFFICER- GSMC	(i)	0	0	0	0	0	0	0
	(ii)	269,737	31,076	7,038	45,317	-	-	0
						18,619	371,787	
13CHRISTINA JOHNSON VP OPERATIONS LMC	(i)	0	0	0	0	0	0	0
	(ii)	396,375	43,642	2,529	70,580	-	-	0
						0	513,126	
14SUSAN KERSCHEN VP-CHIEF NURSING OFFICER GSMC	(i)	0	0	0	0	0	0	0
	(ii)	229,757	26,968	4,732	40,212	-	-	0
						20,697	322,366	
15THOMAS MYDLER CHIEF MEDICAL OFFICER GSMC	(i)	0	0	0	0	0	0	0
	(ii)	325,683	37,780	3,653	55,117	-	-	0
						21,363	443,596	
16BRIAN WITWER MD PHYSICIAN	(i)	788,775	165,218	6,304	19,080	22,593	1,001,970	0
	(ii)	0	0	0	0	-	-	0
						0	0	
17JASON SHOFNOS MD PHYSICIAN	(i)	694,849	126,118	17,719	19,080	21,383	879,149	0
	(ii)	0	0	0	0	-	-	0
						0	0	
18JAMES THOMPSON MD PHYSICIAN	(i)	382,957	427,001	2,464	16,430	18,863	847,715	0
	(ii)	0	0	0	0	-	-	0
						0	0	
19ROBERT REPLOGLE MD PHYSICIAN	(i)	800,216	0	3,014	1,346	16,876	821,452	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				
21BASHEAL AGRAWAL MD PHYSICIAN	(i)	790,232	0	1,391	16,430	26,341	834,394	0
	(ii)	0	0	0	0	- 0	- 0	0
1ROBERT LADENBURGER FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	0	0	323,001	0	- 6,893	- 329,894	0
2ROSLAND MCLEOD FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	476,267	76,875	17,503	141,090	- 27,889	- 739,624	0
3KAREN SCREMIN FORMER OFFICER	(i)	0	0	0	0	0	0	0
	(ii)	312,819	28,524	1,436	45,080	- 9,740	- 397,599	0
4AMY PACEY FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	205,320	23,562	912	33,896	- 7,501	- 271,191	0
5GERALDINE TOWNDROW FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	307,717	40,664	53,863	14,617	- 7,698	- 424,559	0

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered
"Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c,
or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (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
SCL HEALTH - FRONT RANGE INC

Employer identification number
84-1103606

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 ▶ \$

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

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

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) JUDY CABOT	SEE PART V	52,697	EMPLOYMENT		No

Part V Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE L, PART IV	ANDREA BURCH (KEY EMPLOYEE), IS THE DAUGHTER OF AN EMPLOYEE OF SCL HEALTH FRONT RANGE, INC , JUDY CABOT

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493310023477
SCHEDULE O (Form 990 or 990-EZ) <div>Department of the Treasury Internal Revenue Service Name of the organization SCL HEALTH - FRONT RANGE INC</div>	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 84-1103606	

