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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

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

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

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

Department of the Treasury  
Internal Revenue Service

A For the 2017 calendar year, or tax year beginning 01-01-2017 , and ending 12-31-2017

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

SUTTER VALLEY HOSPITALS

% CARLA WHITE-SNYDER

Doing business as

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

C/O SH TAX 2200 RIVER PLAZA DRIVE

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

SACRAMENTO, CA 95833

F Name and address of principal officer

JAMES CONFORTI

C/O SH TAX 2200 RIVER PLAZA DR

SACRAMENTO, CA 95816

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

☐ Yes ☒ No

H(b) Are all subordinates included?

☐ Yes ☐ No

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

H(c) Group exemption number ▶

D Employer identification number

94-1156621

E Telephone number

(916) 286-6665

G Gross receipts \$ 3,140,041,699

I Tax-exempt status

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

J Website: ▶ WWW.SUTTERHEALTH.ORG

K Form of organization ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1935

M State of legal domicile CA

Part I Summary

Activities & Governance

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

SEE SCHEDULE O

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

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

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

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a) . . . . .

6 Total number of volunteers (estimate if necessary) . . . . .

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

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

Revenue

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

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

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

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

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

Expenses

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

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

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

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

b Total fundraising expenses (Part IX, column (D), line 25) ▶297,480

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

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

19 Revenue less expenses Subtract line 18 from line 12 . . . . .

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . .

21 Total liabilities (Part X, line 26) . . . . .

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

Prior Year

Current Year

6,942,98911,572,760

2,293,708,8783,122,910,112

992,3262,172,814

1,499,8582,365,199

2,303,144,0513,139,020,885

11,901,87715,051,726

00

1,041,345,8461,342,195,183

00

1,095,046,9091,453,132,630

2,148,294,6322,810,379,539

154,849,419328,641,346

Beginning of Current Year

End of Year

1,955,045,3912,405,146,153

1,215,306,3121,519,849,064

739,739,079885,297,089

Part II Signature Block

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

Sign Here

Signature of officer

2018-11-06

Date

PAIGE TERRA CFO

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

DEBRA HEISKALA

Preparer's signature

DEBRA HEISKALA

Date

Check ☐ if self-employed

PTIN

P00649485

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶

Firm's address ▶ 4365 EXECUTIVE DRIVE STE 1600

Phone no (858) 535-7200

SAN DIEGO, CA 92121

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

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2017)

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

SEE SCHEDULE O

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

<b>4a</b>	(Code )	(Expenses \$ 2,483,398,653	including grants of \$ 15,051,726	(Revenue \$ 3,122,957,799 )
See Additional Data				

<b>4b</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4e</b>	<b>Total program service expenses</b> ▶	2,483,398,653
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> 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	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> 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	<b>4</b>	No
<b>5</b> 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	<b>5</b>	No
<b>6</b> 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	<b>6</b>	No
<b>7</b> 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	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> 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	<b>9</b>	No
<b>10</b> 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	<b>10</b> Yes	
<b>11</b> 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		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</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	<b>11b</b>	No
<b>c</b> 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	<b>11c</b>	No
<b>d</b> 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	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> 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	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</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	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b> Yes	
<b>19</b> 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	<b>19</b>	No

**Part IV Checklist of Required Schedules** (continued)

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	<b>20b</b> Yes	
<b>21</b> 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> . . . . .	<b>21</b> Yes	
<b>22</b> 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> . . . . .	<b>22</b>	No
<b>23</b> 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> . . . . .	<b>23</b> Yes	
<b>24a</b> 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> . . . . .	<b>24a</b> Yes	
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	No
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	<b>24c</b>	No
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	No
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> 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> . . . . .	<b>25a</b>	No
<b>b</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> . . . . .	<b>25b</b>	No
<b>26</b> 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> . . . . .	<b>26</b>	No
<b>27</b> 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> . . . . .	<b>27</b>	No
<b>28</b> 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) <b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28a</b>	No
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28b</b> Yes	
<b>c</b> 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> . . . . .	<b>28c</b> Yes	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>29</b> Yes	
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>30</b>	No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	<b>31</b>	No
<b>32</b> 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> . . . . .	<b>32</b>	No
<b>33</b> 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> . . . . .	<b>33</b>	No
<b>34</b> 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> . . . . .	<b>34</b> Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b> Yes	
<b>b</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> . . . . .	<b>35b</b> Yes	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	<b>36</b>	No
<b>37</b> 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> . . . . .	<b>37</b>	No
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	<b>38</b> Yes	

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

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	961	
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
<b>2a</b>	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.	14,235	
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	Yes	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
<b>b</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	
<b>4a</b>	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>b</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).		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		No
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
<b>6a</b>	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>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	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?	Yes	
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?	Yes	
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year.		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966?		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12.		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders.		
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.		
<b>b</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.		
<b>c</b>	Enter the amount of reserves on hand.		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		No
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O.		

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

		Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 16		
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>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 11		
<b>2</b> 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?	<b>2</b>		No
<b>3</b> 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?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>	Yes	
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> 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?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> 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.	<b>9</b>		No

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

	Yes	No
<b>10a</b> Did the organization have local chapters, branches, or affiliates?	<b>10a</b>	No
<b>b</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?	<b>10b</b>	
<b>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	<b>11a</b>	Yes
<b>b</b> Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b> Did the organization have a written conflict of interest policy? If "No," go to line 13.	<b>12a</b>	Yes
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	<b>12b</b>	Yes
<b>c</b> Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done.	<b>12c</b>	Yes
<b>13</b> Did the organization have a written whistleblower policy?	<b>13</b>	Yes
<b>14</b> Did the organization have a written document retention and destruction policy?	<b>14</b>	Yes
<b>15</b> 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?		
<b>a</b> The organization's CEO, Executive Director, or top management official	<b>15a</b>	Yes
<b>b</b> Other officers or key employees of the organization	<b>15b</b>	Yes
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b> Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	<b>16a</b>	Yes
<b>b</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?	<b>16b</b>	Yes

**Section C. Disclosure**

<b>17</b> List the States with which a copy of this Form 990 is required to be filed: CA	
<b>18</b> 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)	
<b>19</b> 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.	
<b>20</b> State the name, address, and telephone number of the person who possesses the organization's books and records. CARLA WHITE-SNYDER 9100 FOOTHILLS BLVD ROSEVILLE, CA 95747 (916) 286-6665	

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 ▶ 4,586

## Section B. Independent Contractors

(A)	(B)	(C)
Name and business address	Description of services	Compensation
RIGHTSOURCING INC, PO BOX 515743 LOS ANGELES, CA 90051	STAFFING SERVICES	17,855,495
PULMONARY MEDICINE ASSOCIATES, 1300 ETHAN WAY STE 600 SACRAMENTO, CA 95825	TRAINING SERVICES	5,628,061
TOTAL RENAL CARE INC, PO BOX 8500-1607 PHILADELPHIA, PA 191781607	MEDICAL SERVICES	5,622,676
ACUTE CARE SURGERY MEDICAL GROUP I, PO BOX 1528 SACRAMENTO, CA 95812	MEDICAL SERVICES	5,170,606
DIAGNOSTIC PATHOLOGY MEDICAL GROUP, 3301 C ST STE 200E SACRAMENTO, CA 95816	MEDICAL SERVICES	4,919,885

Form **990** (2017)



**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
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . .	<b>1a</b>				
	<b>b</b> Membership dues . . .	<b>1b</b>				
	<b>c</b> Fundraising events . . .	<b>1c</b>	140,134			
	<b>d</b> Related organizations	<b>1d</b>	9,779,698			
	<b>e</b> Government grants (contributions)	<b>1e</b>	901,366			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	751,562			
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____		25,794			
	<b>h Total.</b> Add lines 1a-1f . . . . .		11,572,760			
<b>Program Service Revenue</b>		Business Code				
	<b>2a</b> PATIENT SERVICE REVENUE	621110	3,111,823,529	3,111,823,529	0	0
	<b>b</b> RENTAL TO AFFILIATES	621110	10,778,846	10,778,846	0	0
	<b>c</b> HEALTHCARE RELATED JV INCOME	621110	307,737	307,737	0	0
	<b>d</b> _____					
	<b>e</b> _____					
	<b>f</b> All other program service revenue					
	<b>g Total.</b> Add lines 2a-2f . . . . .		3,122,910,112			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		1,581,006			1,581,006
	<b>4</b> Income from investment of tax-exempt bond proceeds		0			
	<b>5</b> Royalties . . . . .		0			
	<b>6a</b> Gross rents	(i) Real (ii) Personal				
		2,909,198				
	<b>b</b> Less rental expenses	935,241				
	<b>c</b> Rental income or (loss)	1,973,957 0				
	<b>d</b> Net rental income or (loss) . . . . .		1,973,957			1,973,957
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
		475,898 118,444				
	<b>b</b> Less cost or other basis and sales expenses		2,534			
	<b>c</b> Gain or (loss)	475,898 115,910				
	<b>d</b> Net gain or (loss) . . . . .		591,808			591,808
	<b>8a</b> Gross income from fundraising events (not including \$ _____ 140,134 of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>	98,225			
	<b>b</b> Less direct expenses . . . . .	<b>b</b>	83,039			
	<b>c</b> Net income or (loss) from fundraising events . . . . .		15,186			15,186
	<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>	10,444			
	<b>b</b> Less direct expenses . . . . .	<b>b</b>	0			
<b>c</b> Net income or (loss) from gaming activities . . . . .		10,444			10,444	
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>	0				
<b>b</b> Less cost of goods sold . . . . .	<b>b</b>	0				
<b>c</b> Net income or (loss) from sales of inventory . . . . .		0				
Miscellaneous Revenue		Business Code				
<b>11a</b> PARKING	812930	189,122	0	189,122	0	
<b>b</b> LABORATORY	621500	128,803	0	128,803	0	
<b>c</b> TELECOM	517000	47,687	47,687	0	0	
<b>d</b> All other revenue . . . . .						
<b>e Total.</b> Add lines 11a-11d . . . . .		365,612				
<b>12 Total revenue.</b> See Instructions . . . . .		3,139,020,885	3,122,957,799	317,925	4,172,401	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	15,051,726	15,051,726		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.	0			
<b>4</b> Benefits paid to or for members.	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	10,023,515		10,023,515	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	126,966	126,966		
<b>7</b> Other salaries and wages.	870,155,031	795,195,262	74,855,180	104,589
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	60,400,476	54,569,511	5,830,965	
<b>9</b> Other employee benefits.	327,157,005	295,573,792	31,553,954	29,259
<b>10</b> Payroll taxes.	74,332,190	67,156,279	7,175,911	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	11,867,877	3,590,190	8,277,018	669
<b>b</b> Legal.	3,932,343		3,932,343	
<b>c</b> Accounting.	47,139		47,139	
<b>d</b> Lobbying.	0			
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	518,139		518,139	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	147,755,216	131,754,709	16,000,507	0
<b>12</b> Advertising and promotion.	11,217		11,217	
<b>13</b> Office expenses.	27,475,659	21,550,182	5,923,062	2,415
<b>14</b> Information technology.	98,148,654	59,567,622	38,581,032	
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	39,618,795	30,076,513	9,542,282	
<b>17</b> Travel.	1,771,384	944,642	824,107	2,635
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
<b>19</b> Conferences, conventions, and meetings.	813,605	638,582	175,023	
<b>20</b> Interest.	32,718,216	32,718,216		
<b>21</b> Payments to affiliates.	0			
<b>22</b> Depreciation, depletion, and amortization.	158,417,224	135,076,102	23,341,122	
<b>23</b> Insurance.	16,481,844	13,588,943	2,892,901	
<b>24</b> 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.)				
<b>a</b> INCOME TAX EXPENSE	43,461	0	43,461	0
<b>b</b> MEDICAL SUPPLIES	393,568,953	393,568,953	0	0
<b>c</b> HOSPITAL PROVIDER FEES	167,593,292	167,593,292	0	0
<b>d</b> SYSTEM ALLOCATIONS	141,645,314	71,121,707	70,401,997	121,610
<b>e</b> All other expenses.	210,704,298	193,935,464	16,732,531	36,303
<b>25</b> Total functional expenses. Add lines 1 through 24e.	2,810,379,539	2,483,398,653	326,683,406	297,480
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		0	<b>1</b>	0
	<b>2</b>	Savings and temporary cash investments . . . . .		69,580,426	<b>2</b>	42,848,654
	<b>3</b>	Pledges and grants receivable, net . . . . .		468,130	<b>3</b>	277,482
	<b>4</b>	Accounts receivable, net . . . . .		294,946,475	<b>4</b>	395,638,546
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .		0	<b>5</b>	0
	<b>6</b>	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 . . . . .		0	<b>6</b>	0
	<b>7</b>	Notes and loans receivable, net . . . . .		36,445	<b>7</b>	0
	<b>8</b>	Inventories for sale or use . . . . .		28,321,456	<b>8</b>	41,329,146
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		12,152,221	<b>9</b>	15,548,487
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	<b>10a</b> 2,980,994,867			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b> 1,446,283,098	1,315,774,138	<b>10c</b>	1,534,711,769
	<b>11</b>	Investments—publicly traded securities . . . . .		84,128,480	<b>11</b>	11,953,306
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		0	<b>12</b>	0
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .		984,002	<b>13</b>	1,179,224
	<b>14</b>	Intangible assets . . . . .		0	<b>14</b>	0
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		148,653,618	<b>15</b>	361,659,539
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		1,955,045,391	<b>16</b>	2,405,146,153	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		239,649,138	<b>17</b>	480,458,420
	<b>18</b>	Grants payable . . . . .		0	<b>18</b>	0
	<b>19</b>	Deferred revenue . . . . .		0	<b>19</b>	0
	<b>20</b>	Tax-exempt bond liabilities . . . . .		956,986,128	<b>20</b>	1,014,890,127
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .		0	<b>21</b>	0
	<b>22</b>	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 . . . . .		0	<b>22</b>	0
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		5,061,525	<b>23</b>	5,163,444
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .		0	<b>24</b>	0
	<b>25</b>	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 . . . . .		13,609,521	<b>25</b>	19,337,073
<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		1,215,306,312	<b>26</b>	1,519,849,064	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>					
	<b>27</b>	Unrestricted net assets		738,007,214	<b>27</b>	882,877,974
	<b>28</b>	Temporarily restricted net assets . . . . .		1,731,865	<b>28</b>	2,419,115
	<b>29</b>	Permanently restricted net assets		0	<b>29</b>	0
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>	
	<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		739,739,079	<b>33</b>	885,297,089
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		1,955,045,391	<b>34</b>	2,405,146,153	

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	3,139,020,885
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	2,810,379,539
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	328,641,346
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	739,739,079
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	78,702
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	-1,061
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-183,160,977
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	885,297,089

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

	Yes	No
<b>1</b> 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		
<b>2a</b> 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>b</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	
<b>c</b> 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	
<b>3a</b> As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	Yes	
<b>b</b> If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

Additional Data

Software ID:

Software Version:

EIN: 94-1156621

Name: SUTTER VALLEY HOSPITALS

Form 990 (2017)

Form 990, Part III, Line 4a:

SEE SCHEDULE O

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
David Adkins MD ..... Trustee	2 0 ..... 4 0	X						0	0	0
Timothy Byrd ..... Trustee	2 0 ..... 4 0	X						0	0	0
James Conforti ..... President SH Valley Area	40 0 ..... 9 0	X		X				0	1,927,277	428,024
Viva Ettin MD ..... Trustee	2 0 ..... 4 0	X						0	0	0
Gary Hooper ..... Trustee	2 0 ..... 4 0	X						0	0	0
Scott Howell ..... Trustee	2 0 ..... 4 0	X						0	0	0
I-Mei Hsiu MD ..... Trustee	2 0 ..... 4 0	X						0	0	0
Peter Hull MD ..... Trustee/CME, SVH	40 0 ..... 4 0	X						0	336,898	72,144
Sarah Krevans ..... President & CEO, Sutter Health	4 0 ..... 40 0	X		X				0	4,314,787	1,951,858
Ted Leland PhD ..... Trustee	2 0 ..... 4 0	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			
Michael Newell ..... TRUSTEE, CHAIR	4 0 ..... 8 0	X		X				0	0	0
Maria Pallavicini ..... Trustee	2 0 ..... 2 0	X						0	0	0
Pat Pathipati ..... Trustee	2 0 ..... 4 0	X						0	0	0
Fatima Seward ..... TRUSTEE, CHAIR F&P	4 0 ..... 8 0	X		X				0	0	0
Kurt Shuler MD ..... Trustee	2 0 ..... 4 0	X						0	0	0
Todd Smith MD ..... Trustee, SH Board	2 0 ..... 11 0	X						0	27,500	0
Helen Thomson ..... Trustee	2 0 ..... 4 0	X						0	0	0
Paige Terra ..... CFO SH, Valley Area	20 0 ..... 20 0			X				0	861,988	142,601
Penny Westfall ..... CHIEF LEGAL OFC SH VALLEY AREA	40 0 ..... 3 0			X				0	736,931	112,163
Doug Archer ..... ADMIN, MEMORIAL HOSP LOS BANOS	40 0 ..... 0 0				X			0	369,119	63,772

