

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission

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

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

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

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

If "Yes," describe these changes on Schedule O

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

4a	(Code) (Expenses \$ 410,424,567 including grants of \$ 2,601,253) (Revenue \$ 515,133,893)
See Additional Data	


















4b	(Code) (Expenses \$ 69,144,531 including grants of \$) (Revenue \$ 41,300,678)
See Additional Data	

4c	(Code) (Expenses \$ 67,506,383 including grants of \$) (Revenue \$ 82,026,085)
See Additional Data	

4d	Other program services (Describe in Schedule O)
	(Expenses \$ 79,517,029 including grants of \$) (Revenue \$ 97,205,547)

4e	Total program service expenses ▶	626,592,510
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Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21 Yes	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	22	No
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23 Yes	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a Yes	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	No
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c	No
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	No
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a	No
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b	No
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>	26	No
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>	27	No
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a	No
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b	No
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	No
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29 Yes	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30	No
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31	No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>	32	No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33 Yes	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	34 Yes	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a Yes	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b	No
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36	No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37	No
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38 Yes	

Part V Statements Regarding Other IRS Filings and Tax 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.	479	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.	5,057	
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	Yes	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		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?		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
d	If "Yes," indicate the number of Forms 8282 filed during the year.	0	
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		No
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		No
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		No
9a	Did the sponsoring organization make any taxable distributions under section 4966?		No
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		No
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12.	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders.	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		No
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a	No
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.	13b	
c	Enter the amount of reserves on hand.	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?		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	1a 12		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b Enter the number of voting members included in line 1a, above, who are independent	1b 12		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6		No
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		No
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		No
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.	9		No

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed	OR
18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O)	
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.	
20 State the name, address, and telephone number of the person who possesses the organization's books and records. JENNIFER WELANDER 2500 NE Neff Rd BEND, OR 97701 (541) 706-7707	

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

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

Form **990** (2017)

[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 ▶ 681

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DR BEND, OR 97701	Imaging Services	33,096,468
SKANSKA 222 SW COLUMBIA STREET STE 300 PORTLAND, OR 97201	CONSTRUCTION	9,570,067
CENTRAL OREGON MRI LLC PO BOX 6059 BEND, OR 97708	MRI services	4,370,347
NEENAN COMPANY LLP 2607 MIDPOINT DRIVE FORT COLLINS, CO 80525	CONSTRUCTION	5,203,716
HOWARD S WRIGHT CONSTRUCTORS LP 1455 NW IRVING STREET STE 400 PORTLAND, OR 97209	CONSTRUCTION	6,466,956

<p>2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 68</p>	
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Part VIII **Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a					
	b Membership dues . . .	1b					
	c Fundraising events . . .	1c					
	d Related organizations	1d	1,588,414				
	e Government grants (contributions)	1e	569,227				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,702,620				
	g Noncash contributions included in lines 1a-1f \$ <u>25,462</u>						
	h Total. Add lines 1a-1f ▶		4,860,261				
Program Service Revenue			Business Code				
	2a St Charles Bend		900099	515,133,893	515,133,893		
	b St Charles Madras		900099	27,812,434	27,812,434		
	c St Charles Medical Group		621110	41,300,678	41,300,678		
	d St Charles Prineville		900099	34,066,205	34,066,205		
	e St Charles Redmond		900099	82,026,085	82,026,085		
	f All other program service revenue			35,326,908	35,326,908		
	g Total. Add lines 2a-2f ▶		735,666,203				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		14,895,577			14,895,577	
	4 Income from investment of tax-exempt bond proceeds ▶		0				
	5 Royalties ▶		0				
	6a Gross rents	(i) Real	(ii) Personal				
		157,461					
	b Less rental expenses	8,391					
	c Rental income or (loss)	149,070					
	d Net rental income or (loss) ▶		149,070			149,070	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		663,617	11,378				
	b Less cost or other basis and sales expenses	560,748	657,800				
	c Gain or (loss)	102,869	-646,422				
	d Net gain or (loss) ▶		-543,553			-543,553	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 a						
	b Less direct expenses b						
	c Net income or (loss) from fundraising events . . . ▶		0				
9a Gross income from gaming activities See Part IV, line 19 a							
b Less direct expenses b							
c Net income or (loss) from gaming activities . . . ▶		0					
10a Gross sales of inventory, less returns and allowances . . . a							
		618,730					
b Less cost of goods sold . . . b		322,475					
c Net income or (loss) from sales of inventory . . . ▶		296,255	296,255				
Miscellaneous Revenue		Business Code					
11a Education Programs, etc		900099	657,522	657,522			
b Healthcare JV Income		900099	48,957,244	48,957,244			
c Reimbursed Salaries		446110	4,139,018	4,139,018			
d All other revenue			8,241		8,241		
e Total. Add lines 11a-11d ▶			53,762,025				
12 Total revenue. See Instructions ▶			809,085,838	789,716,242	8,241	14,501,094	

Part IX Statement of Functional Expenses

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

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

**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	2,379,095	2,379,095		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
4 Benefits paid to or for members.	0			
5 Compensation of current officers, directors, trustees, and key employees.	6,060,305		6,060,305	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	0			
7 Other salaries and wages.	322,235,762	269,941,347	51,865,677	428,738
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	12,983,534	11,142,151	1,820,953	20,430
9 Other employee benefits.	53,021,777	41,465,469	11,470,444	85,864
10 Payroll taxes.	24,149,718	19,106,926	5,010,729	32,063
11 Fees for services (non-employees):				
a Management.	0			
b Legal.	3,496,646		3,496,646	
c Accounting.	318,782		318,782	
d Lobbying.	0			
e Professional fundraising services. See Part IV, line 17.	0			
f Investment management fees.	145,832		145,832	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	85,181,191	67,105,867	18,008,892	66,432
12 Advertising and promotion.	664,717	32,743	600,590	31,384
13 Office expenses.	18,177,731	15,854,360	2,306,869	16,502
14 Information technology.	13,660,921	1,015,966	12,619,622	25,333
15 Royalties.	0			
16 Occupancy.	10,943,825	8,427,347	2,516,478	
17 Travel.	1,069,516	826,544	239,561	3,411
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
19 Conferences, conventions, and meetings.	2,215,887	1,230,665	970,960	14,262
20 Interest.	6,787,747		6,787,747	
21 Payments to affiliates.	2,760,141	632,519	2,082,683	44,939
22 Depreciation, depletion, and amortization.	35,242,169	25,826,225	9,415,944	
23 Insurance.	2,180,388	37,520	2,142,868	
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	113,916,797	113,793,596	123,196	5
b PROVIDER TAX EXPENSE	27,490,201	27,490,201		
c EQUIPMENT MAINTENANCE	7,713,800	6,160,186	1,553,614	
d BAD DEBT EXPENSE	5,873,727	5,873,727		
e All other expenses	8,971,129	8,250,056	718,244	2,829
25 Total functional expenses. Add lines 1 through 24e.	767,641,338	626,592,510	140,276,636	772,192
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		56,330,221	1	21,610,719
	2	Savings and temporary cash investments		723,821	2	35,994,975
	3	Pledges and grants receivable, net			3	0
	4	Accounts receivable, net		99,910,940	4	105,107,273
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		30,269	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L			6	0
	7	Notes and loans receivable, net			7	0
	8	Inventories for sale or use		13,829,213	8	14,709,178
	9	Prepaid expenses and deferred charges		10,349,891	9	8,760,164
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	10a	646,225,530		
	b	Less: accumulated depreciation	10b	312,030,588		
				302,342,746	10c	334,194,942
	11	Investments—publicly traded securities		403,950,920	11	484,803,689
	12	Investments—other securities. See Part IV, line 11		83,007,468	12	51,122,129
	13	Investments—program-related. See Part IV, line 11		-1,665,558	13	-1,464,253
	14	Intangible assets		4,504,494	14	4,504,494
15	Other assets. See Part IV, line 11		6,527,321	15	6,804,518	
16	Total assets. Add lines 1 through 15 (must equal line 34)		979,841,746	16	1,066,147,828	
Liabilities	17	Accounts payable and accrued expenses		88,760,276	17	104,439,042
	18	Grants payable			18	
	19	Deferred revenue		859,915	19	1,844,031
	20	Tax-exempt bond liabilities		303,315,695	20	294,460,682
	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		4,363,668	23	6,360,491
	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		11,164,376	25	14,036,097
26	Total liabilities. Add lines 17 through 25		408,463,930	26	421,140,343	
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		571,377,816	27	645,007,485
	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		571,377,816	33	645,007,485	
34	Total liabilities and net assets/fund balances		979,841,746	34	1,066,147,828	