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINES 4A - 4D	<p>DESCRIPTION OF PROGRAM SERVICE ACHIEVEMENTS SCL HEALTH - FRONT RANGE, INC (SCLHFR) OPERATES LUTHERAN MEDICAL CENTER (LMC) SERVING PRIMARILY WESTERN AND SOUTHERN SUBURBAN AREAS OF METRO DENVER AND GOOD SAMARITAN MEDICAL CENTER (GSMC), SERVING PRIMARILY BOULDER AND NORTH WEST COUNTIES OF METRO DENVER, AND OTHER AFFILIATED MEDICAL OPERATIONS THE SYSTEM'S COLLECTIVE PROGRAM SERVICES ACCOMPLISHMENTS INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING MEDICAL SERVICES ARE PROVIDED TO ALL WHO SEEK SERVICE REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR ABILITY TO PAY ALTHOUGH REIMBURSEMENT FOR SERVICES IS CRITICAL FOR THE OPERATION AND STABILITY OF THE SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, IT IS RECOGNIZED THAT NOT ALL INDIVIDUALS POSSESS THE ABILITY TO PURCHASE ESSENTIAL MEDICAL SERVICES THE MISSION OF SCL HEALTH IS "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" THEREFORE, IN KEEPING WITH SCLHFR'S COMMITMENT TO SERVE ALL MEMBERS OF ITS COMMUNITY, FREE CARE AND/OR SUBSIDIZED CARE WILL BE CONSIDERED AND PROVIDED WHERE THE NEED AND /OR AN INDIVIDUAL'S INABILITY TO PAY EXIST IN ADDITION, SCLHFR RECOGNIZES THE ESSENTIAL NEED TO BE EXCEPTIONAL STEWARDS OF MEDICARE, MEDICAID AND COMMUNITY/PRIVATE FUNDING DOLLARS FOR 2016, SCL HEALTH - FRONT RANGE, INC PROVIDED BENEFITS TO THE COMMUNITY WHICH WENT TO CARING FOR THOSE WHO ARE POOR AND VULNERABLE THROUGH CHARITY CARE, UNREIMBURSED MEDICAID AND OTHER MEANS - TESTED GOVERNMENT PROGRAMS SCLHFR PROVIDED ADDITIONAL BENEFITS TO THE COMMUNITY WHICH WENT TO IMPROVING THE HEALTH OF THE HOSPITAL'S COMMUNITY THROUGH HEALTH EDUCATION, COMMUNITY PROGRAMS, SUBSIDIZED HEALTH SERVICES AND ENVIRONMENTAL IMPROVEMENTS SCLHFR ALSO RECOGNIZES THE ESSENTIAL NEED TO ENHANCE AND IMPROVE MEDICAL OUTCOMES, QUALITY AND SERVICES IN RESPONSE, A BEST IN THE NATION STRATEGY AND PROGRAM WAS IMPLEMENTED THE OBJECTIVES OF THE PROGRAM ARE TO BE THE BEST IN THE NATION IN PREDEFINED QUALITY, SERVICE AND COST INDICATORS THE QUALITY INDICATORS ARE IN ALIGNMENT WITH MAJOR PUBLICLY COMPARABLE DATABASES, INCLUDING THE COLORADO HEALTH AND HOSPITAL ASSOCIATION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES COLLECTIVELY WITH ITS 560 LICENSED BEDS AT LMC AND GSMC, SCLHFR SERVED THE COMMUNITY WITH OVER 25,000 INPATIENT ADMISSIONS AND NEARLY 243,000 TOTAL OUTPATIENT VISITS WHILE PROVIDING SURGICAL SERVICES TO OVER 17,000 RECIPIENTS TOTAL BIRTHS AT SCLHFR WERE 4,817 -COMPREHENSIVE MEDICAL SERVICES INCLUDE, BUT ARE NOT LIMITED TO, CARDIOLOGY, ONCOLOGY, ORTHOPEDIC, WOMEN AND FAMILY, PEDIATRICS, EMERGENCY AND TRAUMA, NEONATAL INTENSIVE CARE, NEUROLOGY, NEUROSURGERY, OB/GYN, GENERAL SURGICAL AND MEDICAL, PRIMARY CARE, INTERNAL MEDICINE, BEHAVIORAL