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			
Pat Brady ..... CEO, SRMC (PART-YEAR)	40 0 ..... 0 0				X			0	974,551	108,996
David Cheney ..... CEO, SMCS (part-year)	40 0 ..... 0 0				X			0	527,757	97,935
Michael Cohill ..... CEO, SMCS (part-year)	40 0 ..... 0 0				X			0	1,191,932	87,098
Grant Davies ..... CEO, Valley Area Hospitals	40 0 ..... 0 0				X			0	1,361,658	229,553
Abhishek Dosi ..... CEO, SSMC	40 0 ..... 0 0				X			0	220,373	52,853
Mitch Hanna ..... CEO, SCH & SAFH	25 0 ..... 25 0				X			0	752,568	140,779
Daryn Kumar ..... CEO, MMC	40 0 ..... 0 0				X			0	809,699	75,746
Jennifer Maher ..... CEO, SRMC (PART-YEAR)	40 0 ..... 0 0				X			0	516,651	90,057
Anne Platt ..... CEO, Sutter Amador Hospital	40 0 ..... 0 0				X			0	562,627	99,608
David Thompson ..... CEO, STCH & MHLB	40 0 ..... 1 0				X			0	775,506	136,233



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			
Brian Alexander ..... VP, Strgy & Bus Dev, SH Valley	40 0 ..... 0 0					X		0	591,984	82,696
Asit Gokli MD ..... CMO, SH Valley Area	40 0 ..... 0 0					X		0	1,063,215	140,521
John Mesic MD ..... PHYSICIAN EXEC, SH VALLEY AREA	40 0 ..... 0 0					X		0	1,144,379	195,310
Faraaz Yousuf ..... COO, SUTTER MED CTR SACRAMENTO	40 0 ..... 0 0					X		0	533,524	37,054
Phillip Yu MD ..... CME, SUTTER TRACY COMM HOSP	40 0 ..... 0 0					X		0	489,794	83,225
Jeff Sprague ..... SVP & CFO, SVH FINANCE ADMIN	0 0 ..... 40 0						X	0	1,648,581	585,930
John W Boyd ..... CEO, Mental Health Services	40 0 ..... 0 0						X	0	666,462	111,982
Thomas Blinn ..... CEO, SH VALLEY AREA FOUNDATION	0 0 ..... 40 0						X	0	723,176	37,518
Terry Glubka ..... CEO, SSCD	0 0 ..... 40 0						X	0	826,964	146,010
Carrie Owen-Plietz ..... FORMER CEO, SUTTER MED CTR SAC	0 0 ..... 0 0						X	0	159,228	438

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Thomas Ream II ..... REG CIO SUTTER VALLEY HOSPITLS	40 0 ..... 0 0						X	0	153,019	438
Janet Wagner ..... CEO, MILLS PENINSULA DIVISION	0 0 ..... 40 0						X	0	869,864	166,322

**SCHEDULE A**  
(Form 990 or 990EZ)

Department of the Treasury  
Internal Revenue Service

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

OMB No 1545-0047  
**2017**  
**Open to Public Inspection**

**Name of the organization**  
SUTTER VALLEY HOSPITALS

**Employer identification number**  
94-1156621

**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		
<b>Total</b>						

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	<b>Total.</b> 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	<b>Public support.</b> 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	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					<b>12</b>	
13	<b>First five years.</b> 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 <b>stop here</b> . . . . . ► <input type="checkbox"/>						

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	<b>33 1/3% support test—2017.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
b	<b>33 1/3% support test—2016.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
17a	<b>10%-facts-and-circumstances test—2017.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
b	<b>10%-facts-and-circumstances test—2016.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <span>► <input type="checkbox"/></span>	
18	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <span>► <input type="checkbox"/></span>	

**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
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> 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						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (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
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (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**

<b>15</b> Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2016 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

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

**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
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	<b>1</b>	
<b>2</b> 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 <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	<b>2</b>	
<b>3a</b> 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>	<b>3a</b>	
<b>b</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 <b>Part VI</b> when and how the organization made the determination.</i>	<b>3b</b>	
<b>c</b> 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 <b>Part VI</b> what controls the organization put in place to ensure such use.</i>	<b>3c</b>	
<b>4a</b> 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>	<b>4a</b>	
<b>b</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 <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	<b>4b</b>	
<b>c</b> 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 <b>Part VI</b> 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>	<b>4c</b>	
<b>5a</b> 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 <b>Part VI</b>, 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>	<b>5a</b>	
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	<b>5b</b>	
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?	<b>5c</b>	
<b>6</b> 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 <b>Part VI</b>.</i>	<b>6</b>	
<b>7</b> 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>	<b>7</b>	
<b>8</b> 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>	<b>8</b>	
<b>9a</b> 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 <b>Part VI</b>.</i>	<b>9a</b>	
<b>b</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 <b>Part VI</b>.</i>	<b>9b</b>	
<b>c</b> 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 <b>Part VI</b>.</i>	<b>9c</b>	
<b>10a</b> 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>	<b>10a</b>	
<b>b</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>	<b>10b</b>	

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> 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>b</b> A family member of a person described in (a) above?		
<b>c</b> 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>		
	<b>11a</b>	
	<b>11b</b>	
	<b>11c</b>	

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> 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>		
	<b>1</b>	
<b>2</b> 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>		
	<b>2</b>	

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> 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>		
	<b>1</b>	

**Section D. All Type III Supporting Organizations**

	Yes	No
<b>1</b> 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?		
	<b>1</b>	
<b>2</b> 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>		
	<b>2</b>	
<b>3</b> 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>		
	<b>3</b>	

**Section E. Type III Functionally-Integrated Supporting Organizations**

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

**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

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>		
<b>2</b> Recoveries of prior-year distributions	<b>2</b>		
<b>3</b> Other gross income (see instructions)	<b>3</b>		
<b>4</b> Add lines 1 through 3	<b>4</b>		
<b>5</b> Depreciation and depletion	<b>5</b>		
<b>6</b> 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)	<b>6</b>		
<b>7</b> Other expenses (see instructions)	<b>7</b>		
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>		
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>		
<b>a</b> Average monthly value of securities	<b>1a</b>		
<b>b</b> Average monthly cash balances	<b>1b</b>		
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>		
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>		
<b>e Discount</b> claimed for blockage or other factors (explain in detail in Part VI)			
<b>2</b> Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>		
<b>3</b> Subtract line 2 from line 1d	<b>3</b>		
<b>4</b> Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>		
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>		
<b>6</b> Multiply line 5 by .035	<b>6</b>		
<b>7</b> Recoveries of prior-year distributions	<b>7</b>		
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>		
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>		
<b>2</b> Enter 85% of line 1	<b>2</b>		
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>		
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>		
<b>5</b> Income tax imposed in prior year	<b>5</b>		
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>		
<b>7</b> <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)			



Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 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:  
Software Version:  
EIN: 94-1156621  
Name: SUTTER VALLEY HOSPITALS

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

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493317083028	
<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 <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</div>			<div>OMB No 1545-0047</div> <div>2017</div> <div>Open to Public Inspection</div>
Name of the organization SUTTER VALLEY HOSPITALS				Employer identification number 94-1156621	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(a) Donor advised funds		(b) Funds and other accounts	
1		Total number at end of year			
2		Aggregate value of contributions to (during year)			
3		Aggregate value of grants from (during year)			
4		Aggregate value at end of year			
5		Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
6		Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>			
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
1 Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space</div>					
2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year					
				Held at the End of the Year	
a Total number of conservation easements				2a	
b Total acreage restricted by conservation easements				2b	
c Number of conservation easements on a certified historic structure included in (a)				2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register				2d	
3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►					
4 Number of states where property subject to conservation easement is located ►					
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►					
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$					
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements					
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.					
1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items					
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items					
(i) Revenue included on Form 990, Part VIII, line 1 ► \$					
(ii) Assets included in Form 990, Part X ► \$					
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items					
a Revenue included on Form 990, Part VIII, line 1 ► \$					
b Assets included in Form 990, Part X ► \$					
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
Cat No 52283D		Schedule D (Form 990) 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
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

**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
<b>1a</b> Beginning of year balance . . . . .	20,064,697	19,173,834	19,993,368	20,085,053	17,651,842
<b>b</b> Contributions . . . . .	239,395	329,568	408,961	999	151,996
<b>c</b> Net investment earnings, gains, and losses	4,080,760	1,007,628	-670,838	293,955	1,678,960
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .	1,438,328	446,333	557,657	386,639	335,757
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	22,946,524	20,064,697	19,173,834	19,993,368	19,147,041

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

**a** Board designated or quasi-endowment ▶ 51 540 %

**b** Permanent endowment ▶ 29 930 %

**c** Temporarily restricted endowment ▶ 18 530 %

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
<b>3a(i)</b>		No
<b>3a(ii)</b>	Yes	
<b>3b</b>	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
<b>1a</b> Land . . . . .	0	45,509,266		45,509,266
<b>b</b> Buildings . . . . .	0	2,048,895,490	801,660,765	1,247,234,725
<b>c</b> Leasehold improvements	0	29,806,096	15,559,392	14,246,704
<b>d</b> Equipment . . . . .	0	747,667,597	592,220,723	155,446,874
<b>e</b> Other . . . . .	0	109,116,418	36,842,218	72,274,200
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				1,534,711,769

Part VII

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

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

Part VIII

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

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

Part IX

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

(a) Description	(b) Book value
(1) INTERCOMPANY RECEIVABLES	16,932,344
(2) NOTES RECEIVABLE	1,424,154
(3) OTHER RECEIVABLES	309,208,439
(4) OTHER CURRENT ASSETS	34,094,602
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . .	361,659,539

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	0
INSURANCE LIABILITIES	8,624,083
THIRD PARTY SETTLEMENTS	5,719,063
OTHER LIABILITIES	4,993,927
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 )	19,337,073

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.

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

**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.

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 94-1156621  
**Name:** SUTTER VALLEY HOSPITALS

**Supplemental Information**

Return Reference	Explanation
SCHEDULE D, PART V, LINE 1A, COLUMN (B)	THE BEGINNING BALANCE FOR 2014 INCLUDES A PRIOR YEAR ADJUSTMENT TO THE AUDITED FINANCIALS IN THE AMOUNT OF \$938,012 SCHEDULE D, PART V, LINE 4 INTENDED USE OF ENDOWMENT FUNDS END OWMENTS ARE HELD BY RELATED FUNDRAISING ORGANIZATIONS FOR THE EXCLUSIVE PURPOSE OF VARIOUS PROGRAMS OF SUTTER VALLEY HOSPITALS



**Supplemental Information**

Return Reference	Explanation
SCHEDULE D, PART X, LINE 2	<p>ASC 740 FOOTNOTE FROM AUDIT THIS ORGANIZATION WAS PART OF A CONSOLIDATED FINANCIAL SYSTEM AUDIT THE ASC 740 AUDIT FOOTNOTE DISCLOSURE FOR THE SUTTER SYSTEM IS AS FOLLOWS SUTTER HEALTH, THE LEGAL ENTITY, AND MANY AFFILIATES HAVE BEEN DETERMINED TO BE EXEMPT ORGANIZATIONS BY THE INTERNAL REVENUE SERVICE AND THE CALIFORNIA FRANCHISE TAX BOARD AND GENERALLY ARE NOT SUBJECT TO TAXES ON INCOME CERTAIN ACTIVITIES OF SUTTER ARE SUBJECT TO INCOME TAXES, HOWEVER, SUCH ACTIVITIES ARE NOT SIGNIFICANT TO THE CONSOLIDATED FINANCIAL STATEMENTS WITH RESPECT TO ITS TAXABLE ACTIVITIES, SUTTER RECORDS INCOME TAXES USING THE LIABILITY METHOD, UNDER WHICH DEFERRED TAX ASSETS AND LIABILITIES ARE DETERMINED BASED ON THE DIFFERENCES BETWEEN THE FINANCIAL ACCOUNTING AND TAX BASES OF ASSETS AND LIABILITIES DEFERRED TAX ASSETS OR LIABILITIES AT THE END OF EACH PERIOD ARE DETERMINED USING THE CURRENTLY ENACTED TAX RATE EXPECTED TO APPLY TO TAXABLE INCOME IN THE PERIODS THAT THE DEFERRED TAX ASSET OR LIABILITY IS EXPECTED TO BE REALIZED OR SETTLED SUTTER RECOGNIZES THE TAX BENEFIT FROM UNCERTAIN TAX POSITIONS, ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITIONS WILL BE SUSTAINED ON EXAMINATION BY THE TAX AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION THE TAX BENEFIT IS MEASURED BASED ON THE LARGEST BENEFIT THAT HAS A GREATER THAN 50% LIKELIHOOD OF BEING REALIZED UPON ULTIMATE SETTLEMENT THE STATUTE OF LIMITATIONS FOR TAX YEARS 2014 THROUGH 2016 REMAIN OPEN IN U S TAX JURISDICTIONS IN WHICH SUTTER AND ITS AFFILIATES ARE SUBJECT TO TAXATION SUTTER RECOGNIZES INTEREST AND PENALTIES RELATED TO INCOME TAX MATTERS IN OPERATING EXPENSES AT DECEMBER 31, 2017 AND 2016, THERE WERE NO SUCH UNCERTAIN TAX POSITIONS THE TAX CUTS AND JOBS ACT (TAX ACT) WAS ENACTED ON DECEMBER 22, 2017 THE TAX ACT REDUCES THE US FEDERAL CORPORATE TAX RATE FROM 35% TO 21%, REQUIRES COMPANIES TO PAY A ONE-TIME TRANSITION TAX ON EARNINGS OF CERTAIN FOREIGN SUBSIDIARIES THAT WERE PREVIOUSLY TAX DEFERRED, CREATES NEW TAXES ON CERTAIN FOREIGN SOURCED EARNINGS, PROVIDES FOR A NEW EXCISE TAX ON CERTAIN COMPENSATION OF EXEMPT ORGANIZATIONS OVER \$1 MILLION, AND REQUIRES THE SEPARATE CALCULATION OF UNRELATED BUSINESS TAXABLE INCOME FOR EACH TRADE OR BUSINESS CARRIED ON AS OF DECEMBER 31, 2017, WE HAVE NOT COMPLETED OUR ACCOUNTING FOR THE TAX EFFECTS OF ENACTING THE TAX ACT, THEREFORE WE CONTINUE TO ACCOUNT FOR THOSE ITEMS BASED ON OUR EXISTING ACCOUNTING UNDER ASC 740, INCOME TAXES, AND THE PROVISIONS OF THE TAX LAWS THAT WERE IN EFFECT IMMEDIATELY PRIOR TO ENACTMENT WE WILL CONTINUE TO MAKE AND REFINE OUR CALCULATIONS AS ADDITIONAL ANALYSIS IS COMPLETED IN ADDITION, OUR ESTIMATES MAY ALSO BE AFFECTED AS WE GAIN A MORE THOROUGH UNDERSTANDING OF THE TAX LAW AS WELL AS RECEIVING GUIDANCE FROM THE INTERNAL REVENUE SERVICE ON HOW THESE PROVISIONS APPLY TO TAX-EXEMPT ORGANIZATIONS AND TAXABLE AFFILIATES</p>

SCHEDULE G  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Supplemental Information Regarding  
Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
SUTTER VALLEY HOSPITALS

Employer identification number  
94-1156621

Part I Fundraising Activities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 17.  
Form 990-EZ filers are not required to complete this part.