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	809,085,838
2	Total expenses (must equal Part IX, column (A), line 25)	2	767,641,338
3	Revenue less expenses Subtract line 2 from line 1	3	41,444,500
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	571,377,816
5	Net unrealized gains (losses) on investments	5	40,684,169
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	-8,499,000
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	645,007,485

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?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

Additional Data

Software ID: 17005038
Software Version: 2017v2.2
EIN: 93-0602940
Name: St Charles Health System Inc

Form 990 (2017)

Form 990, Part III, Line 4a:

St Charles BendSCMC-B provided services for 16,561 Inpatients, 1,735 births, 16,633 surgical cases, 42,397 Emergency Room visits, and 65,444 Other Outpatient visits in 2017. As one of the Pacific Northwest's leading regional health care facilities, St Charles Bend provides services typically found in markets many times its size. For almost 100 years, St Charles Bend has taken responsibility for the health and well-being of generations of Oregonians, developing into a Level II Regional Trauma Center with specialized partnerships in heart, cancer, orthopedics and neurosurgery.

Form 990, Part III, Line 4b:

St Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Charles Health System. These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care. SCMG provided over 190,000 visits in Bend clinics, 70,100 visits in Redmond clinics, 7,400 visits in the Sisters clinic, 26,800 visits in Prineville clinics and 4,600 in the Madras Clinic in 2017. SCMG also operates an immediate care clinic to provide low-cost urgent care services to the community, the immediate care clinic provided services for more than 20,200 patient visits in 2017.

Form 990, Part III, Line 4c:

St Charles RedmondSCMC-R provided services for 2,584 inpatients, 507 births, 3,636 surgical cases, 22,044 Emergency Room visits, and 27,511 Other Outpatient Visits in 2017. At St Charles Redmond, the patient experience remains at the center of all we do and each patient is empowered to play an active role in his or her own care and healing. Surgeries are performed in four of Oregon's newest and most advanced surgical suites. Patients and their families enjoy the comfort of state-of-the-art patient rooms. Everyone receives the level of care that is expected of a leading regional health care facility.

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Gardner Mack Director	10 00 0 00	X						25,000	0	0
Sayeg Thomas Director	4 00 0 00	X						23,750	0	0
Schuette Dan Chairman	20 00 0 00	X		X				28,500	0	0
DeGroot Shawn Director	6 00 0 00	X						9,000	0	0
Dempsey Dennis Vice Chair	20 00 0 00	X		X				23,750	0	0
Downer Doug Director	10 00 0 00	X						23,750	0	0
Askari Sanaz MD Director	6 00 0 00	X						26,350	0	0
Van Pelt Greg Director	6 00 0 00	X						23,750	0	0
O'Hollaren Brian Director	10 00 0 00	X						19,000	0	0
Buehler Knute MD Director	10 00 0 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Haase Megan Director	4 00 0 00	X						19,000	0	0
Lin Hartwell MD Director	7 00 0 00	X						19,000	0	0
Gordon Steve Director	6 00 0 00	X						23,750	0	0
Sluka Joseph President	50 00 1 00			X				968,255	0	156,351
Welander Jennifer Senior VP/CFO	50 00 3 00			X				394,275	0	76,151
Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	60 00 1 00				X			566,787	0	90,169
Gomes Robert CEO Bend & Redmond	50 00 0 00				X			653,318	0	26,636
Nunes John MD Chief Quality & Safety Officer	50 00 1 00				X			465,740	0	75,375
Steinke Pamela SVP Quality/CNE	50 00 0 00				X			381,835	0	71,589
Weinsheim John PRESIDENT SCMG	50 00 0 00				X			236,851	0	64,997

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			
Brickhouse Jeremiah SVP/CIO	60 00 0 00				X			304,375	0	53,048
Guyn Jim MD SVP Population Health	40 00 0 00				X			442,710	0	55,311
Bishop John CEO Prineville & Madras	40 00 0 00				X			208,925	0	53,732
Simmons Iman SVP COO	50 00 4 00				X			378,732	0	70,541
Vlessis Angelo MD Physician	50 00 0 00					X		791,389	0	48,768
Laughlin James MD Physician	60 00 0 00					X		639,072	0	46,704
Land John MD Physician	50 00 0 00					X		726,896	0	45,377
Martin William MD Physician	60 00 0 00					X		634,798	0	46,869
Boone Rob MD Physician	60 00 0 00					X		691,747	0	41,833
Martin Richard Former VP Service Lines	40 00 0 00						X	444,588	0	22,851

SCHEDULE A (Form 990 or 990-EZ)	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
		2017 Open to Public Inspection
Department of the Treasury Internal Revenue Service	Name of the organization St Charles Health System Inc	Employer identification number 93-0602940

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

The organization is not a private foundation because it is (For lines 1 through 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), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions)					12	

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

14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2016 Schedule A, Part II, line 14	15	

16a 33 1/3% support test—2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐**b 33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ☐**17a 10%-facts-and-circumstances test—2017.** 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 ☐**b 10%-facts-and-circumstances test—2016.** 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 ☐**18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ☐

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

(Complete only if you checked the box on line 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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 2017 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2016 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2017. 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—2016. 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 (explain in Part VI). **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

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

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

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

- 7** ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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 2017 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-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 Excess distributions carryover to 2018. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

Additional Data

Software ID: 17005038
Software Version: 2017v2.2
EIN: 93-0602940
Name: St Charles Health System Inc

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

2017

Open to Public Inspection

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

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

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

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

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

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

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

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

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions) ▶

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☒ No
- 4a Was a correction made? ☐ Yes ☒ No
- b If "Yes," describe in Part IV

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

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

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
1				
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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?	Yes		
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		31,859
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		49,040
j	Total. Add lines 1c through 1i			80,899
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

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

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

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

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

Part IV Supplemental Information

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

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

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493320016858	
<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>2017</div> <div>Open to Public Inspection</div>
Name of the organization St Charles Health System Inc				Employer identification number 93-0602940	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(a) Donor advised funds		(b) Funds and other accounts	
1		Total number at end of year			
2		Aggregate value of contributions to (during year)			
3		Aggregate value of grants from (during year)			
4		Aggregate value at end of year			
5		Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?			
		<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
6		Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?			
		<div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
1 Purpose(s) of conservation easements held by the organization (check all that apply)					
<div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education)</div> <div><input type="checkbox"/> Preservation of an historically important land area</div> <div><input type="checkbox"/> Protection of natural habitat</div> <div><input type="checkbox"/> Preservation of a certified historic structure</div> <div><input type="checkbox"/> Preservation of open space</div>					
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) 2017			

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	4,527,217	4,475,381	4,564,921	3,495,960	3,228,519
b Contributions	2,577	2,517	51,375	1,027,077	
c Net investment earnings, gains, and losses	573,516	236,984	-29,698	138,332	362,452
d Grants or scholarships	179,114	161,937	90,396	75,764	79,512
e Other expenditures for facilities and programs					
f Administrative expenses	22,187	25,728	20,821	20,684	15,499
g End of year balance	4,902,009	4,527,217	4,475,381	4,564,921	3,495,960