HEALTH, HOSPICE CARE AND INTEGRATIVE HEALTH SERVICES A STRONG COMMITMENT TO THE HEALTH OF THE COMMUNITY IS FURTHER EXEMPLIFIED BY, BUT NOT LIMITED TO, THE FOLLOWING PROGRAMS, -THE</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINES 4A - 4D	<p>CANCER CENTER AT LMC INCLUDES ALL STAGES OF CARE INCLUDING INITIAL DIAGNOSIS, PROVIDING MONITORING, AND MANAGING MEDICATIONS. THE CENTER INCLUDES STATE-OF-THE-ART-RADIATION ONCOLOGY CENTER, INFUSION CENTER, ONCOLOGY UNIT, CLINICAL TRIALS, NUTRITION COUNSELING, SOCIAL WORK SERVICES, SITE SPECIFIC CARE TEAM, EDUCATION AND SUPPORT SERVICES. -AT THE HEART AND NEUROVASCULAR CENTER, PATIENTS ARE TREATED BY AN INTERDISCIPLINARY TEAM FOR CARDIAC AND NEUROLOGICAL CARE. PATIENTS DO NOT NEED TO BE TRANSFERRED TO ANOTHER FACILITY. THE CENTER FEATURES ADVANCED IMAGING EQUIPMENT AND NEUROLOGICAL SUITES TO SPEED PATIENTS' CARE. -THE BREAST CARE CENTER, ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY AND THE NATIONAL ACCREDITATION BREAST CARE CENTER, PROVIDES A FULL RANGE OF HIGH-TECH SERVICES IN ITS SCREENING AND DIAGNOSTIC SUITES INCLUDING DIGITAL MAMMOGRAPHY SCREENINGS AND DIAGNOSTIC SERVICES, ULTRASOUND, STEREOTACTIC BIOPSIES, MEDICAL CONSULTATION, EDUCATION, AS WELL AS AN ALTERNATIVE HEALTH CENTER AND EMOTIONAL SUPPORT. -THE WOMEN AND FAMILY CENTER INCLUDES A LEVEL III NEONATAL INTENSIVE CARE UNIT AND COMPREHENSIVE PRENATAL AND PARENTING EDUCATION. THE ANTEPARTUM FAMILY UNIT HELPS PREGNANT WOMEN WHO NEED SPECIALIZED CARE FOR THEMSELVES AND/OR THEIR UNBORN BABIES. SUPPORT FOR THE NEW UNIT HELPS US REACH OUR GOAL TO HELP WOMEN HAVE HEALTHY PREGNANCIES, BIRTHS AND BABIES. THE DIAGNOSTIC IMAGING CENTER IS ONE OF DENVER'S MOST ADVANCED IMAGING CENTER FEATURING COMPREHENSIVE STATE-OF-THE-ART DIAGNOSTIC IMAGING SERVICES INCLUDING 40 SLICE CT SCANNER, 3.0 TESLA MRI SYSTEM, 3D MAMMO EQUIPMENT ULTRASOUND ROOMS WITH ADJOINED CHANGING ROOMS AND RESTROOMS AND DIAGNOSTIC TECHNOLOGY IN ALL-DIGITAL ENVIRONMENT. -THE HUMAN MOTION INSTITUTE (HMI) OFFERS STATE-OF-THE-ART MUSCULOSKELETAL CARE. HMI COMBINES THE MOST ADVANCED MEDICAL TECHNOLOGY WITH A DEDICATED TEAM OF PHYSICIANS AND MEDICAL PROFESSIONALS. THE FOCUS IS ON PREVENTION, ASSESSMENT, TREATMENT AND REHABILITATION OF MUSCULOSKELETAL INJURIES. -COLLIER HOSPICE CENTER PROVIDES COMPASSIONATE, COMPREHENSIVE, INTERDISCIPLINARY END-OF-LIFE CARE FOR TERMINALLY ILL PATIENTS AND SUPPORT FOR THEIR FAMILIES. PATIENTS ARE SERVED IN THEIR HOMES, IN NURSING HOMES AND IN THE HOSPICE INPATIENT UNIT LOCATED ON LMC'S CAMPUS. THERE ARE FREE COMMUNITY SERVICES INCLUDING VOLUNTEER-BASED PRE-HOSPICE SUPPORT, GRIEF SUPPORT GROUPS, GRIEF EDUCATION WORKSHOPS, CAREGIVER SUPPORT GROUPS AND GRIEF SUPPORT FOR YOUNG PEOPLE. -COLORADO LUTHERAN HOME (CLH) PROVIDES INDEPENDENT AND ASSISTED-LIVING