- 1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- a ☐ Mail solicitations

e ☐ Solicitation of non-government grants

b ☐ Internet and email solicitations

f ☐ Solicitation of government grants

c ☐ Phone solicitations

g ☐ Special fundraising events

d ☐ In-person solicitations
- 2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No
- b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶						

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

**Part II Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events	(d)
		<u>SAH Theme Ball</u> (event type)	<u>Gala</u> (event type)	<u>0</u> (total number)	Total events (add col (a) through col (c))
Revenue	<b>1</b> Gross receipts . . . . .	88,448	149,911		238,359
	<b>2</b> Less Contributions . . . . .	58,859	81,275		140,134
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	29,589	68,636		98,225
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .				
	<b>6</b> Rent/facility costs . . . . .	700	3,402		4,102
	<b>7</b> Food and beverages . . . . .	15,854	27,671		43,525
	<b>8</b> Entertainment . . . . .	600	3,000		3,600
	<b>9</b> Other direct expenses . . . . .	7,151	24,661		31,812
	<b>10</b> Direct expense summary Add lines 4 through 9 in column (d) . . . . . ▶				83,039
	<b>11</b> Net income summary Subtract line 10 from line 3, column (d) . . . . . ▶				15,186

**Part III Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	<b>1</b> Gross revenue . . . . .				
	<b>2</b> Cash prizes . . . . .				
	<b>3</b> Noncash prizes . . . . .				
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .				
Direct Expenses	<b>6</b> Volunteer labor . . . . .	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	<b>7</b> Direct expense summary Add lines 2 through 5 in column (d) . . . . . ▶				
	<b>8</b> Net gaming income summary Subtract line 7 from line 1, column (d) . . . . . ▶				

**9** Enter the state(s) in which the organization conducts gaming activities \_\_\_\_\_

**a** Is the organization licensed to conduct gaming activities in each of these states? ☐ Yes ☐ No

**b** If "No," explain \_\_\_\_\_

**10a** Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

**b** If "Yes," explain \_\_\_\_\_

<b>11</b> Does the organization conduct gaming activities with nonmembers?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>12</b> Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>13</b> Indicate the percentage of gaming activity conducted in							
<b>a</b> The organization's facility	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 10%;"><b>13a</b></td> <td style="width: 80%;"></td> <td style="width: 10%; text-align: right;">%</td> </tr> <tr> <td><b>13b</b></td> <td></td> <td style="text-align: right;">%</td> </tr> </table>	<b>13a</b>		%	<b>13b</b>		%
<b>13a</b>		%					
<b>13b</b>		%					
<b>b</b> An outside facility							
<b>14</b> Enter the name and address of the person who prepares the organization's gaming/special events books and records							
Name ► .....							
Address ► .....							
<b>15a</b> Does the organization have a contract with a third party from whom the organization receives gaming revenue?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>b</b> If "Yes," enter the amount of gaming revenue received by the organization ► \$ ..... and the amount of gaming revenue retained by the third party ► \$ .....							
<b>c</b> If "Yes," enter name and address of the third party							
Name ► .....							
Address ► .....							
<b>16</b> Gaming manager information							
Name ► .....							
Gaming manager compensation ► \$ .....							
Description of services provided ► .....							
<input type="checkbox"/> Director/officer <input type="checkbox"/> Employee <input type="checkbox"/> Independent contractor							
<b>17</b> Mandatory distributions							
<b>a</b> Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>b</b> Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ► \$ .....							

**Part IV Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information (see instructions).

Return Reference	Explanation
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<b>SCHEDULE H</b> <b>(Form 990)</b>  Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Hospitals</h2> <p>► <b>Complete if the organization answered "Yes" on Form 990, Part IV, question 20.</b>                  ► <b>Attach to Form 990.</b>                  ► <b>Information about Schedule H (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</b></p>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2017</div> Open to Public Inspection
<b>Name of the organization</b> SUTTER VALLEY HOSPITALS		<b>Employer identification number</b> 94-1156621

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input type="checkbox"/> Applied uniformly to all hospital facilities <input checked="" type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
<b>3</b> 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			
<b>a</b> 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>400 %</u>	<b>3a</b>	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<b>3b</b>		
<b>c</b> 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			
<b>4</b> 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"?	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>	Yes	
<b>c</b> 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?	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	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
<b>a</b> Financial Assistance at cost (from Worksheet 1)			22,033,250		22,033,250	0 780 %
<b>b</b> Medicaid (from Worksheet 3, column a)			745,040,898	695,183,549	49,857,349	1 770 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			76,040,088	48,258,856	27,781,232	0 990 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			843,114,236	743,442,405	99,671,831	3 540 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)	24	2,903	2,498,164	3,267	2,494,897	0 090 %
<b>f</b> Health professions education (from Worksheet 5)	4	73	6,563,319	4,880,852	1,682,467	0 060 %
<b>g</b> Subsidized health services (from Worksheet 6)	12	9,067	6,649,478	436,845	6,212,633	0 220 %
<b>h</b> Research (from Worksheet 7)	6	0	2,122,752	1,544,025	578,727	0 020 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)	81	0	13,537,587	0	13,537,587	0 480 %
<b>j Total.</b> Other Benefits	127	12,043	31,371,300	6,864,989	24,506,311	0 870 %
<b>k Total.</b> Add lines 7d and 7j	127	12,043	874,485,536	750,307,394	124,178,142	4 410 %

**Part II**

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building	1		14,612		14,612	0 %
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>	1		14,612		14,612	0 %

**Part III** **Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

**1** Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .

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

**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 . . . . .

**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

**2**

12,138,974

**3**

**9a**

Yes

No

**Section B. Medicare**

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

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

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

**8** Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:  

☐ Cost accounting system      ☒ Cost to charge ratio      ☐ Other

**5**

653,288,050

**6**

757,392,700

**7**

-104,104,650

**9b**

Yes

**Section C. Collection Practices**

**9a** Did the organization have a written debt collection policy during the tax year? . . . . .

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

**9a**

Yes

**9b**

Yes

**Part IV** **Management Companies and Joint Ventures**

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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 %
<b>1</b> SUTTER AMADOR SURG	MEDICAL SERVICES	32 %		24 %
<b>2</b> ROSEVILLE ENDOSCOPY	MEDICAL SERVICES	11 %		49 %
<b>3</b> STANISLAUS SURG HOSP	MEDICAL SERVICES	20 %		34 51 %
<b>4</b> MEMORIAL MED BLDG	OFFICE RENTAL	50 03 %		24 96 %
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

Schedule H (Form 990) 2017

**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?

**12**

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

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**

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

A

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b>	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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

A

**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			
<b>13</b> 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	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ % <b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C) <b>c</b> <input type="checkbox"/> Asset level <b>d</b> <input checked="" type="checkbox"/> Medical indigency <b>e</b> <input checked="" type="checkbox"/> Insurance status <b>f</b> <input type="checkbox"/> Underinsurance discount <b>g</b> <input type="checkbox"/> Residency <b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> 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)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application <b>b</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 <b>c</b> <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 <b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications <b>e</b> <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> 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)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C <b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C <b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V <b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) <b>e</b> <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) <b>f</b> <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) <b>g</b> <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 <b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP <b>i</b> <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 <b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

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

A

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged	<b>19</b>	No
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

A

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		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)

B

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b>	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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

B

**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			
<b>13</b> 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	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> 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)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</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			
<b>c</b> <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			
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> 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)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <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)			
<b>f</b> <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)			
<b>g</b> <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			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <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			
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

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

B

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <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)**

B

**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
<b>22</b>		
<b>23</b>		No
<b>24</b>		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)  
MEMORIAL MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**3**

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b>	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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

MEMORIAL MEDICAL CENTER

**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			
<b>13</b> 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	<b>13</b>	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . .	<b>15</b>	Yes	
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)			
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .	<b>16</b>	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V			
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**

MEMORIAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <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)**

MEMORIAL MEDICAL CENTER

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		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)  
SUTTER TRACY COMMUNITY HOSPITAL**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):** \_\_\_\_\_

6

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> 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)	<b>3</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <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		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <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)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> 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 . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b> Yes	
<b>b</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 . . . . .	<b>6b</b> Yes	
<b>7</b> 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)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b> <input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b> Yes	
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)**

SUTTER TRACY COMMUNITY HOSPITAL

**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			
<b>13</b> 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	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . .	<b>15</b>	Yes	
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)			
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</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			
<b>c</b> <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			
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . .	<b>16</b>	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <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)			
<b>f</b> <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)			
<b>g</b> <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			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <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			
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

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

SUTTER TRACY COMMUNITY HOSPITAL

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <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)**

SUTTER TRACY COMMUNITY HOSPITAL

**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
<b>22</b>		
<b>23</b>		No
<b>24</b>		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)  
MEMORIAL HOSPITAL LOS BANOS**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):** \_\_\_\_\_

11

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	No
<b>3</b>	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)	<b>3</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b>	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 . . . . .	<b>5</b>	Yes
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	No
<b>7</b>	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)	<b>7</b>	Yes
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	Yes
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	<b>10</b>	Yes
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

MEMORIAL HOSPITAL LOS BANOS

**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			
<b>13</b> 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	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input type="checkbox"/> Underinsurance discount			
<b>g</b> <input type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> 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)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</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			
<b>c</b> <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			
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> 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)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) SEE PART V, SECTION C			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) SEE PART V			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <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)			
<b>f</b> <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)			
<b>g</b> <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			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <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			
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)			

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

MEMORIAL HOSPITAL LOS BANOS

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <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)**

MEMORIAL HOSPITAL LOS BANOS

**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
<b>23</b>		No
<b>24</b>		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)  
STANISLAUS SURGICAL HOSPITAL**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):** \_\_\_\_\_

12

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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? . . . . .	<b>1</b>	No
<b>2</b>	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 . . . . .	<b>2</b>	Yes
<b>3</b>	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)	<b>3</b>	No
<b>a</b>	<input type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input type="checkbox"/> Demographics of the community		
<b>c</b>	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input type="checkbox"/> How data was obtained		
<b>e</b>	<input type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA 20 ____		
<b>5</b>	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 . . . . .	<b>5</b>	
<b>6a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	
<b>b</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 . . . . .	<b>6b</b>	
<b>7</b>	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)	<b>7</b>	
<b>a</b>	<input type="checkbox"/> Hospital facility's website (list url) _____		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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 . . . . .	<b>8</b>	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy 20 ____		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) _____	<b>10</b>	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b>	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		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .	<b>12a</b>	No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b>	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)**

STANISLAUS SURGICAL HOSPITAL

**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			
<b>13</b> 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	<b>13</b>	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>350</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> 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)	<b>15</b>	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>16</b> 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)	<b>16</b>	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V</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**

STANISLAUS SURGICAL HOSPITAL

**Name of hospital facility or letter of facility reporting group**

	Yes	No
<b>17</b> 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? . . . . .	<b>17</b> Yes	
<b>18</b> 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		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> 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? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <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 <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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)		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? . . . . .	<b>21</b>	No
If "No," indicate why		
<b>a</b> <input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <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)**

STANISLAUS SURGICAL HOSPITAL

**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
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

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

[illegible]



**Part V** **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**  
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 24

Name and address	Type of Facility (describe)
<b>1</b> See Additional Data Table	
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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
SCHEDULE H, PART I, LINES 3A & 3C	FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR UNINSURED PATIENTS TO BE ELIGIBLE FOR FREE CARE THE ORGANIZATION USES THE FEDERAL POVERTY GUIDELINES (FPG) FOR FAMILY INCOMES THAT ARE AT OR BELOW 400% OF FPG IN ADDITION THE ORGANIZATION HAS A HIGH MEDICAL COST CHARITY CARE CATEGORY IN WHICH A WRITE OFF OF THE PATIENT RESPONSIBILITY FOR HOSPITAL SERVICES CAN OCCUR IF THE INSURED PATIENT HAS FAMILY INCOME AT OR BELOW 400% FPG AND EXPENSES INCURRED FOR THEMSELVES OR THEIR FAMILY EXCEED 10% OF THE PATIENT'S FAMILY INCOME SUTTER VALLEY HOSPITALS ACQUIRED A 20% OWNERSHIP INTEREST IN STANISLAUS SURGICAL HOSPITAL IN 2016 THIS HOSPITAL PROVIDES PREDOMINANTLY ELECTIVE SURGERIES AND DOES NOT PROVIDE EMERGENCY CARE STANISLAUS SURGICAL HOSPITAL PROVIDES FREE CHARITY CARE FOR MEDICALLY NECESSARY PROCEDURES FOR UNINSURED PATIENTS FOR FAMILY INCOMES THAT ARE AT OR BELOW 100% OF FPG SCHEDULE H, PART I, LINE 3B SUTTER VALLEY HOSPITALS IS COMMITTED TO PROVIDING CHARITY CARE SUTTER VALLEY HOSPITALS PROVIDES FREE CARE AT HIGH PERCENTAGE OF FPG IT DOES NOT PROVIDE DISCOUNTED CARE STANISLAUS SURGICAL HOSPITAL PROVIDES DISCOUNTED CHARITY CARE BASED ON A SLIDING SCALE UP TO 350% OF FPG

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	COSTING METHODOLOGY USED COST TO CHARGE RATIO UTILIZING WORKSHEET 2 METHODOLOGY

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART II	COMMUNITY BUILDING ACTIVITIES SUTTER VALLEY HOSPITALS, WITH THE EXCEPTION OF SUTTER TRACY COMMUNITY HOSPITAL, DID NOT HAVE ANY COMMUNITY BUILDING ACTIVITIES TO REPORT IN 2017 SUTTER TRACY COMMUNITY HOSPITAL FUNDS THE FOLLOWING PROGRAMS THAT HELP ADDRESS THE ROOT CAUSE OF HEALTH PROBLEMS AND IMPACT THE HEALTH AND WELL-BEING IN THE COMMUNITIES WE SERVE (ALSO KNOWN AS COMMUNITY-BUILDING ACTIVITIES) THESE PROGRAMS HELP SUPPORT COMMUNITY ASSETS BY OFFERING THE EXPERTISE AND RESOURCES OF SUTTER HEALTH SUTTER TRACY COMMUNITY HOSPITAL SUPPORTS COALITION BUILDING EFFORTS ACROSS THE COMMUNITY INCLUDING THE HEALTHIER COMMUNITY COALITION (HCC) THE HCC IS A COALITION CHARGED WITH DEVELOPING THE HEALTH IMPROVEMENT EFFORTS IN SAN JOAQUIN COUNTY

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 2	METHODOLOGY FOR CALCULATING BAD DEBT (AT COST) THE RATIO OF PATIENT CARE COST TO CHARGES IS APPLIED TO THE BAD DEBT ATTRIBUTABLE TO PATIENT ACCOUNTS TO CALCULATE THE ESTIMATED COST OF BAD DEBT ATTRIBUTABLE TO PATIENT ACCOUNTS THAT IS REPORTED ON LINE 2 DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE RECORDED AS AN ADJUSTMENT TO REVENUE, NOT BAD DEBT EXPENSE

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 3	METHODOLOGY FOR DETERMINING THE AMOUNT OF BAD DEBT LIKELY ATTRIBUTABLE TO CHARITY CARE AMOUNTS MAY BE INCLUDED IN BAD DEBT PENDING A CHARITY CARE DETERMINATION UPON ELIGIBILITY THESE AMOUNTS WOULD BE RECLASSIFIED AS CHARITY CARE

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 4	<p>AUDIT FOOTNOTE THE ORGANIZATION IS AN AFFILIATE OF SUTTER HEALTH WHICH UNDERWENT A SYSTEM-WIDE AUDIT THE AUDIT REPORT DOES NOT INCLUDE A BAD DEBT EXPENSE FOOTNOTE PROVISION FOR BAD DEBTS IS LISTED ON A SEPARATE LINE ITEM IN THE FINANCIAL STATEMENTS THE AUDIT DOES INCLUDE A FOOTNOTE FOR PATIENT SERVICE REVENUES LESS PROVISION FOR BAD DEBTS PATIENT SERVICE REVENUES ARE REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS AND THIRD-PARTY PAYERS FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT PROGRAMS WITH THIRD-PARTY PAYERS ESTIMATED SETTLEMENTS UNDER THIRD-PARTY REIMBURSEMENT PROGRAMS ARE ACCRUED IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS, PRIMARILY AS A RESULT OF FINAL COST REPORT SETTLEMENTS WITH GOVERNMENTAL AGENCIES PATIENT SERVICE REVENUES LESS PROVISION FOR BAD DEBTS ARE REPORTED NET OF THE PROVISION FOR BAD DEBTS ON THE CONSOLIDATED STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS SUTTER'S SELF-PAY WRITE-OFFS WERE 189 MILLION AND \$204 MILLION FOR 2017 AND 2016, RESPECTIVELY</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 7	MEDICARE COSTS    MEDICARE COST REPORTS THAT THE ORGANIZATION FILES DO NOT INCLUDE ALL OF THE COSTS REQUIRED TO TREAT MEDICARE PATIENTS