2

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

a

Board designated or quasi-endowment ▶ 61 000 %

b

Permanent endowment ▶ 31 000 %

c

Temporarily restricted endowment ▶ 8 000 %

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

	Yes	No
3a(i)		No
3a(ii)	Yes	
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		9,636,252		9,636,252
b Buildings		344,694,406	141,782,138	202,912,268
c Leasehold improvements		5,247,025	2,717,598	2,529,427
d Equipment		226,874,695	156,713,183	70,161,512
e Other		59,773,152	10,817,669	48,955,483
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				334,194,942

Schedule D (Form 990) 2017

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) JOINT VENTURES	-1,464,253	C
(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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	

Part X

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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
COST REPORT SETTLEMENT EST LIABILITIES	3,626,931
LEASE LIABILITY	1,274,166
PROF LIAB INSURANCE	7,801,000
RAC LIABILITY	1,334,000
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	14,036,097

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: 17005038
Software Version: 2017v2.2
EIN: 93-0602940
Name: St Charles Health System Inc

Supplemental Information

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

Supplemental Information

Return Reference	Explanation
Part X FIN48 Footnote	<p>The audited financial statements contain the following footnote Accounting principles generally accepted in the United States of America require SCHS' management to evaluate tax positions taken by the Corporation and recognize a tax liability (or asset) if the Corporation has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS Management has analyzed tax positions taken by the Corporation and has concluded that as of December 31, 2017, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements The Corporation is subject to routine audits by taxing jurisdictions, however, there are currently no audits for any tax periods in progress The Corporation's management believes it is no longer subject to income tax examinations for years prior to 2014</p>

SCHEDULE H (Form 990) Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Hospitals</h2> <p>► Complete if the organization answered "Yes" on Form 990, Part IV, question 20. ► Attach to Form 990. ► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.</p>	OMB No 1545-0047 <div style="font-size: 2em; font-weight: bold; text-align: center;">2017</div> Open to Public Inspection
Name of the organization St Charles Health System Inc		Employer identification number 93-0602940

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b If "Yes," was it a written policy?	1b	Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>30000 0000000 %</u>	3a	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	3b	Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		No
6a Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b If "Yes," did the organization make it available to the public?	6b	Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		26,709	11,404,389		11,404,389	1 500 %
b Medicaid (from Worksheet 3, column a)		144,397	180,435,932	129,902,294	50,533,638	6 630 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		171,106	191,840,321	129,902,294	61,938,027	8 130 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		6,598	905,171	39,579	865,592	0 110 %
f Health professions education (from Worksheet 5)		3,445	631,268	483,804	147,464	0 020 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)		97	1,757		1,757	
i Cash and in-kind contributions for community benefit (from Worksheet 8)		1,515	992,329	1,302	991,027	0 130 %
j Total. Other Benefits		11,655	2,530,525	524,685	2,005,840	0 260 %
k Total. Add lines 7d and 7j		182,761	194,370,846	130,426,979	63,943,867	8 390 %

Part III

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development		275,770	255,904		255,904	0.030 %
9 Other						
10 Total		275,770	255,904		255,904	0.030 %

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	5,873,727		
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	174,610,862
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	206,774,853
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-32,163,991
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

(a) Name of entity <small>(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)</small>	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 Cascade Medical Imaging LLC	CT, Mammography and Other	70.000 %		30.000 %
2 Central Oregon Magnetic Res	Magnetic Resonance Imaging	33.300 %		66.700 %
3 Heart Center of the Cascade	Owns & manages a medical bu	50.000 %		50.000 %
4 Cascade SurgiCenter LLC	Outpatient surgery	50.000 %		50.000 %
5 Institute of the Cascades L	Administration & Marketing	50.000 %		50.000 %
6 Cascade Medical Buildings L	Owns & manages a medical bu	50.000 %		50.000 %
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?

4

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

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

1

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>16</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 Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW STCHARLESHEALTHCARE ORG</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?	10 Yes	
a If "Yes" (list url) <u>http //www stcharleshealthcare org/</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

St Charles Bend

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 <u>300 0000</u> % and FPG family income limit for eligibility for discounted care of <u>400 0000</u> % b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) c <input type="checkbox"/> Asset level d <input checked="" type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input checked="" type="checkbox"/> Underinsurance discount g <input checked="" type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u> b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u> c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u> 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 checked="" type="checkbox"/> Other (describe in Section C)			

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

St Charles Bend

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 nonpayment?	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 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)**

St Charles Bend

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

2

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>16</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 Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW STCHARLESHEALTHCARE ORG</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>http //www stcharleshealthcare org/</u>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

St Charles Redmond

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 <u>300 0000</u> % and FPG family income limit for eligibility for discounted care of <u>400 0000</u> %			
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
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 checked="" type="checkbox"/> Other (describe in Section C)			

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

St Charles Redmond

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 nonpayment?	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 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)**

St Charles Redmond

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
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)
St Charles Prineville**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____**3****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 <u>20 16</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 Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW STCHARLESHEALTHCARE ORG</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 <u>20 16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>http //www stcharleshealthcare org/</u>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

St Charles Prineville

Name of hospital facility or letter of facility reporting group _____

		Yes	No
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 <u>300 0000</u> % and FPG family income limit for eligibility for discounted care of <u>400 0000</u> %			
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE.ORG</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE.ORG</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE.ORG</u>			
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 checked="" type="checkbox"/> Other (describe in Section C)			

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

St Charles Prineville

Name of hospital facility or letter of facility reporting group

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 nonpayment?

	Yes	No
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** ☐ Reporting to credit agency(ies)
- b** ☐ Selling an individual's debt to another party
- c** ☐ 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** ☐ Actions that require a legal or judicial process
- e** ☐ Other similar actions (describe in Section C)
- f** ☒ 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** ☐ Reporting to credit agency(ies)
- b** ☐ Selling an individual's debt to another party
- c** ☐ 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** ☐ Actions that require a legal or judicial process
- e** ☐ 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** ☒ 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** ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- c** ☒ Processed incomplete and complete FAP applications
- d** ☒ Made presumptive eligibility determinations
- e** ☐ Other (describe in Section C)
- f** ☐ 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** ☐ The hospital facility did not provide care for any emergency medical conditions
- b** ☐ The hospital facility's policy was not in writing
- c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d** ☐ Other (describe in Section C)

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

St Charles Prineville

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

4

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>16</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 Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW STCHARLESHEALTHCARE ORG</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?	10 Yes	
a If "Yes" (list url) <u>http //www stcharleshealthcare org/</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

St Charles Madras

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 <u>300 0000</u> % and FPG family income limit for eligibility for discounted care of <u>400 0000</u> %			
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //STCHARLESHEALTHCARE ORG</u>			
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 checked="" type="checkbox"/> Other (describe in Section C)			

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

St Charles Madras

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 nonpayment?	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 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)**

St Charles Madras

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 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? _____

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 7 - Explanation of Costing Methodology	The costing methodology used was derived from SCHS's financial systems, which address all hospital-based patient segments and other services provided. A cost-to-charge ratio from the financial systems was used to calculate the cost of Financial Assistance in line 7a. Numbers reported in column (b) in lines 7a and 7b refer to the number of patient encounters.
Part I, Line 7, Column F - Explanation of Bad Debt Expense	5,873,727