ACCOMMODATIONS FOR OLDER ADULTS AND IS RECOGNIZED AS AN EDEN ALTERNATIVE FACILITY. IT IS AN ELDER-CENTERED COMMUNITY THAT IMBUES DAILY LIFE WITH VARIETY AND SPONTANEITY. CLH IS A SKILLED NURSING FACILITY THAT INCLUDES A SECURED ALZHEIMER'S UNITS FOR PATIENTS NEEDING 24/7 CARE. -WEST PINES IS A BEHAVIORAL HEALTH FACILITY THAT PROVIDES INPATIENT AND OUTPATIENT PSYCHIATRIC AND ADDICTION SERVICES TO ADULTS. THE WEST PINES RECOVERY CENTER OFFERS AN INNOVATIVE TWO-W</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINES 4A - 4D	<p>EEK ADDICTION RECOVERY PROGRAM TO CLIENTS AND THEIR FAMILIES WHO STRUGGLE WITH ADDICTION, OR ADDICTION PLUS MENTAL ILLNESS AFTER THE TWO-WEEK STAY, CLIENTS RECEIVE INTENSIVE OUTPATIENT ASSISTANCE AND OPTIONAL MEDICATION MANAGEMENT THE PROGRAM PROVIDES SHORTER STAYS AND LOWER COSTS THE SENIOR BEHAVIORAL HEALTH IS A 20 BED UNIT LOCATED AT LMC TO TREAT SENIORS WITH PSYCHIATRIC ILLNESSES -BRIDGES INTEGRATIVE HEALTH AND WELLNESS OFFERS INTEGRATIVE CARE ACUPUNCTURE, MASSAGE, HEALING TOUCH, PULMONARY REHABILITATION, PHYSICAL THERAPY AND CARDIAC REHABILITATION -ESTES STREET COMMUNITY CLINIC IS A PARTNERSHIP BETWEEN LMC, THE JEFFCO ACTION CENTER AND METRO COMMUNITY PROVIDER NETWORK THE CLINIC SERVES HOMELESS AND LOW-INCOME CHILDREN AND ADULTS WITHOUT INSURANCE IT PROVIDES ACUTE AND PREVENTIVE CARE, IMMUNIZATIONS, WELL-CHILD AND WELL-WOMEN CHECKUPS -LMC PROVIDES COMPREHENSIVE EDUCATION PROGRAMS WITH OPPORTUNITIES FOR ALL AGES THROUGH EDUCATION, RELIABLE HEALTH INFORMATION AND SUPPORT, THE PROGRAM PARTNERS WITH DOCTORS AND OTHER HEALTH CARE EXPERTS TO IMPROVE COMMUNITY HEALTH -CARDIAC AND VASCULAR SERVICES INCLUDES THE CARDIAC CALCIUM SCORE FOR DETECTING HEART DISEASE RISK -EMERGENCY AND TRAUMA SERVICES INCLUDES A LEVEL III TRAUMA CENTER - BONE AND JOINT INSTITUTE INCLUDES A COMPREHENSIVE TREATMENT OF ALL JOINT INJURIES AND REPLACEMENT FULL SERVICE PHYSICAL THERAPY IS ALSO AVAILABLE -NEUROSCIENCES THE GOOD SAMARITAN MEDICAL CENTER ADDED TWO BREAKTHROUGH NEUROSCIENCE TECHNOLOGIES - THE INFRARED 800TM AND THE OPMI PENTERO - FOR TREATMENT OF STROKES, ANEURYSMS, BRAIN TUMORS AND OTHER CONDITIONS THE HOSPITAL EMPLOYS A STROKE FELLOWSHIP-TRAINED PHYSICIAN AND HAS CREATED A STROKE CENTER -OTOLARYNGOLOGY INCLUDES BALLOON SINUPLASTY -WOMEN AND FAMILY CENTER INCLUDES A LEVEL II NEONATAL INTENSIVE CARE AND COMPREHENSIVE PRENATAL AND PARENTING EDUCATION SUPPORT FOR THE UNIT HELPS US REACH OUR GOAL TO HELP WOMEN HAVE HEALTHY PREGNANCIES, BIRTHS AND BABIES GSMC ALSO IS THE FIRST HOSPITAL TO RECEIVE THE BABY-FRIENDLY DESIGNATION IN COLORADO INPATIENT AND OUTPATIENT SURGICAL SERVICES INCLUDES A BONE & JOINT INSTITUTE</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINES 4A - 4D (CONT'D)	<p>-NEUROSURGERY, INCLUDING O-ARM TECHNOLOGY FOR COMPLEX