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 8	COSTING METHODOLOGY MEDICARE ALLOWABLE COSTS WERE CALCULATED USING A COST TO CHARGE RATIO COMMUNITY BENEFIT MEDICARE SHORTFALL THE IRS COMMUNITY BENEFIT STANDARD INCLUDES THE PROVISION OF CARE TO THE ELDERLY AND MEDICARE PATIENTS CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED AND RELIEVES A GOVERNMENT BURDEN AS THESE PATIENTS TYPICALLY HAVE LOW AND/OR FIXED INCOMES MEDICARE DOES NOT PROVIDE SUFFICIENT REIMBURSEMENT TO COVER THE COST OF PROVIDING CARE FOR THESE PATIENTS FORCING THE HOSPITAL TO USE OTHER FUNDS TO COVER THE DEFICIT

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 9B	DEBT COLLECTION POLICY COLLECTION PRACTICES ARE CONSISTENT FOR ALL PATIENTS AND COMPLY WITH APPLICABLE PROVISIONS OF FEDERAL AND CALIFORNIA LAW DURING PREADMISSION OR REGISTRATION, THE HOSPITAL PROVIDES ALL PATIENTS WITH INFORMATION REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AN UNINSURED PATIENT WHO INDICATES THE FINANCIAL INABILITY TO PAY A BILL IS EVALUATED FOR FINANCIAL ASSISTANCE AT DISCHARGE PATIENTS WILL BE GIVEN AN APPLICATION WHICH WILL DOCUMENT THE PATIENT'S OVERALL FINANCIAL SITUATION IF AN UNINSURED PATIENT DOES NOT COMPLETE THE APPLICATION FORM WITHIN 30 DAYS OF DELIVERY, THE HOSPITAL WILL NOTIFY THE PATIENT THAT THE APPLICATION HAS NOT BEEN RECEIVED AND WILL PROVIDE THE PATIENT AN ADDITIONAL 210 DAYS TO COMPLETE THE APPLICATION IF A PATIENT HAS APPLIED FOR CHARITY CARE, HAS BEEN APPROVED TO RECEIVE CHARITY CARE, OR IS COOPERATING WITH THE HOSPITAL'S EFFORTS TO SETTLE AN OUTSTANDING BILL WITHIN A REASONABLE TIME PERIOD, THE HOSPITAL WILL NOT PURSUE COLLECTIONS

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2	SUTTER MEDICAL CENTER SACRAMENTO THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED MEMORIAL MEDICAL CENTER THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER ROSEVILLE MEDICAL CENTER THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER SOLANO MEDICAL CENTER THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER TRACY COMMUNITY HOSPITAL THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER AUBURN FAITH HOSPITAL THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER AMADOR HOSPITAL THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SUTTER DAVIS HOSPITAL THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED MEMORIAL HOSPITAL LOS BANOS THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 3	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE SUTTER HOSPITALS FOLLOW A SUTTER HEALTH SYSTEM-WIDE FINANCIAL ASSISTANCE POLICY, WHICH INCLUDES THE FOLLOWING DETAILS OF HOW THE ORGANIZATION INFORMS AND EDUCATES PATIENTS AND PERSONS WHO MAY BE BILLED FOR PATIENT CARE LANGUAGES THE POLICY SHALL BE AVAILABLE IN THE PRIMARY LANGUAGE(S) OF HOSPITAL'S SERVICE AREA IN ADDITION, ALL NOTICES/COMMUNICATIONS PROVIDED IN THIS SECTION SHALL BE AVAILABLE IN PRIMARY LANGUAGE(S) OF HOSPITAL'S SERVICE AREA AND IN A MANNER CONSISTENT WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS INFORMATION PROVIDED TO PATIENTS DURING THE PROVISION OF HOSPITAL SERVICES A DURING PREADMISSION OR REGISTRATION (OR AS SOON THEREAFTER AS PRACTICABLE) HOSPITALS SHALL PROVIDE ALL PATIENTS WITH A COPY OF A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND IDENTIFY THE DEPARTMENT THAT PATIENTS CAN VISIT TO RECEIVE INFORMATION ABOUT, AND ASSISTANCE WITH APPLYING FOR, FINANCIAL ASSISTANCE B FINANCIAL ASSISTANCE COUNSELORS PATIENTS WHO MAY BE UNINSURED PATIENTS SHALL BE ASSIGNED FINANCIAL COUNSELORS, WHO SHALL VISIT WITH THE PATIENTS IN PERSON AT THE HOSPITAL, PROVIDE PATIENTS A FINANCIAL ASSISTANCE APPLICATION, ASSIST WITH THE APPLICATION PROCESS, AND PROVIDE CONTACT INFORMATION FOR THE PATIENT TO CALL FOR QUESTIONS C EMERGENCY SERVICES IN THE CASE OF EMERGENCY SERVICES, HOSPITALS SHALL PROVIDE ALL PATIENTS A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AS SOON AS PRACTICABLE AFTER STABILIZATION OF THE PATIENT'S EMERGENCY MEDICAL CONDITION OR UPON DISCHARGE D APPLICATIONS PROVIDED AT DISCHARGE AT THE TIME OF DISCHARGE, HOSPITALS SHALL PROVIDE ALL PATIENTS WITH A COPY OF A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY E INFORMATION PROVIDED TO PATIENTS AT OTHER TIMES 1 CONTACT INFORMATION WHICH INCLUDES A PHONE NUMBER AND HOSPITAL DEPARTMENT TO OBTAIN ADDITIONAL INFORMATION ABOUT FINANCIAL ASSISTANCE AND ASSISTANCE WITH THE APPLICATION PROCESS 2 BILLING STATEMENTS BILLING STATEMENTS PROVIDED TO PATIENTS SHALL INCLUDE A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY, A PHONE NUMBER FOR PATIENTS TO CALL WITH QUESTIONS ABOUT FINANCIAL ASSISTANCE, AND THE WEBSITE ADDRESS WHERE PATIENTS CAN OBTAIN ADDITIONAL INFORMATION ABOUT FINANCIAL ASSISTANCE INCLUDING THE FINANCIAL ASSISTANCE POLICY, A PLAIN LANGUAGE SUMMARY OF THE POLICY, AND THE APPLICATION FOR FINANCIAL ASSISTANCE 3 UPON REQUEST HOSPITALS SHALL PROVIDE PATIENTS WITH PAPER COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY UPON REQUEST AND WITHOUT CHARGE F PUBLICITY OF FINANCIAL ASSISTANCE INFORMATION 1 PUBLIC POSTING HOSPITALS SHALL POST COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IN A PROMINENT LOCATION IN THE EMERGENCY ROOM, ADMISSIONS AREA, AND ANY OTHER LOCATION IN THE HOSPITAL WHERE THERE IS A HIGH VOLUME OF PATIENT TRAFFIC, INCLUDING BUT NOT LIMITED TO THE WAITING ROOMS, BILLING OFFICES, AND HOSPITAL OUTPATIENT SERVICE SETTINGS THESE PUBLIC NOTICES SHALL INCLUDE INFORMATION ABOUT THE RIGHT TO REQUEST AN ESTIMATE OF FINANCIAL RESPONSIBILITY FOR SERVICES 2 WEBSITE THE FINANCIAL ASSISTANCE POLICY, APPLICATION FOR FINANCIAL ASSISTANCE AND PLAIN LANGUAGE SUMMARY SHALL BE AVAILABLE IN A PROMINENT PLACE ON THE SUTTER HEALTH WEBSITE (WWW.SUTTERHEALTH.ORG) AND ON EACH INDIVIDUAL HOSPITAL'S WEBSITE PERSONS SEEKING INFORMATION ABOUT FINANCIAL ASSISTANCE SHALL NOT BE REQUIRED TO CREATE AN ACCOUNT OR PROVIDE ANY PERSONAL INFORMATION BEFORE RECEIVING INFORMATION ABOUT FINANCIAL ASSISTANCE 3 MAIL PATIENTS MAY REQUEST A COPY OF THE FINANCIAL ASSISTANCE POLICY, APPLICATION FOR FINANCIAL ASSISTANCE AND PLAIN LANGUAGE SUMMARY BE SENT BY MAIL, AT NO COST TO THE PATIENT 4 ADVERTISEMENTS/PRESS RELEASES AS NECESSARY AND ON AT LEAST AN ANNUAL BASIS, SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT HOSPITALS IN THE PRINCIPAL NEWSPAPER(S) IN THE COMMUNITIES SERVED BY SUTTER HEALTH, OR WHEN DOING SO IS NOT PRACTICAL, SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THIS INFORMATION, OR USE OTHER MEANS THAT SUTTER HEALTH CONCLUDES WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY TO AFFECTED PATIENTS IN OUR COMMUNITIES 5 COMMUNITY AWARENESS SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY (ESPECIALLY THOSE WHO ARE MOST LIKELY TO REQUIRE FINANCIAL ASSISTANCE) ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE</p>

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 4	<p>SUTTER MEDICAL CENTER SACRAMENTO (SMCS) THE HOSPITAL SERVICE AREA (HSA) IS DEFINED AS THE GEOGRAPHIC AREA (BY ZIP CODE) IN WHICH OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY RECEIVE THEIR TOP 80% OF DISCHARGES THERE ARE FOUR HOSPITALS THAT SERVE THE COMMUNITY THE SMCS HSA IS LOCATED IN NORTHERN CALIFORNIA AND HAS APPROXIMATELY 1 MILLION RESIDENTS THE AREA IS CONSIDERABLY DIVERSE IN POPULATION, ECONOMIC STABILITY (INCOME AND POVERTY), AND INSURANCE STATUS THE POPULATION OF THE SMCS HSA MAKES UP APPROXIMATELY 2.68% OF ALL RESIDENTS IN THE STATE OF CALIFORNIA THE MAJORITY OF THE POPULATION COUNT FOR THE HSA COMES FROM RESIDENTS LIVING IN SACRAMENTO COUNTY POPULATION COUNTS AT THE ZIP CODE LEVEL VARIED FROM 240 RESIDENTS IN ZIP CODE 95837 (SACRAMENTO INTERNATIONAL AIRPORT) TO 74,154 RESIDENTS IN ZIP CODE 95823 (FRUITRIDGE) THE MEDIAN AGE AT THE ZIP CODE LEVEL RANGED FROM 26.2 YEARS IN 95832 (SOUTH MEADOWVIEW) TO 53.3 YEARS IN 95612 (SOUTHEASTERN YOLO) THE MEDIAN INCOME BY ZIP CODE FOR THE HSA RANGED SIGNIFICANTLY FROM APPROXIMATELY \$29,771 IN 95824 (PARKWAY) TO \$81,076 IN 95819 (EAST SAC/RIVER PARK), A RANGE OF \$51,305 PER YEAR IN AN ATTEMPT TO UNDERSTAND THE EXTENT OF AND LOCATION OF THE MEDICALLY UNDERSERVED, LOW INCOME AND MINORITY POPULATIONS LIVING IN THE SMCS HSA, SPECIFIC INDICATORS WERE EXAMINED THE PERCENT OF POPULATION LIVING IN POVERTY IN THE SMCS HSA WAS GREATER THAN BOTH THE SACRAMENTO AND YOLO COUNTY AND STATE PERCENTAGES THE SMCS HSA ZIP CODE WITH THE HIGHEST PERCENT OF POPULATION IN POVERTY WAS 95824 (PARKWAY) AT 36.7%, COMPARED TO THE LOWEST PERCENT POVERTY IN ZIP CODE 95830 (EAST FLORIN ROAD) AT 4.1% THE PERCENT OF RESIDENTS UNINSURED WAS LOWEST IN YOLO COUNTY AS COMPARED TO THE SMCS HSA, SACRAMENTO COUNTY AND THE STATE PERCENT BENCHMARKS THE ZIP CODE WITH THE HIGHEST PERCENT UNINSURED WAS 95824 (PARKWAY) AT 24.7% AND THE LOWEST PERCENT WAS 4.7% IN ZIP CODE 95830 (EAST FLORIN ROAD) THE SMCS HSA PERCENT OF MINORITY RESIDENTS WAS 58.7%, LOWER THAN STATE RATE OF 60.3%, BUT HIGHER THAN BOTH THE SACRAMENTO COUNTY (52.1%) AND YOLO COUNTY (50.6%) PERCENTAGES AN EXAMINATION OF AREAS THROUGHOUT THE COUNTY REVEALED A LARGE VARIATION IN THE DEGREE OF DIVERSITY, OR PERCENT MINORITY ZIP CODE 95832 (MEADOWVIEW) SHOWED A PERCENT OF MINORITY POPULATIONS AT 85.6% THIS PERCENT IS DRASTICALLY DIFFERENT FROM THE ZIP CODE OF 95837 (SACRAMENTO INTERNATIONAL AIRPORT) WHICH ONLY HAD 15.0% MINORITY RESIDENTS CENSUS DATA SHOWED THAT WHITES/CAUCASIANS MAKE UP THE HIGHEST PERCENT OF RESIDENTS IN THE SMCS HSA, FOLLOWED BY HISPANICS/LATINOS AND ASIANS AN IN-DEPTH VIEW OF THE DEMOGRAPHICS AND GEOGRAPHY OF THE SERVICE AREA IS AVAILABLE IN THE SUTTER MEDICAL CENTER CHNA AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a> MEMORIAL MEDICAL CENTER SUTTER HEALTH MEMORIAL MEDICAL CENTER IS LOCATED IN MODESTO, CALIFORNIA, AND ITS SERVICE AREA INCLUDES THE CITIES OF CERES, HUGHSON, MODESTO, NEWMAN, OAKDALE, PATTERSON, RIVERBANK, TURLOCK AND WATERFORD THE SERVICE AREA INCLUDES ALL OF STANISLAUS COUNTY, MAKING STANISLAUS COUNTY DATA A GOOD PROXY FOR DATA FOR THE SHMC AREA THERE ARE THREE HOSPITALS THAT SERVE THE COMMUNITY THE DEMOGRAPHICS INCLUDE A TOTAL POPULATION OF 518,321 CITIZENS, WITH 76.51% WHITE (INCLUDING HISPANIC), 2.82% BLACK, 5.28% ASIAN, AND OF THAT POPULATION, 42.5% LATINO THE POPULATION DENSITY IS MUCH HIGHER IN STANISLAUS COUNTY THAN CALIFORNIA AS A WHOLE 44.19% LIVE IN POVERTY, 28.32% CHILDREN ARE LIVING IN POVERTY, 10.4% ARE UNEMPLOYED, 17.84% ARE UNINSURED AND 23.59% HAVE NOT GRADUATED FROM HIGH SCHOOL AN IN-DEPTH VIEW OF THE DEMOGRAPHICS AND GEOGRAPHY OF THE SERVICE AREA IS AVAILABLE IN THE MEMORIAL MEDICAL CENTER 2016 CHNA AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a> SUTTER ROSEVILLE MEDICAL CENTER THE COMMUNITY OR HOSPITAL SERVICE AREA (HSA) IS DEFINED AS THE GEOGRAPHIC AREA (BY ZIP CODE) IN WHICH THE HOSPITAL RECEIVES ITS TOP 80% OF DISCHARGES THERE ARE FOUR HOSPITALS THAT SERVE THE COMMUNITY THE SUTTER ROSEVILLE MEDICAL CENTER/SUTTER AUBURN FAITH HOSPITAL HSA IS LOCATED IN NORTHERN CALIFORNIA AND HAS NEARLY 700,000 RESIDENTS THE AREA IS DIVERSE IN POPULATION, ECONOMIC STABILITY (INCOME AND POVERTY), AND INSURANCE STATUS TABLE 1 (IN THE FULL REPORT) IN THE CHNA SHOWS THE TOTAL POPULATION COUNT, THE MEDIAN AGE AND THE MEDIAN INCOME OF ALL 41 ZIP CODES IN THE SRMC/SAFH HSA COMPARED TO THE STATE AND COUNTY BENCHMARKS TABLE 2 (IN THE FULL REPORT) PROVIDES INFORMATION ON THE PRESENCE OF MEDICALLY UNDERSERVED, LOW INCOME, AND MINORITY RESIDENTS IN ALL 41 ZIP CODES IN THE SRMC/SAFH HSA COMPARED TO THE STATE AND COUNTY BENCHMARKS THE POPULATION OF THE SRMC/SAFH HSA MAKES UP NEARLY 2% OF ALL RESIDENTS IN THE STATE OF CALIFORNIA THE MAJORITY OF THE POPULATION COUNT FOR THE SRMC/SAFH HSA COMES FROM RESIDENTS LIVING IN PLACER COUNTY TWENTY-TWO OF</p>