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense	<p>When SCHS provides care to patients, it does not require collateral, however, it maintains an estimated allowance for doubtful accounts. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (generally deductibles and copayments) remain outstanding. The allowance for doubtful accounts is estimated based primarily upon SCHS historical collection experience, the age of the patient's account, management's estimate of the patient's economic ability to pay, and the effectiveness of collection efforts. Patient accounts receivable balances are routinely reviewed in conjunction with historical collection rates and other economic conditions that might ultimately affect the collectability of patient accounts when considering the adequacy of the amounts recorded in the allowance for doubtful accounts. Actual write offs have historically been within management's expectations.</p>
Part III, Line 3 - Methodology of Estimated Amount & Rationale for Including in Community Benefit	<p>SCHS currently has no reasonable way to track or estimate the amount of bad debt expense attributable to charity care, and accordingly this line has been left blank.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part III, Line 4 - Bad Debt Expense	See page 9, footnote 1 (f) "Patient Accounts Receivable, Allowance for Doubtful Accounts, and Other Receivables", in the attached Audited Financial Statements
Part III, Line 8 - Explanation Of Shortfall As Community Benefit	<p>As a response to efforts to improve the health and quality of life of people living in the community, SCHS provided \$32,163,991 in unreimbursed services to patients enrolled in traditional Medicare programs SCHS believes that the Medicare shortfall should be treated as a community benefit since it has a clear mission to serving and improving the health status of the elderly If SCHS should cease to exist, this shortfall would have to be absorbed by another health care provider Costs are from the Medicare Cost Report, but none of these costs are being claimed as a community benefit in Part I, line 7 Our community benefit report shows a Medicare shortfall of \$64,387,500 which differs from the shortfall of \$32,163,991 reported in Part III Section B because Part III Section B includes only those costs allowed in the Medicare Cost Report which excludes the Medicare Advantage shortfall, this shortfall is included in our annual community benefit report</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part III, Line 9b - Provisions On Collection Practices For Qualified Patients	Collection policies are the same for all patients. Every effort will be made to identify patients who may need financial assistance at the earliest point during the patients experience with St. Charles. Patients may be identified as a candidate for financial assistance at any time before, during or after services are delivered. If at any point during the collection process documentation or information is received that indicates the patient may be eligible for our financial assistance program, the account will be reviewed by our financial assistance team for presumptive eligibility. If the responsible party does not respond to statements, letters or phone calls within 120 days of billing the patient balance due, St. Charles will run all accounts through charity advisor software and the probability of payment will be determined electronically. If the probability of payment is low, the encounter will be written off to free care.
Part VI, Line 2 - Needs Assessment	St. Charles Health System (SCHS) assesses the needs of each of our communities in many different ways other than the facility community health needs assessments. SCHS partners with Healthy Communities Institute (HCI) to purchase a dashboard of each community and population risk profiling data that is continuously updated, accessible to the community, easy to understand and directly embeddable in our existing website. This information helps SCHS to keep a finger on the pulse of each population's many health indicators, helping us to continually assess each community's needs, positive changes and/or opportunities for improvement. This information can be found at http://www.stcharleshealthcare.org/Healthy-Communities/CHNA . Each year St. Charles also produces the St. Charles Health System Annual Report. This report is comprised of a summary of each of the following: Community Benefit, Financial Overview, Days cash on hand, Operating margin, Excess margin, Operating Expenses, Full time employee count, Each health system facility (St. Charles Bend, St. Charles Redmond, St. Charles Prineville and St. Charles Madras), Births, Discharges, In-patient cases, Out-patient cases, Emergency visits, St. Charles Medical Group, Patient visits for each clinic. The 2016-17 Annual Report is posted online on the St. Charles Health System website at https://www.stcharleshealthcare.org/About-Us/Reports . This report and the primary data collected for its creation let us know what the trends are for different hospital stays, conditions and out-patient visits, helping to decide what services we offer and where the needs are. St. Charles also plays a significant role in local, regional and State groups in order to stay abreast of the newest information, trends, health data and best practices. SCHS has representation on the Central Oregon Health Council (COHC), the governance entity over the region's Coordinated Care Organization, PacificSource Community Solutions, County Commissions, patients, community members, local medical clinics and the regional dental clinic also participate in the COHC. BY PARTICIPATING ON THIS COUNCIL, ST. CHARLES IS ABLE TO WORK WITH THE EXPERTS IN EACH OF THE THREE COUNTIES TO HEAR FIRSTHAND HOW EACH COMMUNITY IS DOING AND WHAT THEIR HEALTH NEEDS ARE. ST. CHARLES ALSO SITS ON DIFFERENT COMMITTEES FOR THE OREGON ASSOCIATION FOR HOSPITALS AND HEALTH SYSTEMS (OAHHS) AND LOCAL NON-PROFITS. BEING PART OF THESE GROUPS HELPS ST. CHARLES TO BETTER UNDERSTAND THE NEEDS OF OUR COMMUNITIES WHILE ALSO LEARNING HOW TO BETTER COLLECT, TRACK, REPORT AND IMPROVE UPON COLLECTED INFORMATION.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI, Line 3 - Patient Education of Eligibility for Assistance	The Financial assistance program policy is posted on the SCHS website Financial Counselors and registration staff in our facilities & primary care clinics offer financial assistance to patients, both upon request and when patients are uninsured SCHS works to identify patients who may qualify for coverage through the following government programs (uninsured patients seen in our Emergency departments & those admitted to all of our facilities are automatically referred to a Financial Counseling Patient Advocate) Cobra (these are referred to Financial Counselors)Crime Victims AssistanceEmergency Medicaid for Aliens Medicaid for pregnant women and children Medicaid, Medicare Supplemental Security Income (SSI)Temporary Aid for Needy Families (TANF) VeteransOur Financial Counseling Patient Advocate will work with these individuals through the process of qualifying for coverage or denial of coverage from all applicable government programs Patients working with the Financial Counseling Patient Advocate have their accounts put on hold from collections Patients will be referred to the SCHS Financial Assistance Department for follow-up
Part VI, Line 4 - Community Information	Deschutes County (St Charles Bend and St Charles Redmond) Information taken from United States Census Bureau(https://www.census.gov/quickfacts/fact/table/deschutescountyoregon/PST045217) unless otherwise noted URBANLAND AREA IN SQUARE MILES (2010) 3,018POPULATION (2017 ESTIMATE) 186,875POPULATION (2017) UNDER 5 YEARS 5 2% UNDER 18 YEARS 20 5% 65 YEARS AND OVER 19 4% FEMALE 50 6%HOUSEHOLDS (2012-2016) 67,880PERSONS PER HOUSEHOLD (2012-2016) 2 50MEDIAN HOUSEHOLD INCOME (2012-2016) \$54,211PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2012-2016) 10 6%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2012-2016) 93 0%POPULATION BY RACE (2016) WHITE ALONE, NOT HISPANIC 94 4% HISPANIC OR LATINO 8 0% TWO OR MORE RACES 2 6% AMERICAN INDIAN AND ALASKA NATIVE ALONE 1 1% ASIAN ALONE 1 2% BLACK OR AFRICAN AMERICAN ALONE 5% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 2%HEALTH CARE PROVIDER ASSETS IN DESCHUTES COUNTY (OUTSIDE OF ST CHARLES BEND AND REDMOND) MOSAIC MEDICAL CLINIC, (BEND AND REDMOND) (FQHC) LYNCH COMMUNITY CLINIC (SCHOOL-BASED HEALTH CENTER PARTNERSHIP BETWEEN MOSAIC MEDICAL, REDMOND SCHOOL DISTRICT AND DESCHUTES COUNTY) ENSWORTH COMMUNITY SCHOOL-BASED HEALTH CENTER (PARTNERSHIP BETWEEN MOSAIC MEDICAL, BEND-LAPINE SCHOOL DISTRICT AND DESCHUTES COUNTY) BEND MEMORIAL CLINIC, (BEND, REDMOND AND SISTERS) HIGH LAKES HEALTH CARE (BEND, REDMOND AND SISTERS) CROOK COUNTY (ST CHARLES PRINEVILLE) INFORMATION TAKEN FROM UNITED STATES CENSUS BUREAU(https://www.census.gov/quickfacts/fact/table/crookcountyoregon/PST045217) UNLESS OTHERWISE NOTED RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2010) 2,979POPULATION (2017 ESTIMATE) 21,630POPULATION (2017) UNDER 5 YEARS 5 4% UNDER 18 YEARS 19 6% 65 YEARS AND OVER 24 5% FEMALE 50 3%HOUSEHOLDS (2012-2016) 9,155PERSONS PER HOUSEHOLD (2012-2016) 2 32MEDIAN HOUSEHOLD INCOME (2012-2016) \$39,583PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2012-2016) 14 2%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2012-2016) 87 6%POPULATION BY RACE (2016) WHITE ALONE, NOT HISPANIC 94 8% HISPANIC OR LATINO 7 8% TWO OR MORE RACES 2 3% AMERICAN INDIAN AND ALASKA NATIVE ALONE 1 7% ASIAN ALONE 0 7% BLACK OR AFRICAN AMERICAN ALONE 0 5% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 1%HEALTH CARE PROVIDER ASSETS IN CROOK COUNTY (OUTSIDE OF ST CHARLES PRINEVILLE) MOSAIC MEDICAL (FQHC)CROOK KIDS CLINIC (SCHOOL-BASED HEALTH CENTER PARTNERSHIP BETWEEN MOSAIC MEDICAL AND CROOK COUNTY SCHOOL DISTRICT) JEFFERSON COUNTY (ST CHARLES MADRAS) INFORMATION TAKEN FROM UNITED STATES CENSUS BUREAU(https://www.census.gov/quickfacts/fact/table/jeffersoncountyoregon/PST045217) UNLESS OTHERWISE NOTED RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2010) 1,781POPULATION (2017 ESTIMATE) 23,758POPULATION (2016) UNDER 5 YEARS 6 6% UNDER 18 YEARS 23 6% 65 YEARS AND OVER 19 0% FEMALE 48 4%HOUSEHOLDS (2012-2016) 7,577PERSONS PER HOUSEHOLD (2012-2016) 2 84MEDIAN HOUSEHOLD INCOME (2012-2016) \$47,063PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2012-2016) 17 3%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2012-2016) 83 5%POPULATION BY RACE (2016) WHITE ALONE, NOT HISPANIC 75 1% HISPANIC OR LATINO 19 8% TWO OR MORE RACES 3 3% AMERICAN INDIAN AND ALASKA NATIVE ALONE 19 0% ASIAN ALONE 1 0% BLACK OR AFRICAN AMERICAN ALONE 1 4% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 3%HEALTH CARE PROVIDER ASSETS IN JEFFERSON COUNTY (OUTSIDE OF ST CHARLES MADRAS) MOSAIC MEDICAL (FQHC)CONFEDERATED TRIBES OF WARM SPRINGS MADRAS MEDICAL GROUP