NEUROSURGICAL CASES AND THE OPMI PENTERO MICROSCOPE, A STATE OF THE ART IMPROVEMENT IN INTRA-OPERATIVE VISUALIZATION FOR BRAIN TUMORS AND ANEURYSMS, THE ONLY ONE OF ITS KIND IN THE REGION GSMC ALSO BEGAN A DEEP BRAIN STIMULATION SERVICE FOR TREATMENT OF SEVERE MOVEMENT DISORDER LIKE ADVANCED PARKINSON'S DISEASE -INTERVENTIONAL AND DIAGNOSTIC RADIOLOGY INCLUDING A 64-SLICE CT SCANNER OTHER SERVICES INCLUDE MRI, ULTRASOUND AND DIAGNOSTIC IMAGING -GSMC'S HEALTH & HEALING CENTER OFFERS INPATIENT AND OUTPATIENT INTEGRATIVE CARE (ACUPUNCTURE, MASSAGE, HEALING TOUCH, PULMONARY REHABILITATION, PHYSICAL THERAPY AND CARDIAC REHABILITATION) -GSMC PROVIDES WELLNESS QUEST, A COMPREHENSIVE EDUCATION PROGRAM WITH OPPORTUNITIES FOR ALL AGES THROUGH EDUCATION, RELIABLE HEALTH INFORMATION AND SUPPORT, THE PROGRAM PARTNERS WITH DOCTORS, OTHER HEALTH CARE EXPERTS AND SCHOOLS TO IMPROVE COMMUNITY HEALTH -GSMC WORKS CLOSELY WITH CLINICA CAMPESINA, A LAFAYETTE-BASED, FEDERALLY-QUALIFIED CLINIC FOR INDIGENT AND LOW INCOME INDIVIDUALS IN BOULDER COUNTY, PROVIDING ASSISTANCE TO FAMILIES IN NEED LMC WORKS CLOSELY WITH METRO COMMUNITY PROVIDER NETWORK, A FEDERALLY QUALIFIED HEALTH CENTER ALSO SERVING INDIGENT AND LOW INCOME INDIVIDUALS AND FAMILIES IN JEFFERSON COUNTY -GSMC AND LMC ARE DESIGNATED "BABY-FRIENDLY HOSPITALS" THAT SUPPORT BREASTFEEDING ON NEWBORNS AND PROMOTES THE INITIATION OF BREASTFEEDING WITHIN 1 HOUR OF BIRTH AND ALLOWS MOTHERS AND INFANTS TO REMAIN TOGETHER 24 HOURS A DAY -GSMC AND LMC OFFER THE "BABY'S FIRST RIDE PROGRAM" AS A SERVICE TO ALL FAMILIES DELIVERING AT OUR HOSPITAL PARENTS ARE TAUGHT THE PROPER WAY TO INSTALL AND USE A CAR SEAT TO ENSURE THEIR BABY'S FIRST RIDE IS A SAFE ONE</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 4	THE PRIMARY PURPOSE FOR AMENDING AND RESTATING THE BYLAWS OF SCL HEALTH - FRONT RANGE, INC IS TO CLARIFY THAT SCLH-FR IS A PROVIDER NETWORK THAT INCLUDES EMPLOYED PHYSICIANS NOT ONLY IN THE METROPOLITAN DENVER REGION BUT ALSO IN MESA COUNTY, COLORADO THE FOLLOWING ARE THE KEY CHANGES TO SCLH-FR'S BYLAWS * CLARIFY THAT SCLH-FR IS A PROVIDER NETWORK, INCLUDING EMPLOYED PHYSICIANS IN THE METROPOLITAN DENVER REGION AND MESA COUNTY, COLORADO, * CLARIFY THAT THE APPOINTMENT OF A FINANCE COMMITTEE IS PERMISSIVE NOT MANDATORY, * CLARIFY THAT A "SENIOR ADMINISTRATOR" MAY BE APPOINTED IN LIEU OF HAVING A PRESIDENT/CEO, * EXPRESSLY DEFINE THAT THE MEMBER (SCL HEALTH) MAY FROM TIME TO TIME SERVE AS THE MANAGER OF ONE OR MORE CONTROLLED AFFILIATES AND/OR DESIGNATE SCLH-FR, OR ANY OTHER SCL HEALTH CONTROLLED ENTITY, AS MANAGER OF ANY CONTROLLED ENTITY, * EXPRESSLY DEFINE THE ROLE OF THE SCLH-FR BOARD IN OVERSEEING QUALITY AND PATIENT SAFETY, AND, * ALIGN INCONSISTENCIES WITHIN THE BYLAWS REGARDING THE ELECTION OF OFFICERS OF THE BOARD