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 4	<p>THE 41 ZIP CODES THAT MAKE UP THE SRMC/SAFH HSA ARE LOCATED IN PLACER COUNTY, TEN ZIP CODE S ARE LOCATED IN SACRAMENTO COUNTY, THREE ZIP CODES ARE LOCATED IN EL DORADO COUNTY, TWO Z IP CODES ARE LOCATED IN YUBA COUNTY AND ONE ZIP CODE IS LOCATED IN NEVADA COUNTY. POPULATI ON COUNTS AT THE ZIP CODE LEVEL VARIED FROM 88 RESIDENTS IN ZIP CODE 95715 (EMIGRANT GAP) TO 53,452 RESIDENTS IN ZIP CODE 95747 (ROSEVILLE). THE MEDIAN AGE OF THE SRMC/SAFH HSA AT THE ZIP CODE LEVEL RANGED FROM 21.5 YEARS IN 95736 (WEIMAR) TO 62.4 YEARS IN 95714 (DUTCH FLAT). THE MEDIAN INCOME BY ZIP CODE FOR THE SRMC/SAFH HSA RANGED SIGNIFICANTLY FROM APPRO XIMATELY \$36,967 IN 95841 (NORTH HIGHLANDS) TO \$127,736 IN 95746 (GRANITE BAY), A RANGE OF ALMOST \$90,000 DOLLARS A YEAR. IN AN ATTEMPT TO UNDERSTAND THE EXTENT OF AND LOCATION OF THE MEDICALLY UNDERSERVED, LOW INCOME AND MINORITY POPULATIONS LIVING IN THE SRMC/SAFH HSA , SPECIFIC INDICATORS WERE EXAMINED. THE PERCENT OF POPULATION LIVING IN POVERTY FOR THE S RMC/SAFH HSA WAS 11.8%, MUCH GREATER THAN THE PLACER COUNTY BENCHMARK, BUT LOWER THAN BOTH THE SACRAMENTO COUNTY BENCHMARK AND STATE BENCHMARK. THE ZIP CODE IN THE SRMC/SAFH HSA WI TH THE HIGHEST PERCENT OF POPULATION IN POVERTY WAS 95841 (NORTH HIGHLANDS) WITH 27.9% OF ITS POPULATION LIVING BELOW 100% FEDERAL POVERTY LEVEL, COMPARED TO THE LOWEST PERCENT OF POPULATION IN POVERTY IN 95714 (DUTCH FLAT) AND 95715 (EMIGRANT GAP), BOTH WITH 0% OF THEI R POPULATIONS LIVING IN POVERTY. THE PERCENT OF UNINSURED RESIDENTS IN THE SRMC/SAFH HSA W AS 12.1%, HIGHER THAN THE PERCENT UNINSURED IN PLACER COUNTY, BUT LOWER THAN BOTH THE STAT E AND SACRAMENTO COUNTY PERCENTAGES. THE ZIP CODE WITH THE HIGHEST PERCENT UNINSURED WAS 9 5736 (WEIMAR) WITH 36.3%, WHILE ZIP CODE 95715 (EMIGRANT GAP) HAD 0% OF ITS POPULATION IN POVERTY. THE PERCENT OF MINORITY RESIDENTS IN THE SRMC/SAFH HSA WAS 27.4%, WHICH IS HIGHER THAN THE PLACER COUNTY PERCENT MINORITY, BUT LOWER THAN THE SACRAMENTO COUNTY AND STATE P ERCENTAGES OF MINORITY. AN EXAMINATION OF THE ZIP CODES IN THE SRMC/SAFH HSA REVEALED A LA RGE VARIATION IN THE DEGREE OF DIVERSITY, OR PERCENT MINORITY. THE HIGHEST PERCENT MINORIT Y IN THE SRMC/SAFH HSA WAS FOUND IN 95736 (WEIMAR) WITH 48.9% AND THE LOWEST PERCENT MINORIT Y IN THE SRMC/SAFH HSA WAS FOUND IN 95715 (EMIGRANT GAP), WITH 0% OF ITS POPULATION CLAS SIFIED AS MINORITY. AN IN-DEPTH VIEW OF THE DEMOGRAPHICS AND GEOGRAPHY OF THE SERVICE AREA IS AVAILABLE IN THE SUTTER ROSEVILLE MEDICAL CENTER CHNA AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessmen">https://www.sutterhealth.org/for-patients/community-health-needs-assessmen</a> T SUTTER SOLANO MEDICAL CENTER. FOR THE PURP OSES OF THIS REPORT, THE HEALTH SERVICE AREA (HSA) IS THE 18 ZIP CODES WHICH MAKE UP SOLAN O COUNTY, CALIFORNIA. THE HSA WAS DESIGNATED AS SOLANO COUNTY BECAUSE ALL SOLANO CHNA COLL ABORATIVE PARTNERS SERVE COMMUNITIES WITHIN THE COUNTY. DUE TO DATA AVAILABILITY, THE HSA WAS EXAMINED TWO SEPARATE WAYS. ONE APPROACH WAS TO USE SOLANO COUNTY AS THE SERVICE AREA. WHILE THIS APPROACH WAS THE MOST NATURAL AND BEST REFLECTED THE FOCUS AREA OF COLLABORATI VE MEMBERS, IT DID NOT ALLOW FOR A CONSIDERATION OF VARIATION IN CONDITIONS ACROSS THE COU NTY. AN ALTERNATIVE APPROACH WAS ALSO USED IN WHICH THE SERVICE AREA WAS DEFINED BASED ON THE ZIP CODE TABULATION AREAS (ZCTAS), AS DEFINED BY THE US CENSUS BUREAU. IN THIS APPROAC H, ALL ZCTAS THAT HAD A MEANINGFUL OVERLAP WITH SOLANO COUNTY WERE INCLUDED IN THE ANALYSE S. THE BENEFIT OF THIS APPROACH WAS THAT IT ALLOWED FOR THE CALCULATION OF MORBIDITY AND M ORTALITY RATES BASED ON DATA AVAILABLE AT THE ZIP CODE LEVEL. THIS ALLOWED FOR A BETTER UN DERSTANDING OF HOW THESE CONDITIONS VARIED WITHIN THE COUNTY. THERE ARE THREE HOSPITALS TH AT SERVE THE COMMUNITY. THE HEALTH SERVICE AREA OF SOLANO COUNTY IS LOCATED IN NORTHERN CA LIFORNIA AND HAS APPROXIMATELY 417 THOUSAND RESIDENTS. AS TABLES 2 AND 3 (IN THE FULL REPO RT) SHOW, THE AREA IS CONSIDERABLY DIVERSE IN POPULATION, ECONOMIC STABILITY (INCOME AND P OVERTY), AND INSURANCE STATUS. TABLE 2 S</p>

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 5	<p>PROMOTION OF COMMUNITY HEALTH SUTTER HEALTH'S MISSION IS TO "ENHANCE THE WELL-BEING OF TH E PEOPLE IN THE COMMUNITIES WE SERVE, THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AN D EXCELLENCE IN HEALTH CARE SERVICES " SUTTER HEALTH'S MISSION REACHES BEYOND THE WALLS OF OUR HOSPITALS AND FACILITIES OUR AFFILIATES FURTHER THEIR TAX-EXEMPT PURPOSE BY - BUILD ING RELATIONSHIPS OF TRUST BY WORKING COLLABORATIVELY WITH COMMUNITY GROUPS, SCHOOLS AND G OVERNMENT ORGANIZATIONS TO EFFECTIVELY LEVERAGE RESOURCES AND ADDRESS IDENTIFIED COMMUNITY NEEDS, - SUPPORTING NONPROFIT ORGANIZATIONS THAT ARE COMMITTED TO COMMUNITY HEALTH IMPROV EMENT THROUGH FINANCIAL INVESTMENTS, IN-KIND SERVICES AND EMPLOYEE VOLUNTEERISM, AND - PRO VIDING GENEROUS CHARITY CARE POLICIES FOR OUR MOST VULNERABLE COMMUNITY MEMBERS SUTTER ME DICAL CENTER SACRAMENTO THE 2016 - 2018 IMPLEMENTATION STRATEGIES FOR SUTTER MEDICAL CENTE R SACRAMENTO (SMCS) DEFINE A VARIETY OF PROGRAMS AND PARTNERSHIPS THAT ADDRESS IDENTIFIED PRIORITY HEALTH NEEDS AND IMPROVE THE OVERALL HEALTH OF THE COMMUNITIES THEY SERVE A FEW OF THOSE PROGRAMS AND PARTNERSHIPS ARE DESCRIBED BELOW SMCS SUPPORTED THE EXPANSION OF PE ACH TREE HEALTH, A FEDERALLY QUALIFIED HEALTH CENTER (FQHC) THAT OPERATES SIX PRIMARY CARE CLINICS AND TWO MOBILE DENTAL CLINICS, WHICH SERVED OVER 25,000 UNIQUE AND ACTIVE PATIENT S THROUGH 85,000 VISITS IN MID 2016, WITH SMCS SUPPORT PEACH TREE NORTH SACRAMENTO OPENED ITS NEW 14,000 SQ FT SITE, AND IN 2017 SERVED 5,679 PATIENTS SACRAMENTO COVERED (SC), IS A COMMUNITY-BASED NON-PROFIT ORGANIZATION DEDICATED TO IMPROVING THE OVERALL HEALTH OF TH E REGION BY CONNECTING PEOPLE TO MEDICAL COVERAGE, PRIMARY AND PREVENTATIVE CARE, AND OTHE R NEEDED RESOURCES THE HEALTH NAVIGATION PROGRAMS GOAL IS TO ESTABLISH MEDICAL HOMES, THE REBY REDUCING DEPENDENCE ON EMERGENCY ROOM SYSTEMS OF CARE IN 2017, SACRAMENTO COVERED PR OVIDED A TOTAL OF 9,839 HEALTH NAVIGATION SERVICES TO 3,211 UNIQUE CLIENTS DURING THIS RE PORTING PERIOD, 4,163 ACCESS SERVICES WERE PROVIDED IN THE CLIENT'S PREFERRED LANGUAGE, TH E SERVICES ACCOUNTED FOR 42% OF THE TOTAL SERVICES PROVIDED SMCS PROVIDES SUPPORT TO THE SACRAMENTO BALLET FOR HOSPITAL VISITS AND TO FUND A COMMUNITY BASED PROGRAM IN 2017, THE BALLET WAS ABLE TO PROVIDE THREE ENTIRE SCHOOL COMMUNITIES WITH TWO ON-SITE SCHOOL ASSEMB LIES, A CALIFORNIA APPROVED VISUAL AND PERFORMING ARTS (VAPA) EDUCATION PACKET FOR TEACHER S TO INCORPORATE, UP TO 500 TICKETS PER SCHOOL AND FREE TRANSPORTATION TO AND FROM THE EVE NT WITH THE SUPPORT OF SUTTER HEALTH, IN 2016 SOIL BORN FARMS STARTED DEVELOPING AN INNOV ATIVE COMMUNITY DEVELOPMENT MODEL THAT WEAVES TOGETHER VITAL FOOD ACCESS, FOOD PRODUCTION AND FOOD EDUCATION ACTIVITIES DIRECTLY INTO THE HEART OF OUR URBAN NEIGHBORHOODS, RELYING ON A COLLABORATION AND LAYERING OF COMPLEMENTARY SERVICES THIS FOOD SYSTEM MODEL WILL LEA D TO LONG TERM MEASUREABLE IMPROVEMENTS IN PERSONAL AND COMMUNITY HEALTH IN 2017, 1,916 C HILDREN WERE SERVED AND A TOTAL OF 17,500 PEOPLE WERE REACHED BY COMMUNITY EVENTS AND OUTR EACH EFFORTS THE SAC DOWNTOWN PARTNERSHIP NAVIGATOR PROGRAM WAS THE FIRST OF ITS KIND WOR KING WITH THOSE THAT FIND THEMSELVES HOMELESS ON THE STREETS OF DOWNTOWN SACRAMENTO THE P ROGRAM IS DESIGNED TO ASSIST THOSE WITH THE MOST NEEDS IN NAVIGATING EXISTING SERVICES OF THE COUNTY AND REGION WITH A FOCUS ON HOUSING AS THE FINAL GOAL IN 2017, 1,304 PEOPLE WER E TOUCHED BY THIS PROGRAM WITH 25 CONNECTED TO MENTAL HEALTH SERVICES, 41 OBTAINED PERMANE NT HOUSING AND 45 PEOPLE ENROLLED IN INCOME ASSISTANCE PROGRAMS SMCS FUNDED DENTAL EMERGE NCY SERVICE EXPANSION TO INCREASE THE CAPACITY OF THE SACRAMENTO NATIVE AMERICAN HEALTH CE NTER DENTAL DEPARTMENT TO OFFER PREVENTATIVE TREATMENT AND REDUCE EMERGENCY DENTAL VISITS TO THE SUTTER ED IN 2017, 9,149 ADULTS AND 1,821 CHILDREN RECEIVED SERVICES WITH 1,051 EM ERGENCY PROCEDUREES PERFORMED AND 919 ER APPOINTMENTS THAT ENDED WITH EXTRACTION OF THE TO OTH THE COMMUNITY NAVIGATOR THROUGH SACRAMENTO STEPS UP ENGAGES INDIVIDUALS THAT FIND THE MSELVES EXPERIENCING HOMELESSNESS SEEKING SERVICES AND CONNECTS THEM TO RESOURCES THESE R ESOURCES RANGE FROM PRIMARY AND MENTAL HEALTH CARE, ASSISTANCE WITH HEALTH INSURANCE, SUBS TANCE ABUSE TREATMENT, AND ACQUIRING THE NECESSARY DOCUMENTATION FOR HOUSING, ALL AIMED TO WARDS THE GOAL OF ENDING THE CLIENTS CURRENT CYCLES OF HOMELESSNESS THE COMMUNITY NAVIGAT OR WORKS IN CONJUNCTION WITH THE SUTTER HOSPITAL DISCHARGE TEAM TO CONNECT WITH INDIVIDUAL S BEFORE AND AFTER DISCHARGE IN 2017, 141 CLIENTS WERE SERVICED THROUGH THIS PROGRAM WAY UP MEDZONE IS A PROGRAM WORKING TO BRING ECONOMIC DEVELOPMENT (COMPANIES AND JOBS), WORKFO RCE DEVELOPMENT, AND COMMUNITY DEVELOPMENT TO THE OAK PARK COMMUNITY IN 2017, SMCS CONDOC TED THREE IN-PERSON MEETINGS WITH 5-10 COMMUNITY LEADERS REPRESENTING THE NEIGHBORHOOD ASS OCIATIONS TO PROVIDE UPDATES TO THE MEDZONE PLANS AND GATHER THEIR INPUT THESE MEETINGS H AVE BEEN POSITIVE AS EXCITEMENT AROUND THE COMMUNI</p>