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI, Line 4 - Community Building Activities	Our community building activities focused on workforce development activities which support the community by offering the expertise and resources of our hospital systems caregivers for the betterment of the community. Specifically these programs address community-wide workforce issues, potentially providing health care workers to promote the health of the community.
Part VI, Line 5 - Promotion of Community Health	<p> SCHS provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. SCHS criteria for the determination of charity care include the patients' other responsible parties' annual household income, number of people in the home and amount claimed on taxes, credit history, existing medical debt obligations and other indicators of the patients' ability to pay. Generally, those individuals with an annual household income at or less than 250% of the Federal Poverty Guidelines (the Guidelines) qualify for charity care under SCHS policy. In addition, SCHS provides discounts on a sliding scale to those individuals with an annual household income of between 250% and 400% of the Guidelines. Since SCHS does not pursue collection of amounts determined to qualify as charity care, those amounts are not reported as net patient service revenue. Because Madras, Prineville and La Pine are located in medically underserved areas (MUAs), the resources used for provider recruitment in those communities are counted as community benefit. St. Charles also allows nursing students, high school students and other providers to partake in job-shadowing with our paid caregivers to help them complete their course work and/or earn credits, without restrictions related to future employment. The St. Charles Health System Board of Directors is comprised of members from all communities served by the system: Bend, Redmond, Prineville and Madras, etc., allowing for diverse views and leadership related to promoting the health of the community. Various community classes are offered at each campus, including Preventing Osteoporosis, NEW Start (nutrition education), Childbirth Education, Diabetes Education, etc. In order to continue to promote health in the community and eliminate barriers, scholarships are available for those who are unable to pay but would still like to participate in any of these classes. Being the only health care system in Central Oregon, many non-profit community organizations come to St. Charles needing funds and other donations, such as in-kind support. During 2017, St. Charles facility caregivers provided thousands of hours of in-kind support to these organizations who share in St. Charles' vision of Creating America's healthiest community, together. In-kind support activities include but are not limited to membership on non-profit community organization boards, below fair market value rent fees, free cleaning and landscaping services and hours spent coordinating events promoting health improvement for vulnerable and low-income community members. </p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI, Line 7 - States Filing of Community Benefit Report	OR

Schedule H (Form 990) 2017

Additional Data**Software ID:** 17005038**Software Version:** 2017v2.2**EIN:** 93-0602940**Name:** St Charles Health System Inc**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 4		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	St Charles Bend 2500 NE NEFF RD BEND, OR 97701	X	X					X			
2	St Charles Redmond 2500 NE NEFF RD BEND, OR 97701	X	X					X			
3	St Charles Prineville 2500 NE NEFF RD BEND, OR 97701	X	X			X		X			
4	St Charles Madras 2500 NE NEFF RD BEND, OR 97701	X	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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 5 - Account Input from Persons Who Represent the Community	Methodologyprimary researchTHE CHNA WAS CONDUCTED USING MANY FORMS OF DATA COLLECTION AND ANALYSIS INCLUDING THE FOLLOWING PRIMARY RESEARCH SURVEYS DHM RESEARCH CONDUCTED TELEPHONE INTERVIEWS OF APPROXIMATELY 700 RESIDENTS THROUGHOUT THE FOUR COMMUNITIES (BEND, REDMOND, PRINEVILLE AND MADRAS) SERVED BY A ST CHARLES FACILITY TO DETERMINE THE HEALTH-RELATED PRIORITIES OF THE POPULATION RESIDING IN CENTRAL OREGON THE SURVEY WAS DESIGNED TO ESTABLISH A BASELINE OF IMPORTANCE, PRIORITIES AND NEEDS AROUND HEALTH AND WELLNESS, INCLUDING ACCESS, QUALITY AND COST COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, DESCHUTES COUNTY HEALTH SERVICES, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, CENTRAL OREGON COMMUNITY COLLEGE, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE
Part V, Line 5 - Account Input from Persons Who Represent the Community	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research Surveys DHM Research conducted telephone interviews of approximately 700 residents throughout the four communities (Bend, Redmond, Prineville and Madras) served by a St Charles facility to determine the health-related priorities of the population residing in Central Oregon The survey was designed to establish a baseline of importance, priorities and needs around health and wellness, including access, quality and cost COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, DESCHUTES COUNTY HEALTH SERVICES, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, CENTRAL OREGON COMMUNITY COLLEGE, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 5 - Account Input from Persons Who Represent the Community	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research SURVEYS DHM RESEARCH CONDUCTED TELEPHONE INTERVIEWS OF APPROXIMATELY 700 RESIDENTS THROUGHOUT THE FOUR COMMUNITIES (BEND, REDMOND, PRINEVILLE AND MADRAS) SERVED BY A ST CHARLES FACILITY TO DETERMINE THE HEALTH-RELATED PRIORITIES OF THE POPULATION RESIDING IN CENTRAL OREGON THE SURVEY WAS DESIGNED TO ESTABLISH A BASELINE OF IMPORTANCE, PRIORITIES AND NEEDS AROUND HEALTH AND WELLNESS, INCLUDING ACCESS, QUALITY AND COST COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, CROOK COUNTY HEALTH DEPARTMENT, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE
Part V, Line 5 - Account Input from Persons Who Represent the Community	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research Surveys DHM Research conducted telephone interviews of approximately 700 residents throughout the four communities (Bend, Redmond, Prineville and Madras) served by a St. Charles facility to determine the health-related priorities of the population residing in Central Oregon The survey was designed to establish a baseline of importance, priorities and needs around health and wellness, including access, quality and cost Community stakeholder interviews The St Charles Health System Community Benefit department conducted meetings and discussions with local community stakeholders that included, but is not limited to, representatives from each countys public health department The interviewees included persons with special knowledge or expertise in public health and persons who represent the medically underserved and vulnerable populations throughout the Central Oregon region, including the St Charles defined communities The majority of these took place at either the interviewees location, the St Charles Community Benefit department office or by email/phone, between the months of January and September of 2016 The recommendations from these organizations were compiled and considered while selecting the significant health needs for the local communities Participants included representatives from WEBCo, Jefferson County Public Health Department, Saving GraceImagine Life without Violence, PacificSource Community Solutions, Lets Talk Diversity, Madras CHIP, Central Oregon Health Council, Family Resource Center, Better Together, Central Oregon Community College, MountainStar Family Relief Nursery and Warm Springs Prevention Team