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	MEMBERS OR STOCKHOLDERS SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) IS THE SOLE MEMBER OF SCL HEALTH-FRONT RANGE, INC

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	POWER TO ELECT OR APPOINT MEMBERS SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC , THE SOLE MEMBER OF SCL HEALTH - FRONT RANGE, INC , APPROVES MEMBERS OF SCL HEALTH - FRONT RANGE, INC BOARD OF DIRECTORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	DECISIONS RESERVED TO MEMBERS OR STOCKHOLDERS, 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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	PROCESS USED TO REVIEW THE FORM 990, THE FORM 990 IS PREPARED BY THE TAX DEPARTMENT OF THE PARENT ORGANIZATION, SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCLHS) THE FORM 990 IS REVIEWED BY CERTAIN MEMBERS OF 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

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 SCL HEALTH - FRONT RANGE, INC. AND THE PARENT ORGANIZATION, SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (COLLECTIVELY REFERRED TO AS 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</p> <ul style="list-style-type: none"> * 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 <p>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</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>THAT AN ARRANGEMENT WITH RESPECT TO WHICH HE OR SHE HAS A CONFLICT OF INTEREST IS BEING CONSIDERED, 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 SCL HEALTH CEO OR A BOARD OR COMMITTEE MEMBER), EVEN IF THE CONFLICT OF INTEREST HAS BEEN PREVIOUSLY DISCLOSED WITH REGARD TO EMPLOYEES OTHER THAN THE SCL HEALTH CEO. THE INTERESTED 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 LEAVE THE MEETING OR OTHERWISE REMOVE HIM OR HERSELF FROM THE DELIBERATIONS OR OTHER DECISION-MAKING PROCESS UNTIL SUCH TIME AS A DETERMINATION IS REACHED. IF A DETERMINATION HAS BEEN MADE THAT NO CONFLICT OF INTEREST EXISTS, THE INTERESTED PERSON MAY BE PRESENT AND PARTICIPATE IN THE DELIBERATION REGARDING THE TRANSACTION OR ARRANGEMENT. HOWEVER, IF AN INTERESTED PERSON HAS BEEN DETERMINED TO HAVE A CONFLICT OF INTEREST, HE OR SHE MAY NOT PARTICIPATE IN THE DELIBERATION OR DECISION REGARDING THE TRANSACTION OR ARRANGEMENT, BE PRESENT DURING THE DELIBERATION OR DECISION-MAKING, OR BE ALLOWED TO MAKE A PRESENTATION PRIOR TO THE DELIBERATION AND DECISION-MAKING ACTIVITIES. WHEN AN INTERESTED PERSON HAS A CONFLICT OF INTEREST, THE DECISION-MAKER/DECISION-MAKING BODY CONSIDERING THE TRANSACTION OR ARRANGEMENT 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 HAVING BEEN FULLY INFORMED OF THE MATERIAL FACTS ESTABLISHING THE CONFLICT OF INTEREST, DETERMINES 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 DETERMINATION IS MADE BY A BOARD, COMMITTEE OR OTHER DECISION-MAKING BODY. MANAGEMENT OF POTENTIAL CONFLICTS IS DONE BY THE CHIEF INTEGRITY AND COMPLIANCE OFFICER AND/OR CARE SITE COMPLIANCE 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 CONFLICTS OR POTENTIAL CONFLICTS WILL ALSO BE REPORTED TO AND REVIEWED BY THE SCL HEALTH TAX DIRECTOR 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>FORM 990, PART VI, SECTION B (POLICIES) LINES 15(A) & 15(B) THE ORGANIZATION'S OFFICERS AND SENIOR MANAGEMENT ARE PAID BY A RELATED ORGANIZATION, SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM, INC (SCL HEALTH) 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	AVAILABILITY OF GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC 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	EQUITY TRANSFER - SYSTEM ACQUISITION COST -187,177,805 EQUITY TRANSFER - CAPITALIZE DENVER JOINT VENTURES 7,233,334 EQUITY TRANSFER - MOUNT SAINT VINCENT SUBSIDIES -2,533,334 EQUITY TRANSFER - INTEREST EXPENSE PAID IN EXCESS OF INTEREST INCOME EARNED -27,702,200 BOOK VS TAX DEPRECIATION 18,675