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 5	<p>TY BENEFITS AND IMPACT THIS PROJECT WILL HAVE ARE THOUGHTFULLY DEVELOPED OAK PARK SMART IS A PLACE-BASED NETWORK OF OAK PARK SCHOOLS AND OTHER EDUCATIONAL FACILITIES THAT PROMOTE THE POSITIVE ACHIEVEMENTS OF SCHOOLS IN THE COMMUNITY AND PROVIDE A SPRINGBOARD FOR COORDINATED EDUCATION-FOCUSED INITIATIVES OAK PARK SMART FOCUSES ON THE FOLLOWING STRATEGIES 1 ) DEVELOP A VIBRANT COLLABORATION BETWEEN PUBLIC, PUBLIC CHARTER, AND PRIVATE SCHOOLS IN OAK PARK TO SHARE PRACTICES, LEVERAGE RESOURCES, AND SUPPORT SUCCESS OF STUDENTS AND TEACHERS, 2) BOLSTER COMMUNITY PRIDE THROUGH A COORDINATED BRANDING STRATEGY, SUCH AS EASILY-IDENTIFIABLE BANNER-LINED STREETS, 3) ENGAGE STUDENTS THROUGH EXPERIENTIAL LEARNING OPPORTUNITIES, 4) LAUNCH EFFECTIVE, COMMUNITY-INCLUSIVE EDUCATIONAL INITIATIVES, AND 5) STRENGTHEN RELATIONSHIPS AMONG STAKEHOLDERS IN OAK PARK THROUGH COMMUNITY ENGAGEMENT IN 2017, 2800 CHILDREN WERE SERVED WEAVES VIOLENCE PREVENTION NAVIGATOR (VPN) PROGRAM FUNCTIONS IN ALIGNMENT WITH THE CONTINUUM OF CARE SYSTEM AND BETTER INTEGRATES WITH LAW ENFORCEMENT AND THE MEDICAL COMMUNITY TO PROVIDE SPECIALIZED RESPONSE SERVICES TO VICTIMS OF DOMESTIC VIOLENCE , EDUCATE OTHER COMMUNITY SERVICE PROVIDERS, AND WORK WITH WEAVE LEADERSHIP TO IDENTIFY AND IMPLEMENT INTERNAL POLICY CHANGES TO BETTER ALIGN WEAVES RESPONSE MODEL WITH EXISTING COMMUNITY EFFORTS IN 2017, VPN SERVED 60 UNIQUE INDIVIDUALS THE INCREASE IN CLIENTS SERVED CAN BE ATTRIBUTED TO THE CONSISTENT OUTREACH THE VPN HAS BEEN DOING OVER THE YEAR WITH HOSPITAL STAFF AND THE COMMUNITY WELLSPACE HEALTH ED NAVIGATION PROGRAM CONNECTS PATIENTS WITH HEALTH AND SOCIAL SERVICES, AND ULTIMATELY A MEDICAL HOME, AS WELL AS OTHER PROGRAMS ( LIKE T3) WHEN APPROPRIATE IN 2017, THE PROGRAM WORKED WITH 578 PATIENTS PROVIDING 12,912 REFERRALS TO A VARIETY OF SOCIAL SERVICES WELLSPACE HEALTHS SUICIDE PREVENTION ED FOLLOW UP (EDFUSP) PROGRAM IS DESIGNED TO PREVENT SUICIDE DURING A HIGH RISK PERIOD, MONITOR FOR ONGOING SUICIDALITY POST-DISCHARGE, PROVIDE EMOTIONAL SUPPORT AND CONTINUING EVIDENCE-BASED RISK ASSESSMENT AND MONITORING FOR SUICIDALITY, CREATE PERSONALIZED SAFE PLANS, PROVIDE EDUCATIONAL AND SENSITIVE OUTREACH MATERIALS ABOUT SURVIVING A SUICIDE ATTEMPT AND RECOVERY, 24HR ACCESS TO WELLSPACE HEALTHS SUICIDE PREVENTION CRISIS LINES, AND REFERRALS OFFERED TO COMMUNITY-BASED RESOURCES FOR ONGOING TREATMENT AND SUPPORT IN 2017, 27 PATIENT REFERRALS WERE RECEIVED FROM SUTTER DURING THE REPORTING PERIOD, A CONSIDERABLE DECREASE IN REFERRAL RATES OF THESE, 20 WERE REFERRED POST DISCHARGE, 7 AFTER A SUICIDE ATTEMPT A TOTAL OF 176 CONTACTS WERE MADE WITH THESE PATIENTS THE GROUP WAS DIVERSE ETHNICALLY, 5 AFRICAN AMERICAN, 12 CAUCASIAN, 4 HISPANIC, 2 MULTIRACIAL, 1 NATIVE AMERICAN AND 2 UNDISCLOSED IN PARTNERSHIP WITH WELLSPACE HEALTH, THE INTERIM CARE PROGRAM (ICP) IS A SHORT TERM LAY-IN RESPITE SHELTER HOUSED AT VOLUNTEERS OF AMERICA SERVICING CLIENTS THAT ARE EXPERIENCING HOMELESSNESS POST HOSPITALIZATION CLIENTS HAVE ACCESS TO FOOD, SHELTER AND A CLEAN ENVIRONMENT FOR UP TO FOUR WEEKS WHILE RECUPERATING THE ICP OFFERS INTENSIVE CASE MANAGEMENT SERVICES THAT INCLUDE TRANSPORTATION TO APPOINTMENTS, ASSISTANCE WITH SECURING IDENTIFICATION, GOVERNMENTAL ASSISTANCE, SOCIAL SECURITY CARD AND REFERRALS TO OTHER SUPPORTIVE SERVICES THE ON-SITE REGISTERED NURSE OFFERS EDUCATION RELATED TO MEDICATION, DISEASE PROCESS AND POST HOSPITAL CARE WHILE ASSISTING CLIENTS WHO MAY HAVE DIFFICULTY NAVIGATING THE HEALTH CARE SYSTEM IN 2017, THE ICP HAS MAINTAINED HIGH BED UTILIZATION WITH LACK OF AVAILABILITY ESPECIALLY FOR MALE BEDS DURING TIMES OF INCLEMENT WEATHER, HOLIDAYS AND TIMES OF HIGH HOSPITAL CENSUS ICP SERVED 181 NEW CLIENTS IN 2017 PROVIDING 5,740 SOCIAL SERVICE REFERRALS THE INTERIM CARE PROGRAM PLUS EXPANSION (ICP+) IS A SHORT TERM SIXTY TO NINETY DAY LAY -IN RESPITE SHELTER HOUSED AT THE SALVATION ARMY SERVICING CLIENTS THAT ARE EXPERIENCING HOMELESSNESS POST HOSPITALIZATION CLIENT</p>



# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 6</p>	<p>AFFILIATED HEALTH CARE SYSTEM THE ORGANIZATION IS AFFILIATED WITH SUTTER HEALTH, A NOT-FOR-PROFIT NETWORK OF HOSPITALS, PHYSICIANS, EMPLOYEES AND VOLUNTEERS WHO CARE FOR MORE THAN 100 NORTHERN CALIFORNIA TOWNS AND CITIES TOGETHER, WERE CREATING A MORE INTEGRATED, SEAMLESS AND AFFORDABLE APPROACH TO CARING FOR PATIENTS THE HOSPITALS MISSION IS TO ENHANCE THE WELL-BEING OF PEOPLE IN THE COMMUNITIES WHERE WE SERVE THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTHCARE SERVICES AT SUTTER HEALTH, WE BELIEVE THERE SHOULD BE NO BARRIERS TO RECEIVING TOP-QUALITY MEDICAL CARE WE STRIVE TO PROVIDE ACCESS TO EXCELLENT HEALTHCARE SERVICES FOR NORTHERN CALIFORNIANS, REGARDLESS OF ABILITY TO PAY AS PART OF OUR NOT-FOR-PROFIT MISSION, SUTTER HEALTH INVESTS MILLIONS OF DOLLARS BACK INTO THE COMMUNITIES WE SERVE AND BEYOND THROUGH THESE INVESTMENTS AND COMMUNITY PARTNERSHIPS, WERE PROVIDING AND PRESERVING VITAL PROGRAMS AND SERVICES, THEREBY IMPROVING THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE SERVE OVER THE PAST FIVE YEARS, SUTTER HEALTH HAS COMMITTED MORE THAN \$4 BILLION TO CARE FOR PATIENTS WHO COULDN'T AFFORD TO PAY, AND TO SUPPORT PROGRAMS THAT IMPROVE COMMUNITY HEALTH OUR 2017 COMMITMENT OF \$612 MILLION INCLUDES UNREIMBURSED COSTS OF PROVIDING CARE TO MEDI-CAL PATIENTS, TRADITIONAL CHARITY CARE AND INVESTMENTS IN HEALTH EDUCATION AND PUBLIC BENEFIT PROGRAMS FOR EXAMPLE - IN 2017, SUTTER HEALTH INVESTED \$334 MILLION MORE THAN THE STATE PAID TO CARE FOR MEDI-CAL PATIENTS MEDI-CAL ACCOUNTED FOR 19 PERCENT OF SUTTER HEALTH'S GROSS PATIENT SERVICE REVENUES IN 2017 - THROUGHOUT OUR HEALTHCARE SYSTEM, WE PARTNER WITH AND SUPPORT COMMUNITY HEALTH CENTERS TO ENSURE THAT THOSE IN NEED HAVE ACCESS TO PRIMARY AND SPECIALTY CARE WE ALSO SUPPORT CHILDRENS HEALTH CENTERS, FOOD BANKS, YOUTH EDUCATION, JOB TRAINING PROGRAMS AND SERVICES THAT PROVIDE COUNSELING TO DOMESTIC VIOLENCE VICTIMS EVERY THREE YEARS, SUTTER HEALTH HOSPITALS PARTICIPATE IN A COMPREHENSIVE AND COLLABORATIVE COMMUNITY HEALTH NEEDS ASSESSMENT, WHICH IDENTIFIES LOCAL HEALTH CARE PRIORITIES AND GUIDES OUR COMMUNITY BENEFIT STRATEGIES THE ASSESSMENTS HELP ENSURE THAT WE INVEST OUR COMMUNITY BENEFIT DOLLARS IN A WAY THAT TARGETS AND ADDRESS REAL COMMUNITY NEEDS FOR MORE FACTS AND INFORMATION VISIT <a href="http://WWW.SUTTERHEALTH.ORG">WWW.SUTTERHEALTH.ORG</a></p>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT CALIFORNIA

Schedule H (Form 990) 2017

Additional Data

Software ID:  
Software Version:  
EIN: 94-1156621  
Name: SUTTER VALLEY HOSPITALS

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? <b>12</b>		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	OSE ADAMS MEDICAL PAVILION 2825 CAPITOL AVENUE SACRAMENTO, CA 95816 WWW.SUTTERMEDICALCENTER.ORG LICENSE #030000102	X	X					X			B
2	SUTTER MED CTR SAC WOMEN & CHILDRENS 2825 CAPITOL AVENUE SACRAMENTO, CA 95816 WWW.SUTTERMEDICALCENTER.ORG LICENSE #030000102	X	X					X			B
3	MEMORIAL MEDICAL CENTER 1700 COFFEE ROAD MODESTO, CA 95355 WWW.MEMORIALMEDICALCENTER.ORG LICENSE #030000061	X	X					X			
4	SUTTER ROSEVILLE MEDICAL CENTER ONE MEDICAL PLAZA ROSEVILLE, CA 956613037 WWW.SUTTERROSEVILLE.ORG LICENSE #030000083	X	X					X			A
5	SUTTER SOLANO MEDICAL CENTER 300 HOSPITAL DRIVE VALLEJO, CA 945892574 WWW.SUTTERSOLANO.ORG LICENSE #110000082	X	X					X			A

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

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>12</b>		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
6	SUTTER TRACY COMMUNITY HOSPITAL 1420 N TRACY BLVD TRACY, CA 95376 WWW.SUTTERTRACY.ORG LICENSE #030000105	X	X					X			
7	SUTTER CENTER FOR PSYCHIATRY 7700 FOLSOM STREET SACRAMENTO, CA 958262608 www.suttermedicalcenter.org/psychiatry LICENSE #030000347	X									B
8	SUTTER AUBURN FAITH HOSPITAL 11815 EDUCATION STREET AUBURN, CA 956022410 WWW.SUTTERAUBURNFAITH.ORG LICENSE #030000012	X	X					X			A
9	SUTTER AMADOR HOSPITAL 200 MISSION BLVD JACKSON, CA 956422564 WWW.SUTTERAMADOR.ORG LICENSE #030000008	X	X					X			A
10	SUTTER DAVIS HOSPITAL 2000 SUTTER PLACE DAVIS, CA 956166201 WWW.SUTTERDAVIS.ORG LICENSE #030000124	X	X					X			A

## 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?**

12

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

**Other (Describe)**

## Facility reporting group

11	MEMORIAL HOSPITAL LOS BANOS 520 West I Street Los Banos, CA 936353419 WWW MEMORIALLOSBANOS ORG LICENSE #040000177	X	X					X			
12	STANISLAUS SURGICAL HOSPITAL 1421 OAKDALE ROAD MODESTO, CA 953553356 WWW STANISLAUSSURGICAL COM LICENSE #030000695	X	X								

**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
REPORTING FACILITY A	<p>SCHEDULE H, PART V, SECTION B, LINE 3E SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA REPORTING FACILITY A SCHEDULE H, PART V, SECTION B, LINE 5 SUTTER ROSEVILLE MEDICAL CENTER (A, 4) IN CONDUCTING ITS MOST RECENT CHNA, SUTTER ROSEVILLE MEDICAL CENTER, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT AND PRIMARY DATA ON HEALTH NEEDS WERE OBTAINED VIA INTERVIEWS WITH SERVICE PROVIDERS AND COMMUNITY KEY INFORMANTS AND THROUGH FOCUS GROUPS WITH MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS TRANSCRIPTS AND NOTES FROM INTERVIEWS AND FOCUS GROUPS WERE ANALYZED TO LOOK FOR THEMES AND TO DETERMINE IF A HEALTH NEED WAS IDENTIFIED AS SIGNIFICANT AND/OR A PRIORITY TO ADDRESS PRIMARY DATA FOR SRMC/SAFH INCLUDED 38 KEY INFORMANT INTERVIEWS WITH 58 PARTICIPANTS AND 11 FOCUS GROUPS CONDUCTED WITH 88 PARTICIPANTS INCLUDING COMMUNITY MEMBERS AND SERVICE PROVIDERS A COMPLETE LIST OF KEY INFORMANT INTERVIEW DATA SOURCES IS AVAILABLE IN APPENDIX F AND A COMPLETE LIST OF FOCUS GROUP DATA IS AVAILABLE IN APPENDIX G OF THE CHNA THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN SUTTER ROSEVILLE MEDICAL CENTER'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment-sutter-solano-medical-center">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT SUTTER SOLANO MEDICAL CENTER (A, 5)</a> IN CONDUCTING ITS MOST RECENT CHNA, SUTTER SOLANO MEDICAL CENTER, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT AND PRIMARY DATA ON HEALTH NEEDS WERE OBTAINED VIA INTERVIEWS WITH SERVICE PROVIDERS AND COMMUNITY KEY INFORMANTS AND THROUGH FOCUS GROUPS WITH MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS IN TOTAL, PRIMARY DATA FOR THE CHNA INCLUDED 11 KEY INFORMANT INTERVIEWS WITH 24 PARTICIPANTS AND 6 FOCUS GROUPS CONDUCTED WITH 67 COMMUNITY MEMBER PARTICIPANTS THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN SUTTER SOLANO MEDICAL CENTER'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment-sutter-auburn-faith-hospital">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT SUTTER AUBURN FAITH HOSPITAL (A, 8)</a> IN CONDUCTING ITS MOST RECENT SUTTER AUBURN FAITH HOSPITAL, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT AND PRIMARY DATA ON HEALTH NEEDS WERE OBTAINED VIA INTERVIEWS WITH SERVICE PROVIDERS AND COMMUNITY KEY INFORMANTS AND THROUGH FOCUS GROUPS WITH MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS TRANSCRIPTS AND NOTES FROM INTERVIEWS</p>