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment	St Charles Redmond, St Charles Madras, St Charles Prineville
Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment	St Charles Bend, St Charles Madras, St Charles Prineville

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment	St Charles Bend, St Charles Redmond, St Charles Madras
Part V, Line 6a - List Other Hospital Facilities that Jointly Conducted Needs Assessment	St Charles Bend, St Charles Redmond, St Charles Prineville

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why	The following are significant health needs identified in the St Charles Bend CHNA that will not be addressed in this implementation plan Jobs/job securityPovertyChronic disease preventionBehavioral healthincluding substance abuseTobacco useThe main reason these health needs were not prioritized this cycle is that they ranked lower in priority relative to the two selected health needs Additionally, as with most health care facilities, St Charles Bend has limited resources However, the driving factor was the desire to make the biggest community impact possible by combining the efforts of all four St Charles Health System facilities toward two high priority health needs
Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why	The following are significant health needs identified in the St Charles Redmond CHNA that will not be addressed in this health implementation plan Jobs/job securityPovertyChronic disease preventionBehavioral healthincluding substance abuseTobacco useThe main reason these health needs were not prioritized this cycle is that they ranked lower in priority relative to the two selected health needs Additionally, as with most health care facilities, St Charles Redmond has limited resources However, the driving factor was the desire to make the biggest community impact possible by combining the efforts of all four St Charles Health System facilities toward two high priority health needs

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why	The following are significant health needs identified in the Pioneer Memorial Hospital CHNA that will not be addressed in this implementation plan Jobs/job securityPovertyBehavioral healthincluding substance abuseTobacco useChronic disease preventionDental issuesThe main reason these health needs were not prioritized this cycle is that they ranked lower in priority relative to the two selected health needs Additionally, as with most health care facilities, Pioneer Memorial Hospital has limited resources However, the driving factor was the desire to make the biggest community impact possible by combining the efforts of all four St Charles Health System facilities toward two high priority health needs
Part V, Line 11 - Explanation of Needs Not Addressed and Reasons Why	The following are significant health needs identified in the St Charles Madras CHNA that will not be addressed in this CHNA implementation plan Jobs/job securityPovertyBehavioral healthincluding substance abuseChronic disease preventionTobacco usePregnancy related issuesThe main reason these health needs were not prioritized this cycle is that they ranked lower in priority relative to the two selected health needs Additionally, as with most health care facilities, St Charles Madras has limited resources However, the driving factor was the desire to make the biggest community impact possible by combining the efforts of all four St Charles Health System facilities toward two high priority health needs

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 16j - Other Means Hospital Facility Publicized the Policy	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS
Part V, Line 16j - Other Means Hospital Facility Publicized the Policy	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Part V, Line 16j - Other Means Hospital Facility Publicized the Policy	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS
Part V, Line 16j - Other Means Hospital Facility Publicized the Policy	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

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 Cascade Medical Imaging 1460 NE Medical Center Dr Bend, OR 97701	Diagnostic Imaging Clinic
1 Central Oregon Magnetic Resonance Imaging 1460 NE Medical Center Dr Bend, OR 97701	MRI Center
2 St Charles Cancer Center Bend 2500 NE Neff Road Bend, OR 97701	Outpatient Cancer Center
3 Cascade SurgiCenter 2200 NE Neff Rd 100 Bend, OR 97701	Surgery Center
4 St Charles Heart & Lung Specialists 2500 NE Neff Rd Bend, OR 97701	Cardiothoracic Surgery
5 Sage View Psychiatric Center 1885 NE Purcell Blvd Bend, OR 97701	Mental Health Services
6 St Charles Family Care Redmond 211 NW Larch Ave Redmond, OR 97756	Primary Care Clinic
7 Redmond Surgical Specialists 1245 NW 4th Street Redmond, OR 97756	Surgical Specialists
8 St Charles Family Care Prineville 384 SE Combs Flat Road Prineville, OR 97754	Rural Health Clinic
9 St Charles Center for Womens Health Redmond 340 NW 5th Street Ste 101 Redmond, OR 97756	OB/GYN Clinic
10 St Charles Family Care Bend East 2965 NE Conners Ave Ste 127 Bend, OR 97701	Primary Care Clinic
11 St Charles Hospice 2500 NE Neff Rd Bend, OR 97754	Hospice Care
12 St Charles Family Care Bend South 61250 SE Coombs Place Bend, OR 97701	Primary Care Clinic
13 St Charles Sleep Center Bend 2042 Williamson Ct Bend, OR 97701	Sleep Lab
14 St Charles Immediate Care East 2600 NE Neff Rd Bend, OR 97701	Immediate Care 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 St Charles Pulmonary Clinic 2500 NE Neff Rd Bend, OR 97701	Lung Clinic
1 St Charles Trauma & Acute Care 2500 NE Neff Rd Bend, OR 97701	Trauma and & Surgical Services
2 Behavioral Health Bend 2542 Courtney Dr Bend, OR 97701	Behavioral Health Clinic
3 St Charles Wound Care & Ostomy Clinic 2600 NE Neff Rd Bend, OR 97701	Wound & Ostomy Care
4 St Charles Sleep Center Redmond 655 NW Jackpine Ave Redmond, OR 97756	Sleep Lab
5 St Charles Immediate Care South 61250 SE Coombs Place Bend, OR 97702	Urgent Care Clinic
6 St Charles Neonatology 2500 NE Neff Rd Bend, OR 97701	Neonatal Intensive Care Unit
7 St Charles Family Care Sisters 630 Arrowleaf Trail Sisters, OR 97759	Primary Care Clinic
8 St Charles Anticoagulation Clinic Bend 2275 NE Doctors Drive Bend, OR 97701	Anticoag Clinic
9 St Charles Center for Womens Health Bend 2000 NE Neff Rd Bend, OR 97701	OB/GYN CLINIC
10 St Charles Family Care Madras 480 NE A St Madras, OR 97741	Primary Care Clinic
11 St Charles Paliative Care 2500 NE Neff Rd Bend, OR 97701	Paliative Care Clinic
12 St Charles Rheumatology 2965 NE Connors Ave Bend, OR 97701	Rheumatology Clinic
13 St Charles Preoperative Medicine 2500 NE Neff Rd Bend, OR 97701	Comprehensive Care for Surgery Patients
14 St Charles Imaging Redmond 211 NW Larch Ave Redmond, OR 97756	Imaging Services

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 St Charles Pulmonary Clinic Redmond 655 NW Jackpine Ave Redmond, OR 97756	Lung Clinic
1 Sisters School Based Health Clinic 1680 W McKimmey Butte Rd Sisters, OR 97759	School Based Clinic
2 St Charles Infectious Disease 2965 NE Conners Ave Suite 127 Bend, OR 97701	Infectious Disease Clinic
3 St Charles Imaging Bend East 2500 NE Neff Road Bend, OR 97701	Imaging Services
4 Sisters Diagnostic Radiology 630 N Arrowleaf Trail Sisters, OR 97759	Radiology
5 Redmond School Based Health Clinic 675 SW Rimrock Way Redmond, OR 97756	School Based Clinic
6 St Charles Sisters Lab Services 630 N Arrowleaf Trail Sisters, OR 97759	Outpatient Lab
7 St Charles Lab Clinic Redmond 1553 NW Canal Blvd Redmond, OR 97756	Lab Services
8 Behavioral Health Redmond 916 SW 17th St Suite 202 Redmond, OR 97756	Behavioral Health Clinic
9 St Charles Anticoagulation Clinic Redmond 244 NW Kingwood Ave Redmond, OR 97756	Anticoag Clinic
10 St Charles Surgical Specialists Prineville 384 SE Combs Flat Road Prineville, OR 97754	Surgical Specialists
11 St Charles Surgical Specialists Madras 480 NE A Street Madras, OR 97741	Surgical Specialists
12 St Charles Lab Clinic Madras 470 NE A Street Madras, OR 97741	Outpatient Lab
13 St Charles Lab Services Bend East 547 NE Bellvue Suite 105 Bend, OR 97701	Outpatient Lab
14 St Charles Cancer Center Redmond 1541 NW Canal Redmond, OR 97756	Outpatient Cancer Center