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
SCL HEALTH - FRONT RANGE INC

Employer identification number
84-1103606

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) GOOD SAMARITAN MEDICAL CENTER LLC 200 EXEMPLA CIRCLE LAFAYETTE, CO 80026 43-1982139	HOSPITAL SERVICES	CO	318,411,742	242,096,062	SCL HEALTH - FRONT RANGE INC
(2) SCL HEALTH MEDICAL GROUP - DENVER LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80026 46-3778226	PHYSICIAN SERVICES	CO	54,118,381	16,111,328	SCL HEALTH - FRONT RANGE INC
(3) SCL PHYSICIANS - RMPC LLC 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80026 35-2563201	PHYSICIAN SERVICES	CO	0	0	SCL HEALTH MEDICAL GROUP - DENVER LLC
(4) SCL HEALTH MEDICAL GROUP - GRAND JUNCTION LLC 2635 NORTH 7TH STREET GRAND JUNCTION, CO 81502 46-3778277	PHYSICIAN SERVICES	CO	44,288,810	4,568,125	SCL HEALTH - FRONT RANGE INC

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?

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) GOOD SAMARITAN MEDICAL CENTER FOUNDATION	B	506,702	CASH
(2) GOOD SAMARITAN MEDICAL CENTER FOUNDATION	C	89,139	CASH
(3) LUTHERAN MEDICAL CENTER FOUNDATION	C	1,476,367	CASH
(4) LUTHERAN MEDICAL CENTER FOUNDATION	B	329,833	CASH

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: 84-1103606
Name: SCL HEALTH - FRONT RANGE INC