**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
REPORTING FACILITY A	<p>AND FOCUS GROUPS WERE ANALYZED TO LOOK FOR THEMES AND TO DETERMINE IF A HEALTH NEED WAS IDENTIFIED AS SIGNIFICANT AND/OR A PRIORITY TO ADDRESS PRIMARY DATA FOR SRMC/SAFH INCLUDED 38 KEY INFORMANT INTERVIEWS WITH 58 PARTICIPANTS AND 11 FOCUS GROUPS CONDUCTED WITH 88 PARTICIPANTS INCLUDING COMMUNITY MEMBERS AND SERVICE PROVIDERS A COMPLETE LIST OF KEY INFORMANT INTERVIEW DATA SOURCES IS AVAILABLE IN APPENDIX F AND A COMPLETE LIST OF FOCUS GROUP DATA IS AVAILABLE IN APPENDIX G OF THE CHNA THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN SUTTER AUBURN FAITH HOSPITAL'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a> SUTTER AMADOR HOSPITAL (A, 9) IN CONDUCTING ITS MOST RECENT CHNA, SUTTER AMADOR HOSPITAL, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) INPUT FROM THE COMMUNITY WAS COLLECTED THROUGH TWO MAIN MECHANISMS KEY INFORMANT INTERVIEWS WITH COMMUNITY HEALTH EXPERTS AND SERVICE PROVIDERS AND FOCUS GROUP DISCUSSIONS WITH COMMUNITY MEMBERS INSTRUMENTS USED IN PRIMARY DATA COLLECTION INCLUDED A PARTICIPANT INFORMED CONSENT, AN INTERVIEW QUESTION GUIDE, A PROJECT SUMMARY SHEET, AND A REFLECTION SHEET ALL PARTICIPANTS WERE GIVEN AN INFORMED CONSENT FORM PRIOR TO THEIR PARTICIPATION, WHICH PROVIDED INFORMATION ABOUT THE PROJECT, ASKED FOR PERMISSION TO RECORD THE INTERVIEW, AND LISTED THE POTENTIAL BENEFITS AND RISKS FOR INVOLVEMENT IN THE INTERVIEW (APPENDIX C) THE INTERVIEW QUESTION GUIDE WAS USED FOR BOTH THE KEY INFORMANT AND FOCUS GROUP INTERVIEWS THE PROJECT SUMMARY SHEET (APPENDIX E) WAS GIVEN TO PARTICIPANTS TO PROVIDE THEM WITH INFORMATION ABOUT THE PROJECT AS WELL AS CONTACT INFORMATION FOR THE CHNA STAFF AFTER THE INTERVIEW OR FOCUS GROUP WAS CONDUCTED THE FACILITATOR CAPTURED THE MAIN FINDINGS IN A REFLECTION SHEET KEY INFORMANT INTERVIEWS WERE CONDUCTED WITH AREA SERVICE PROVIDERS AND EXPERTS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY WHO WERE FAMILIAR WITH THE POPULATIONS IN THE HSA PRIMARY DATA COLLECTION BEGAN BY INTERVIEWING AREA-WIDE SERVICE PROVIDERS WITH KNOWLEDGE OF THE SAH HSA, INCLUDING INPUT FROM THE AMADOR COUNTY PUBLIC HEALTH DEPARTMENT AND THE CALAVERAS COUNTY PUBLIC HEALTH DEPARTMENT FINDINGS FROM THE AREA-WIDE INFORMANTS WERE COMBINED WITH QUANTITATIVE DATA SHOWING LOCATIONS OF POPULATIONS EXPERIENCING DISPARITIES, TO IDENTIFY AND INTERVIEW KEY INFORMANTS WITH KNOWLEDGE ABOUT THESE SPECIFIC POPULATIONS AND LOCATIONS THESE TARGETED PRIMARY DATA SOURCES WERE SELECTED BASED ON THEIR KNOWLEDGE OF THE NEEDS OF PARTICULAR GEOGRAPHIC LOCATIONS AND/OR SUBGROUPS EXPERIENCING DISPARITIES A TOTAL OF 7 KEY INFORMANT INTERVIEWS WERE DONE WITH 33 SERVICE PROVIDERS WHICH ARE LISTED ON APPENDIX F THE KEY INFORMANT INTERVIEWS WERE USED TO IDENTIFY ADDITIONAL KEY SERVICE PROVIDERS TO INCLUDE IN THE ASSESSMENT, AS WELL AS IDENTIFY SPECI</p>



**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
REPORTING FACILITY A	<p>FIC POPULATIONS THAT SHOULD BE INCLUDED IN THE FOCUS GROUP INTERVIEWS FOCUS GROUP INTERVIEWS WERE CONDUCTED WITH COMMUNITY MEMBERS LIVING IN GEOGRAPHIC AREAS OF THE HSA IDENTIFIED AS LOCATIONS WHERE RESIDENTS EXPERIENCE AN OVERWHELMING AMOUNT OF POOR SOCIOECONOMIC CONDITIONS AND POOR HEALTH OUTCOMES RECRUITMENT CONSISTED OF REFERRALS FROM DESIGNATED SERVICE PROVIDERS REPRESENTING VULNERABLE POPULATIONS IN THE SAH HSA, AS WELL AS DIRECT OUTREACH FROM COMMUNITY HEALTH INSIGHT (CHI) TO ACQUIRE INPUT FOR A SPECIAL POPULATION GROUP A TOTAL OF THREE FOCUS GROUP DISCUSSIONS WERE CONDUCTED WITH A TOTAL OF 24 COMMUNITY MEMBERS AND ARE LISTED IN APPENDIX G THE FINDINGS FROM KEY INFORMANT INTERVIEWS IN SUTTER AMADOR HOSPITAL'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH -NEEDS-ASSESSMENT</a> SUTTER DAVIS HOSPITAL (A, 10) IN CONDUCTING ITS MOST RECENT CHNA, SUTTER DAVIS HOSPITAL, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT AND PRIMARY DATA ON HEALTH NEEDS WERE OBTAINED VIA INTERVIEWS WITH SERVICE PROVIDERS AND COMMUNITY KEY INFORMANTS AND THROUGH FOCUS GROUPS WITH MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS TRANSCRIPTS AND NOTES FROM INTERVIEWS AND FOCUS GROUPS WERE ANALYZED TO LOOK FOR THEMES AND TO DETERMINE IF A HEALTH NEED WAS IDENTIFIED AS SIGNIFICANT AND/OR A PRIORITY TO ADDRESS PRIMARY DATA FOR SUTTER DAVIS INCLUDED 16 KEY INFORMANT INTERVIEWS WITH 20 PARTICIPANTS AND SIX FOCUS GROUPS CONDUCTED WITH 69 PARTICIPANTS INCLUDING COMMUNITY MEMBERS AND SERVICE PROVIDERS A COMPLETE LIST OF KEY INFORMANT INTERVIEW DATA SOURCES IS AVAILABLE IN APPENDIX F AND A COMPLETE LIST OF FOCUS GROUP DATA IS AVAILABLE IN APPENDIX F OF THE CHNA THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN SUTTER DAVIS HOSPITAL'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a></p>

**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
SCHEDULE H, PART V, SECTION B, LINE 6A	SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) A COLLECTION OF FOUR NONPROFIT HOSPITAL SYSTEMS, ALL SERVING PORTIONS OF OR THE SAME COMMUNITIES, COLLABORATED TO SPONSOR AND PARTICIPATE IN THE CHNA INCLUDING SUTTER HEALTH, DIGNITY HEALTH, KAISER PERMANENTE AND UC DAVIS HEALTH SYSTEM

**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
SCHEDULE H, PART V, SECTION B, LINES 7A, 7B AND 10A	FILING ORG WEBSITES - SUTTER ROSEVILLE MEDICAL CENTER (A, 4) HTTP //WWW SUTTERROSEVILLE ORG/ABOUT/COMMUNITY-NEEDS-ASSESSMENT HTML - SUTTER SOLANO MEDICAL CENTER (A, 5) HTTP //WWW SUTTERSOLANO ORG/ABOUT/COMMUNITY-NEEDS-ASSESSMENT HTML - SUTTER AUBURN FAITH HOSPITAL (A, 8) HTTP //WWW SUTTERAUBURNFAITH ORG/ABOUT/COMMUNITY-NEEDS- ASSESSMENT HTML - SUTTER AMADOR HOSPITAL (A, 9) HTTP //WWW SUTTERAMADOR ORG/ABOUT/COMMUNITY- NEEDS-ASSESSMENT HTML - SUTTER DAVIS HOSPITAL (A, 10) HTTP //WWW SUTTERDAVIS ORG/ABOUT/COMMUNITY-NEEDS-ASSESSMENT HTML OTHER WEBSITE HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T

**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
SCHEDULE H, PART V, SECTION B, LINE 11	<p>SUTTER ROSEVILLE MEDICAL CENTER (A, 4) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER ROSEVILLE MEDICAL CENTER INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO BEHAVIORAL HEALTH SERVICES 2 ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES 3 ACTIVE LIVING AND HEALTHY EATING 4 BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION) 5 AFFORDABLE AND ACCESSIBLE TRANSPORTATION DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SRMC IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 DISEASE PREVENTION, MANAGEMENT AND TREATMENT WHILE MANY OF OUR PROGRAMS EXPAND ACCESS TO PRIMARY CARE, IN TURN, CONNECTING PATIENTS WITH DISEASE PREVENTION, MANAGEMENT AND TREATMENT RESOURCES, THIS IS NOT A PRIMARY FOCUS IN THE SRMC/SAFH HSA, HOWEVER, WE'RE IN THE PROCESS OF DEVELOPING COMMUNITY DIABETES EDUCATION COURSES 2 SAFE, CRIME AND VIOLENCE FREE COMMUNITIES THIS IS PRIMARILY A LAW ENFORCEMENT ISSUE AND NOT SOMETHING THAT SRMC HAS THE EXPERTISE TO EFFECTIVELY ADDRESS 3 POLLUTION-FREE LIVING AND WORK ENVIRONMENTS WHILE THIS IS AN IMPORTANT ISSUE, THIS IS NOT SOMETHING THAT WE ARE ABLE TO GREATLY AFFECT THROUGH COMMUNITY BENEFIT, THEREFORE, WE ARE FOCUSING OUR RESOURCES ELSEWHERE, ESPECIALLY GIVEN THAT REGIONAL COMMUNITY PARTNERS LIKE SAC OG, THE CLEANER AIR PARTNERSHIP AND OTHERS, ARE WORKING ON THESE VITAL ISSUES</p> <p>SUTTER SOLANO MEDICAL CENTER (A, 5) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER SOLANO MEDICAL CENTER INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO BEHAVIORAL HEALTH SERVICES 2 DISEASE PREVENTION, MANAGEMENT AND TREATMENT 3 AFFORDABLE AND ACCESSIBLE TRANSPORTATION 4 ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SUTTER SOLANO MEDICAL CENTER IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 HEALTHY EATING AND ACTIVE LIVING WHILE THERE ARE CURRENTLY NO HEALTHY EATING OR ACTIVE LIVING SSMC COMMUNITY BENEFIT PRO</p>

**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
SCHEDULE H, PART V, SECTION B, LINE 11	GRAMS IN THE SSMC HSA, WE DO FUND PROGRAMS/ORGANIZATIONS AND EFFORTS THAT ADDRESS THIS NEED THROUGH OUR SPONSORSHIP PROGRAM 2 SAFE, CRIME AND VIOLENCE FREE COMMUNITIES THIS IS PRIMARILY A LAW ENFORCEMENT ISSUE AND NOT SOMETHING THAT SSMC HAS THE EXPERTISE TO EFFECTIVELY ADDRESS 3 BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION) WHILE MANY OF OUR PROGRAMS SEEK TO CONNECT PATIENTS TO BASIC NEEDS LIKE HOUSING, INCOME AND FOOD RESOURCES, THIS PRIORITY NEED IS NOT A MAIN FOCUS AT SSMC AT THIS TIME 4 POLLUTION-FREE LIVING AND WORK ENVIRONMENTS WHILE THIS IS AN IMPORTANT ISSUE, THIS IS NOT SOMETHING THAT WE ARE ABLE TO GREATLY AFFECT THROUGH COMMUNITY BENEFIT, THEREFORE, WE ARE FOCUSING OUR RESOURCES ELSEWHERE, ESPECIALLY GIVEN THAT REGIONAL COMMUNITY PARTNERS AND LOCAL JURISDICTIONS ARE WORKING ON THESE VITAL ISSUES SUTTER AUBURN FAITH HOSPITAL (A, 8) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER AUBURN FAITH HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO BEHAVIORAL HEALTH SERVICES 2 ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES 3 ACTIVE LIVING AND HEALTHY EATING 4 BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION) 5 AFFORDABLE AND ACCESSIBLE TRANSPORTATION DESCRIPTIONS OF THE HEALTH COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SAFH IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 DISEASE PREVENTION, MANAGEMENT AND TREATMENT WHILE MANY OF OUR PROGRAMS EXPAND ACCESS TO PRIMARY CARE, IN TURN, CONNECTING PATIENTS WITH DISEASE PREVENTION, MANAGEMENT AND TREATMENT RESOURCES, THIS IS NOT A PRIMARY FOCUS IN THE SRMC/SAFH HSA, HOWEVER, WE'RE IN THE PROCESS OF DEVELOPING COMMUNITY DIABETES EDUCATION COURSES 2 SAFE, CRIME AND VIOLENCE FREE COMMUNITIES THIS IS PRIMARILY A LAW ENFORCEMENT ISSUE AND NOT SOMETHING THAT SAFH HAS THE EXPERTISE TO EFFECTIVELY ADDRESS 3 POLLUTION-FREE LIVING AND WORK ENVIRONMENTS WHILE THIS IS AN IMPORTANT ISSUE, THIS IS NOT SOMETHING THAT WE ARE ABLE TO GREATLY AFFECT THROUGH COMMUNITY BENEFIT, THEREFORE, WE ARE FOCUSING OUR RESOURCES ELSEWHERE, ESPECIALLY GIVEN THAT REGIONAL COMMUNITY PARTNERS LIKE SACOG, THE CLEANER AIR PARTNERSHIP AND OTHERS, ARE WORKING ON THESE VITAL ISSUES SUTTER AMADOR HOSPITAL (A, 9) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER AMADOR HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO MENTAL, BEHAVIORAL AND SUBSTANCE A

**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
SCHEDULE H, PART V, SECTION B, LINE 11	<p>BUSE SERVICES 2 ACCESS TO QUALITY PRIMARY CARE SERVICES AND PRESCRIPTIONS 3 ACCESS TO TRANSPORTATION AND MOBILITY DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SAH IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 ACCESS TO BASIC NEEDS THIS IS A CRITICAL ISSUE AND SOMETHING SAH HOPES TO ADDRESS IN THE FUTURE, HOWEVER, THE CURRENT FOCUS IS DEVELOPING A COMMUNITY HEALTH CENTER IN AMADOR COUNTY 2 ACCESS TO SPECIALTY CARE THIS IS A CRITICAL ISSUE AND SOMETHING SAH HOPES TO ADDRESS IN THE FUTURE, HOWEVER, THE CURRENT FOCUS IS DEVELOPING A COMMUNITY HEALTH CENTER IN AMADOR COUNTY 3 ACCESS TO HEALTH EDUCATION AND HEALTH LITERACY THIS IS AN IMPORTANT ISSUE AND ONE WE'RE ABLE TO ADDRESS THROUGH OUR COMMUNITY SPONSORSHIP PROGRAM, BY FUNDING EFFORTS LIKE THE ARC OF AMADOR AND CALAVERAS HEALTHY LIFESTYLE PROGRAM, THE AMADOR COUNTY RECREATION AGENCY AND THE SAH COMMUNITY WALKING TRAIL 4 ACCESS TO AFFORDABLE, HEALTHY FOOD THIS IS AN IMPORTANT ISSUE AND ONE WE'RE ABLE TO ADDRESS THROUGH OUR COMMUNITY SPONSORSHIP PROGRAM, BY FUNDING ORGANIZATIONS LIKE THE LOCAL FOOD BANK 5 ACCESS TO DENTAL CARE AND PREVENTION THIS IS A CRITICAL ISSUE AND SOMETHING SAH HOPES TO ADDRESS IN THE FUTURE, HOWEVER, THE CURRENT FOCUS IS DEVELOPING A COMMUNITY HEALTH CENTER IN AMADOR COUNTY, WITH THE POSSIBILITY OF PROVIDING DENTAL SERVICES IN THE YEARS TO COME 6 SAFE AND VIOLENCE FREE ENVIRONMENT THIS IS PRIMARILY A LAW ENFORCEMENT ISSUE AND NOT SOMETHING THAT SAH HAS THE EXPERTISE TO EFFECTIVELY ADDRESS 7 POLLUTION FREE LIVING WHILE THIS IS AN IMPORTANT ISSUE, THIS IS NOT SOMETHING THAT WE ARE ABLE TO GREATLY AFFECT THROUGH COMMUNITY BENEFIT, THEREFORE, WE ARE FOCUSING OUR RESOURCES ELSEWHERE SUTTER DAVIS HOSPITAL (A, 10) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER DAVIS HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACTIVE LIVING AND HEALTHY EATING 2 ACCESS TO BEHAVIORAL HEALTH SERVICES 3 ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES 4 BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION) DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SUTTER DAVIS HOSPITAL IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS</p>

**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
SCHEDULE H, PART V, SECTION B, LINE 15E	SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE-OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE SCHEDULE H, PART V, LINES 16A, 16B, & 16C SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE SUTTER VALLEY HOSPITALS WEBSITE AT <a href="https://www.sutterhealth.org/for-patients/financial-assistance">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/FINANCIAL-ASSISTANCE</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 16j	SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ON AN ANNUAL BASIS SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE SCHEDULE H, PART V, SECTION B, LINE 22D SUTTER ROSEVILLE MEDICAL CENTER, SUTTER SOLANO MEDICAL CENTER, SUTTER AUBURN FAITH HOSPITAL, SUTTER AMADOR HOSPITAL, SUTTER DAVIS HOSPITAL (GROUP A, 4-5, 8-10) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1 501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT