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
St Charles Health System Inc

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

2017

Open to Public Inspection

Employer identification number
93-0602940

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 noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 24

3 Enter total number of other organizations listed in the line 1 table 2

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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
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Additional Data

Software ID: 17005038
Software Version: 2017v2.2
EIN: 93-0602940
Name: St Charles Health System Inc

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BETHLEHEM INN 3705 N Hwy 97 BEND, OR 97701	93-1323419	501(C)(3)	20,000	0			Homeless shelter and services
BOYS & GIRLS CLUB OF BEND 500 NW WALL STREET BEND, OR 97701	93-1127536	501(C)(3)	8,000	0			ENABLE YOUNG PEOPLE TO REACH THEIR

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
CENTRAL OREGON MEDICAL SOCIETY PO BOX 6491 BEND, OR 97702	20-3828872	501(c)(3)	20,000	0			PROVIDER WELLNESS EFFORTS
CO COMMUNITY COLLEGE 2600 NW COLLEGE WAY BEND, OR 97701	93-0505827	Quasi Governmental	16,000	0			College nursing program

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CO COUNCIL ON AGING 373 NE Greenwood Ave BEND, OR 97701	93-0661229	501(C)(3)	12,620	0			Suicide Prevention & Basic Needs
CO INTERGOVERNMENTAL COUNCIL 334 NE Hawthorne Ave BEND, OR 97756	93-0620261	Quasi Governmental	50,000	0			Community health system grant

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CONFEDERATED TRIBES OF WARM PO BOX 1747 REDMOND, OR 97756	93-0639711	Quasi Governmental	10,000	0			Alcohol, tobacco & drug free activi
CROOK COUNTY FOUNDATION PO BOX 1061 PRINEVILLE, OR 97754	93-1250270	501(c)(3)	30,500	0			College scholarships and education

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
CROOK COUNTY SCHOOL DISTRICT 471 NE OCHOCO PLACE PRINEVILLE, OR 97754	93-6000375	Quasi Governmental	11,000	0			AFTER SCHOOL PROGRAMS
DESCHUTES COUNTY FAIR ASSOC 3800 SW Airport Way REDMOND, OR 97756	93-6002353	501(C)(3)	13,779	0			HEALTH EVENTS

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
FAMILY ACCESS NETWORK FOUND 2125 NE DAGGETT LN BEND, OR 97701	20-3534560	501(C)(3)	6,500	0			Access to basic needs for children
HEALTHY BEGINNINGS 1029 NW 14TH STREET BEND, OR 97701	93-1234708	501(C)(3)	6,050	0			HEALTH SCREENINGS FOR CHILDREN

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
J BAR J YOUTH SERVICES 62895 Hamby Rd BEND, OR 97701	93-0677650	501(c)(3)	13,500	0			SUICIDE PREVENTION
JEFFERSON COUNTY 66 SE D ST Suite C MADRAS, OR 97741	93-6002299	Quasi Governmental	19,000	0			Community Programs

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
KEMPLE MEMORIAL CHILD DENTAL 1029 NW 14TH St Ste 101 BEND, OR 97701	93-1241460	501(c)(3)	13,000	0			DENTAL CARE FOR CHILDREN
KIDS CENTER 1375 NW KINGSTON AVE BEND, OR 97701	94-3169200	501(C)(3)	23,500	0			CHILD ABUSE PREVENTION & TREATMENT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LATINO COMMUNITY ASSOC 1130 NW HARRIMAN BEND, OR 97703	93-1260288	501(C)(3)	6,745	0			Community activities
LINES FOR LIFE 5100 SW MACADAM AVE STE 400 PORTLAND, OR 97239	93-0725294	501(C)(3)	25,000	0			Substance abuse and suicide prevent

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MADRAS UNITED METHODIST CHURC 49 NE 12TH MADRAS, OR 97741	93-0497786	501(C)(3)	7,974	0			SUPPLIES FOR YOUTH
MOSAIC MEDICAL 375 NW BEAVER STREET PRINEVILLE, OR 97754	93-1329158	501(C)(3)	10,500	0			MOBILE 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
MOUNTAIN STAR FAMILY RELIEF 2125 NE Daggett Ln BEND, OR 97701	42-1560891	501(C)(3)	13,000	0			Help prevent Child Abuse & Neglect
NEIGHBORIMPACT 2303 SW FIRST STREET REDMOND, OR 97756	93-0884929	501(C)(3)	10,500	0			Provide families access to food

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
SAVING GRACE 1004 NW MILWAUKEE AVE 100 BEND, OR 97701	93-0797194	501(C)(3)	9,000	0			Provide comprehensive family viole
ST CHARLES FOUNDATION 2500 NE Neff Rd BEND, OR 97701	94-3076293	501(C)(3)	1,856,536	0			To support fundraising activities

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TOUR DES CHUTES 70 SW Century Dr STE 100-273 BEND, OR 97702	20-2006038	501(C)(3)	13,000	0			SUPPORTS CANCER CARE
UNITED WAY OF DESCHUTES PO BOX 5969 BEND, OR 97708	93-6012576	501(C)(3)	30,000	0			SUPPORT LOCAL HUMAN SERVICES

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

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.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization St Charles Health System Inc	Employer identification number 93-0602940
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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. <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use										
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence										
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees										
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)										
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.	1b Yes										
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?	2 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. <table border="0"> <tr> <td><input checked="" type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input checked="" type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input checked="" type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study	<input checked="" type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee					
<input checked="" type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract										
<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study										
<input checked="" type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee										
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: <table border="0"> <tr> <td>a Receive a severance payment or change-of-control payment?</td> <td>4a</td> <td>No</td> </tr> <tr> <td>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</td> <td>4b Yes</td> <td></td> </tr> <tr> <td>c Participate in, or receive payment from, an equity-based compensation arrangement?</td> <td>4c</td> <td>No</td> </tr> </table> If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	a Receive a severance payment or change-of-control payment?	4a	No	b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b Yes		c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No		
a Receive a severance payment or change-of-control payment?	4a	No									
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b Yes										
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	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: <table border="0"> <tr> <td>a The organization?</td> <td>5a</td> <td>No</td> </tr> <tr> <td>b Any related organization?</td> <td>5b</td> <td>No</td> </tr> </table> If "Yes," on line 5a or 5b, describe in Part III.	a The organization?	5a	No	b Any related organization?	5b	No					
a The organization?	5a	No									
b Any related organization?	5b	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: <table border="0"> <tr> <td>a The organization?</td> <td>6a</td> <td>No</td> </tr> <tr> <td>b Any related organization?</td> <td>6b</td> <td>No</td> </tr> </table> If "Yes," on line 6a or 6b, describe in Part III.	a The organization?	6a	No	b Any related organization?	6b	No					
a The organization?	6a	No									
b Any related organization?	6b	No									
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7	No									
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.	8	No									
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	No									

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.