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 23-7379161	MANAGEMENT OF RELATED TAX EXEMPT HOSPITALS AND HEALTHCARE SERVICES	KS	501(C)(3)	LINE 12C, III-FI	N/A		No
(1) 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 47-4520350	SUPPORTING ORGANIZATION	CO	501(C)(3)	LINE 12C, III-FI	SCLHS		No
(2) 1600 PRAIRIE CENTER PARKWAY BRIGHTON, CO 80601 84-0482695	HOSPITAL SERVICES	CO	501(C)(3)	LINE 3	INTEGRITY HEALTH		No
(3) 1600 PRAIRIE CENTER PARKWAY BRIGHTON, CO 80601 74-2255936	SUPPORTING ORGANIZATION	CO	501(C)(3)	LINE 12A, I	BRIGHTON COMMUNITY HOSPITAL ASSOCIATION		No
(4) 4159 LOWELL BOULEVARD DENVER, CO 80211 84-0405260	RESIDENT CARE	CO	501(C)(3)	LINE 10	SCLHS		No
(5) 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		No
(6) 1375 EAST 19TH AVENUE DENVER, CO 80218 84-0417134	HOSPITAL SERVICES	CO	501(C)(3)	LINE 3	SCLHS		No
(7) 1375 EAST 19TH AVENUE DENVER, CO 80218 84-0735096	SUPPORT RELATED TAX EXEMPT ORGANIZATIONS	CO	501(C)(3)	LINE 10	SAINT JOSEPH HOSPITAL INC		No
(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		No
(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		No
(12) 818 NORTH 7TH STREET LEAVENWORTH, KS 66048 48-1009910	CLINIC SERVICES	KS	501(C)(3)	LINE 3	SCLHS		No
(13) 3164 EAST 6TH AVENUE TOPEKA, KS 66607 48-1046905	CLINIC SERVICES	KS	501(C)(3)	LINE 3	SCLHS		No
(14) 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 48-0547719	HOSPITAL SERVICES	KS	501(C)(3)	LINE 3	SCLHS		No
(15) 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 48-1092520	SUPPORTING ORGANIZATION	KS	501(C)(3)	LINE 12A, I	ST FRANCIS HEALTH CENTER INC		No
(16) 2600 WILSON STREET MILES CITY, MT 59301 81-0231792	HOSPITAL SERVICES	MT	501(C)(3)	LINE 3	SCLHS		No
(17) 2600 WILSON STREET MILES CITY, MT 59301 20-2270238	SUPPORTING ORGANIZATION	MT	501(C)(3)	LINE 12A, I	HOLY ROSARY HEALTHCARE		No
(18) 400 SOUTH CLARK STREET BUTTE, MT 59701 81-0231785	HOSPITAL SERVICES	MT	501(C)(3)	LINE 3	SCLHS		No
(19) 400 SOUTH CLARK STREET BUTTE, MT 59701 65-1202190	SUPPORTING ORGANIZATION	MT	501(C)(3)	LINE 12A, I	ST JAMES HEALTHCARE		No

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		No
(1) 1106 NORTH 30TH STREET BILLINGS, MT 59101 81-0468034	SUPPORT RELATED TAX EXEMPT ORGANIZATIONS	MT	501(C)(3)	LINE 7	ST VINCENT HEALTHCARE		No

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) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) APEX SURGICAL PARTNERS INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 47-3268324	MEDICAL SERVICES	CO	N/A	C					No
(1) EAGLE RIDGE MEDICAL INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 46-2387681	MEDICAL SERVICES	CO	N/A	C					No
(2) HIGH PLAINS HEART AND VASCULAR CENTER INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-2038197	MEDICAL SERVICES	CO	N/A	C					No
(3) INTEGRATIVE INTERNAL MEDICINE AND MEDICAL ACUPUNCTURE INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-4433325	MEDICAL SERVICES	CO	N/A	C					No
(4) MOUNTAIN VIEW ORTHOPEDICS INC 1610 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 27-5382523	MEDICAL SERVICES	CO	N/A	C					No
(5) PVMC MEDICAL TEAM INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 47-3988808	MEDICAL SERVICES	CO	N/A	C					No
(6) PVMC PHYSICIAN SERVICES INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 94-3458548	MEDICAL SERVICES	CO	N/A	C					No
(7) PLATTE VALLEY MEDICAL TEAM INC 1606 PRAIRIE CENTER PARKWAY SUITE 2 BRIGHTON, CO 80601 84-1110470	MEDICAL SERVICES	CO	N/A	C					No
(8) CARITAS INC AND SUBSIDIARIES 500 ELDORADO BLVD SUITE 4300 BROOMFIELD, CO 80021 48-0941069	HEALTHCARE	KS	N/A	C					No
(9) ST FRANCIS ACCOUNTABLE HEALTH NETWORK INC 1700 SOUTHWEST 7TH STREET TOPEKA, KS 66606 46-2874128	HEALTHCARE	KS	N/A	C					No
(10) LEAVEN INSURANCE COMPANY LTD 23 LIME TREE BAY AVENUE WEST BAY R GRAND CAYMAN KY1-1102 CJ 98-0370522	INSURANCE	CJ	N/A	C					No