See Additional Data Table**Schedule J (Form 990) 2017**

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
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Additional Data

Software ID: 17005038

Software Version: 2017v2.2

EIN: 93-0602940

Name: St Charles Health System Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	(i)	421,829	65,230	79,728	60,363	29,806	656,956	31,517
	(ii)							
1Bishop John CEO Prineville & Madras	(i)	206,869		2,056	25,761	27,971	262,657	
	(ii)							
2Boone Rob MD Physician	(i)	662,095	4,794	24,858	16,200	25,633	733,580	
	(ii)							
3Brickhouse Jeremiah SVP/CIO	(i)	238,106	36,607	29,662	24,821	28,227	357,423	
	(ii)							
4Gomes Robert CEO Bend & Redmond	(i)	139,083	54,423	459,812	13,860	12,776	679,954	
	(ii)							
5Guyn Jim MD SVP Population Health	(i)	364,194		78,516	25,822	29,489	498,021	
	(ii)							
6Land John MD Physician	(i)	708,347		18,549	16,200	29,177	772,273	
	(ii)							
7Laughlin James MD Physician	(i)	638,273		799	16,200	30,504	685,776	
	(ii)							
8Martin Richard Former VP Service Lines	(i)	141,722	37,290	265,576	11,309	11,542	467,439	2,556
	(ii)							
9Martin William MD Physician	(i)	612,171	3,995	18,632	16,200	30,669	681,667	
	(ii)							
10Nunes John MD Chief Quality & Safety Officer	(i)	326,464	52,438	86,838	51,737	23,638	541,115	
	(ii)							
11Simmons Iman SVP COO	(i)	364,554		14,178	41,216	29,325	449,273	
	(ii)							
12Sluka Joseph President	(i)	673,660	142,313	152,282	124,679	31,672	1,124,606	
	(ii)							
13Steinke Pamela SVP Quality/CNE	(i)	278,628	46,202	57,005	47,464	24,125	453,424	18,522
	(ii)							
14Vlessis Angelo MD Physician	(i)	789,067		2,322	16,200	32,568	840,157	
	(ii)							
15Weinsheim John PRESIDENT SCMG	(i)	183,899	31,821	21,131	36,141	28,856	301,848	
	(ii)							
16Welander Jennifer Senior VP/CFO	(i)	338,836	52,450	2,989	51,728	24,423	470,426	
	(ii)							

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
St Charles Health System Inc

Supplemental Information on Tax-Exempt Bonds

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

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number
93-0602940

Part I

Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A HOSPITAL FACILITY AUTHORI	93-0991182	000000000	04-01-2014	75,000,000	SEE PART VI		X		X		X
B HOSPITAL FACILITY AUTHORI	93-0991182	250336DY7	10-12-2016	114,801,653	SEE PART VI		X		X		X

Part II

Proceeds

		A		B		C		D	
1	Amount of bonds retired			1,350,000					
2	Amount of bonds legally defeased								
3	Total proceeds of issue	75,121,021		115,417,752					
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds	44,185		2,226					
6	Proceeds in refunding escrows			42,638,922					
7	Issuance costs from proceeds	290,853		1,200,176					
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	74,785,983		21,452,586					
11	Other spent proceeds			3,329,719					
12	Other unspent proceeds			46,794,123					
13	Year of substantial completion								
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?		X	X					
16	Has the final allocation of proceeds been made?		X		X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III

Private Business Use

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?	X		X					
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0 500 %							
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5	0 500 %							
7 Does the bond issue meet the private security or payment test? . . .		X	X					
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
		X		X					

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

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

SCHEDULE M
(Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
► Attach to Form 990.
►Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded				
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies	X	1	25,462	
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ► (_____)				
26 Other ► (_____)				
27 Other ► (_____)				
28 Other ► (_____)				

29

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

29

30a

During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

30a

No

b

If "Yes," describe the arrangement in Part II

31

Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

31

No

32a

Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

32a

No

b

If "Yes," describe in Part II

33

If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

Part II**Supplemental Information.**

Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Return Reference

Explanation

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
St Charles Health System Inc

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Employer identification number

93-0602940

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part III, Line 4d Other Program Services Description	OTHER PROGRAM SERVICES 4 Sage View mental health, Community Education and rents from affiliates OTHER PROGRAM SERVICES 5 St Charles Prineville OTHER PROGRAM SERVICES 6 St Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Charles Health System These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care SCMG provided over 190,000 visits in Bend clinics, 70,100 visits in Redmond clinics, 7,400 visits in the Sisters clinic, 26,800 visits in Prineville clinics and 4,600 in the Madras Clinic in 2017 SCMG also operates an immediate care clinic to provide low-cost urgent care services to the community, the immediate care clinic provided services for more than 20,200 patient visits in 2017 OTHER PROGRAM SERVICES 7 Home Health/Hospice

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Compensation Review & Approval Process - CEO, Top Management	SCHS utilizes an independent outside consultant to provide comparability data regarding compensation for the CEO and top management officials. The analysis covers all elements of total compensation. The CEO compensation is reviewed and approved by the Board of Directors following an annual performance evaluation and compensation review. The most recent study for the CEO and top management officials was performed in November of 2017.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b Compensation Review and Approval Process for Officers and Key Employees	<p>SCHS utilizes an independent outside consultant to provide comparability data regarding compensation for the Key Employees. The analysis covers all elements of total compensation. The compensation is reviewed by the Board of Directors following an annual performance evaluation and compensation review. The evaluation and review process is prescribed in an internal policy and the process is documented. The most recent study for the key employees was performed in November of 2017. SCHS utilized an independent outside consultant to determine the pros and cons of establishing board compensation. In February 2010 the consultant presented its findings to the St. Charles board governance committee advising that board members not be involved in determining any level of compensation for the board. An external committee was selected to review the consultants analysis along with management recommendations and agreed that compensation for the SCHS board of directors is warranted and will assist in retaining and recruiting highly qualified board members.</p>

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Other Changes In Net Assets Or Fund Balances - Other Decreases	DISTRIBUTIONS PAID TO NONCONTROLLING OWNERS = -\$8499000

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

2017

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DRIVE BEND, OR 97701 85-0484640	IMAGING SERVICES	OR	SCHS	RELATED	19,264,911	13,576,189		No		Yes		70 000 %
(2) HEART CENTER OF THE CASCADES 2500 NE NEFF RD BEND, OR 97701 38-3724947	MEDICAL BUILDING	OR	NA	RELATED	288,840	-1,855,643		No		Yes		50 000 %

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
(1) CHARITABLE REMAINDER TRUST 2500 NE NEFF ROAD BEND, OR 97701	CRUT	OR	NA	TRUST					No

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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

See Additional Data Table

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

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

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation
PART I	ST CHARLES MANAGEMENT SERVICES ORGANIZATION (SCMSO) INCLUDES BOTH MANAGEMENT SERVICES AND PHYSICIAN CLINICS ST CHARLES CEASED PROVIDING THESE PHYSICIAN BUSINESS SERVICES IN 2013 AND THEREFORE NO ACTIVITY IS INCLUDED IN ST CHARLES 2017 INCOME OR EXPENSES END-OF-YEAR ASSETS FOR SCMSO ARE NOT REPORTED IN PART I BECAUSE SEPARATE BALANCE SHEETS WERE NOT MAINTAINED FOR THIS ORGANIZATION



Additional Data

Software ID: 17005038
Software Version: 2017v2.2
EIN: 93-0602940
Name: St Charles Health System Inc

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
ST CHARLES FOUNDATION	b	1,856,536	CASH/BOOK VALUE
ST CHARLES FOUNDATION	c	1,588,414	CASH/BOOK VALUE
ST CHARLES FOUNDATION	o	568,965	BOOK VALUE
ST CHARLES FOUNDATION	r	195,751	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	j	163,026	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	m	33,096,468	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	p	1,100,229	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	q	1,785,380	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	s	19,831,000	CASH
HEART CENTER OF THE CASCADES	d	4,144,000	BOOK VALUE
HEART CENTER OF THE CASCADES	k	1,543,000	BOOK VALUE
HEART CENTER OF THE CASCADES	m	337,583	BOOK VALUE
HEART CENTER OF THE CASCADES	s	210,000	CASH