**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
REPORTING FACILITY B	<p>SCHEDULE H, PART V, SECTION B, LINE 3E OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 &amp; 7) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 &amp; 7) SUTTER MEDICAL CENTER SACRAMENTO INCLUDES THE FOLLOWING FACILITIES LISTED IN PART V SECTION A OSE MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), AND SUTTER CENTER FOR PSYCHIATRY IN CONDUCTING ITS MOST RECENT CHNA, SUTTER MEDICAL CENTER SACRAMENTO, A FACILITY OF SUTTER VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT AND PRIMARY DATA ON HEALTH NEEDS WERE OBTAINED VIA INTERVIEWS WITH SERVICE PROVIDERS AND COMMUNITY KEY INFORMANTS AND THROUGH FOCUS GROUPS WITH MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS TRANSCRIPTS AND NOTES FROM INTERVIEWS AND FOCUS GROUPS WERE ANALYZED TO LOOK FOR THEMES AND TO DETERMINE IF A HEALTH NEED WAS IDENTIFIED AS SIGNIFICANT AND/OR A PRIORITY TO ADDRESS PRIMARY DATA FOR SMCS &amp; SCP INCLUDED 45 KEY INFORMANT INTERVIEWS WITH 56 PARTICIPANTS AND 20 FOCUS GROUPS CONDUCTED WITH 228 PARTICIPANTS INCLUDING COMMUNITY MEMBERS AND SERVICE PROVIDERS A COMPLETE LIST OF KEY INFORMANT INTERVIEW DATA SOURCES IS AVAILABLE IN APPENDIX E AND A COMPLETE LIST OF FOCUS GROUP DATA IS AVAILABLE IN APPENDIX F OF THE CHNA THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN SUTTER MEDICAL CENTER'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T</a></p>

**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
SCHEDULE H, PART V, SECTION B, LINE 6A	OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) A COLLECTION OF FOUR NONPROFIT HOSPITAL SYSTEMS, ALL SERVING PORTIONS OF OR THE SAME COMMUNITIES, COLLABORATED TO SPONSOR AND PARTICIPATE IN THE CHNA INCLUDING SUTTER HEALTH, DIGNITY HEALTH, KAISER PERMANENTE AND UC DAVIS HEALTH SYSTEM SCHEDULE H, PART V, SECTION B, LINES 7A, 7B, 10A OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) FILING ORG WEBSITES - SUTTER MEDICAL CENTER SACRAMENTO <a href="http://www.suttermedicalcenter.org/about/community-needs-assessment.html">HTTP //WWW SUTTERMEDICALCENTER ORG/ABOUT/COMMUNITY-NEEDS-ASSESSMENT HTML</a> OTHER WEBSITE <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 11	OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER MEDICAL CENTER, SACRAMENTO INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO BEHAVIORAL HEALTH SERVICES 2 ACTIVE LIVING AND HEALTHY EATING 3 ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES 4 BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION) DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SUTTER MEDICAL CENTER, SACRAMENTO IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE IMPLEMENTATION STRATEGY DOES NOT INCLUDE SPECIFIC PLANS TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 DISEASE PREVENTION, MANAGEMENT AND TREATMENT WHILE MANY OF OUR PROGRAMS EXPAND ACCESS TO PRIMARY CARE, IN TURN, CONNECTING PATIENTS WITH DISEASE PREVENTION, MANAGEMENT AND TREATMENT RESOURCES, THIS IS NOT A PRIMARY FOCUS IN THE SMCS HSA 2 AFFORDABLE AND ACCESSIBLE TRANSPORTATION WE ARE CONTINUOUSLY LOOKING FOR OPPORTUNITIES TO PROVIDE COLLABORATIVE TRANSPORTATION OPTIONS TO THE UNDERSERVED COMMUNITIES, HOWEVER, WE HAVE NOT YET FOUND THE PERFECT FIT IN SACRAMENTO COUNTY ALTHOUGH WE DON'T HAVE CURRENT PLANS TO ADDRESS TRANSPORTATION, THERE IS ALWAYS A CHANCE THAT ONE MAY DEVELOP IN THE YEARS AHEAD 3 POLLUTION-FREE LIVING AND WORK ENVIRONMENTS WHILE THIS IS AN IMPORTANT ISSUE, THIS IS NOT SOMETHING THAT WE ARE ABLE TO GREATLY AFFECT THROUGH COMMUNITY BENEFIT, THEREFORE, WE ARE FOCUSING OUR RESOURCES ELSEWHERE, ESPECIALLY GIVEN THAT REGIONAL COMMUNITY PARTNERS LIKE SACOG, THE CLEANER AIR PARTNERSHIP AND OTHERS, ARE WORKING ON THESE VITAL ISSUES

**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
SCHEDULE H, PART V, SECTION B, LINE 15E	OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE - OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE PART V, LINES 16A, 16B, & 16C OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE SUTTER VALLEY HOSPITALS WEBSITE AT <a href="https://www.sutterhealth.org/for-patients/financial-assistance">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/FINANCIAL-ASSISTANCE</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 16j	OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE SCHEDULE H, PART V, SECTION B, LINE 22D OSE ADAMS MEDICAL PAVILION, SUTTER MEDICAL CENTER SACRAMENTO (WOMEN'S AND CHILDREN'S HOSPITAL), SUTTER CENTER FOR PSYCHIATRY (GROUP B, 1-2 & 7) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1 501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT

**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
REPORTING FACILITY MEMORIAL MEDICAL CENTER	<p>SCHEDULE H, PART V, SECTION B, LINE 3E MEMORIAL MEDICAL CENTER (FACILITY 3) THE SIGNIFICA NT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMU NITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 MEMORIAL MEDIC AL CENTER (FACILITY 3) IN CONDUCTING ITS MOST RECENT CHNA, MEMORIAL MEDICAL CENTER (MMC) A FACILITY OF SUTTER CENTRAL VALLEY HOSPITALS, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WH O REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA COMMUNITY INPUT WAS PROVIDED BY A BROAD RANGE OF COMMUNITY MEMBERS THROUGH KEY INFORMANT INTERVIEWS AND FOCUS GROUPS INDIVIDUALS WITH THE KNOWLEDGE, INFORMATION, AND EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY WERE CONSULTED THESE INDIVIDUALS INCLUDED REPRESENTATIV ES FROM LOCAL PUBLIC HEALTH DEPARTMENTS AS WELL AS LEADERS, REPRESENTATIVES, OR MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS ADDITIONALLY, WHERE APPLICAB LE, OTHER INDIVIDUALS WITH EXPERTISE OF LOCAL HEALTH NEEDS WERE CONSULTED AD LUCEM CONSUL TING CONDUCTED STAKEHOLDER INTERVIEWS WITH SEVEN INDIVIDUALS REPRESENTING A DIVERSITY OF S ECTORS INCLUDING PUBLIC HEALTH, COMMUNITY BASED ORGANIZATIONS, SAFETY NET, EDUCATION AND GOVERNMENT THE STAKEHOLDERS WERE IDENTIFIED BY MEMORIAL MEDICAL CENTER AND KAISER FOUNDAT ION HOSPITAL (KFH) MODESTO STAFF ALL INTERVIEWS WERE CONDUCTED BY TELEPHONE IN ENGLISH AN D TOOK APPROXIMATELY 30-45 MINUTES TO COMPLETE THE INTERVIEWS FOLLOWED A STANDARD SET OF INTERVIEW QUESTIONS AND THE INTERVIEWER TOOK DETAILED NOTES DURING THE CALL AT THE BEGINN ING OF THE INTERVIEW, CONFIDENTIALITY WAS ASSURED AND THE RESPONDENTS WERE INVITED TO SKIP QUESTIONS NOT APPLICABLE TO THE RESPONDENT'S EXPERIENCE INTERVIEW QUESTIONS WERE DEVELOP ED BY AD LUCEM CONSULTING WITH INPUT FROM MMC AND KFH MODESTO FOR THE COMPLETE LIST OF IN Terview QUESTIONS, SEE APPENDIX C OF THE CHNA QUESTIONS ADDRESSED THE FOLLOWING TOPICS - TOP THREE HEALTH ISSUES IN STANISLAUS COUNTY - FACTORS THAT CONTRIBUTE TO THE TOP HEALTH ISSUES - IMPACTS ON SPECIFIC POPULATIONS (E G LOW INCOME, RACIAL/ETHNIC SUBPOPULATIONS) - SUCCESSFUL STRATEGIES AND COMMUNITY ASSETS TO ADDRESS TOP HEALTH ISSUES - OPPORTUNITIES A ND ROLE FOR COMMUNITY AND MMC TO ADDRESS TOP HEALTH ISSUES UPON COMPLETION OF EACH INTERVI EW, RESPONSES WERE GROUPED BY QUESTION AND ANALYZED FOR COMMON THEMES ACROSS ALL RESPONDEN TS DATA WERE THEN CODED AND A SET OF RELEVANT THEMES SELECTED THE CODES WERE SUBSEQUENTL Y QUANTIFIED AND TALLIED FOR THEIR PRESENCE IN RESPONSE TO EACH QUESTION THE NUMBER OF TI MES EACH THEME OCCURRED WAS TABULATED THE MOST PROMINENT THEMES WERE IDENTIFIED AND INCLU DED IN EACH RELEVANT TOPIC AREA IN THE HEALTH NEEDS PROFILES AND USED TO INFORM BOTH THE I DENTIFICATION AND HEALTH NEED PRIORITIZATION PROCESS AD LUCEM CONSULTING CONDUCTED EIGHT COMMUNITY RESIDENT FOCUS GROUPS IN FIVE DIFFERENT GEOGRAPHIC AREAS WITHIN THE MMC SERVICE AREA, INCLUDING CERES, PATTERS</p>

**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
REPORTING FACILITY MEMORIAL MEDICAL CENTER	<p>ON, TURLOCK, HUGHSON AND MODESTO FOUR GROUPS WERE CONDUCTED IN SPANISH, THREE WERE CONDUCTED IN ENGLISH AND ONE WAS CONDUCTED IN SPANISH AND ENGLISH PARTICIPANTS WERE MALE AND FEMALE ADULTS WHO REPRESENTED UNDERSERVED, LOW-INCOME, AND VARIOUS ETHNIC COMMUNITIES POPULATION GROUPS REPRESENTED INCLUDED PROMOTORS, COMMUNITY SERVICE AGENCY CLIENTS, AND OLDER ADULTS PARTICIPANTS WERE RECRUITED FROM COMMUNITIES THROUGHOUT THE MMC SERVICE AREA MMC AND KFH MODESTO STAFF RECRUITED PARTICIPANTS AND ORGANIZED LOGISTICS FOR THE FOCUS GROUPS, INCLUDING PROVIDING INCENTIVES AND REFRESHMENTS EACH FOCUS GROUP SESSION AVERAGED 90 MINUTES AND WAS FACILITATED BY AD LUCEM CONSULTING ALL FOCUS GROUPS WERE RECORDED AND THE MODERATOR OR CO-MODERATOR TOOK NOTES COMMUNITY RESIDENT PARTICIPANTS WERE PROVIDED WITH A MEAL OR SNACK AND RECEIVED A GIFT CARD IN APPRECIATION OF THEIR PARTICIPATION A FOCUS GROUP GUIDE WAS USED TO ENSURE CONSISTENCY ACROSS GROUPS THE FOCUS GROUP QUESTIONS WERE DEVELOPED BY AD LUCEM CONSULTING WITH INPUT FROM MMC AND KFH MODESTO QUESTIONS WERE OPEN-ENDED AND ADDITIONAL PROBING QUESTIONS WERE USED AS NEEDED TO ELICIT MORE IN-DEPTH RESPONSES AND RICHER DETAILS THE QUESTIONS WERE TRANSLATED INTO SPANISH BY A NATIVE SPANISH-SPEAKER EXPERIENCED IN TRANSLATION, THE GUIDE WAS MODIFIED SLIGHTLY TO MAINTAIN QUESTION FLOW AND INTEREST IN SPANISH AT THE BEGINNING OF EACH FOCUS GROUP SESSION, PARTICIPANTS WERE WELCOMED AND ASSURED ANONYMITY OF THEIR RESPONSES AND IDENTITY AN OVERVIEW OF THE DISCUSSION WAS PROVIDED AS WELL AS A REVIEW OF DISCUSSION GROUND RULES, SUCH AS "THERE ARE NO RIGHT OR WRONG ANSWERS " FOR THE COMPLETE LIST OF FOCUS GROUP QUESTIONS, SEE APPENDIX D OF THE CHNA QUESTIONS ADDRESSED THE FOLLOWING TOPICS 1 VISION FOR A HEALTHY COMMUNITY 2 TOP THREE HEALTH ISSUES IN STANISLAUS COUNTY 3 FACTORS THAT CONTRIBUTE TO THE TOP HEALTH ISSUES 4 SUCCESSFUL STRATEGIES AND COMMUNITY ASSETS TO ADDRESS TOP HEALTH ISSUES AND RESOURCES NEEDED 5 OPPORTUNITIES TO ENGAGE COMMUNITY MEMBERS IN CREATING A HEALTHY COMMUNITY AUDIO RECORDINGS OF THE FOCUS GROUPS WERE TRANSCRIBED VERBATIM BY A PROFESSIONAL TRANSCRIPTION COMPANY RESPONSES WERE ANALYZED BY KEY QUESTIONS AND THEMES WERE IDENTIFIED AND CODED ACROSS FOCUS GROUPS IN A SYSTEMATIC MANNER IN REPORTING THE RESULTS, CARE WAS TAKEN TO ENSURE THAT THE VIEWS OF THE PARTICIPANTS WERE VOICED THE MOST PROMINENT THEMES WERE IDENTIFIED AND INCLUDED IN EACH RELEVANT TOPIC AREA IN THE HEALTH NEEDS PROFILES AND USED TO INFORM BOTH THE IDENTIFICATION AND HEALTH NEED PRIORITIZATION PROCESS</p>

**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
SCHEDULE H, PART V, SECTION B, LINE 6A	MEMORIAL MEDICAL CENTER (FACILITY 3) MEMORIAL MEDICAL CENTER AND KAISER FOUNDATION HOSPITAL - MODESTO COLLABORATED ON THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT SCHEDULE H, PART V, SECTION B, LINES 7A, 7B AND 10A MEMORIAL MEDICAL CENTER (FACILITY 3) HTTP //WWW MEMORIALMEDICALCENTER ORG/ABOUT/COMMUNITY-BENEFIT HTML OTHER WEBSITE HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T



**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
SCHEDULE H, PART V, SECTION B, LINE 11	MEMORIAL MEDICAL CENTER (FACILITY 3) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT MEMORIAL MEDICAL CENTER INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY - HIGH RATE OF OBESITY HEALTHY EATING, ACTIVE LIVING, DIABETES - MENTAL HEALTH - ACCESS TO CARE - CANCERS - CARDIOVASCULAR DISEASE/STROKE - SUBSTANCE ABUSE AND TOBACCO DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL THE HEALTH NEEDS IN THE COMMUNITY MEMORIAL MEDICAL CENTER IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT - ASTHMA IS AN IDENTIFIED LOW PRIORITY HEALTH NEED THAT MEMORIAL MEDICAL CENTER IS NOT ADDRESSING THE RATIONALE FOR THIS IS THERE ARE RESOURCES AVAILABLE THROUGH OUR SISTER AFFILIATE, SUTTER GOULD MEDICAL CENTER THEY OFFER EXPERT PHYSICIAN CARE, AN ANNUAL ASTHMA FAIR AND THEY PARTICIPATE ON THE COMMUNITY ASTHMA COALITION - VIOLENCE THIS IS A SIGNIFICANT NEED BUT WAS IDENTIFIED AS A "LOW PRIORITY" THE HOSPITAL HAS DECIDED NOT TO ADDRESS THIS AREA AS OUR CITY OFFICIALS AND LAW ENFORCEMENT AS WELL AS THE COMMUNITY ARE ADDRESSING THIS NEED WE WILL SUPPORT THEIR ENDEAVORS WHENEVER POSSIBLE - ECONOMIC SECURITY ALSO IDENTIFIED AS A "LOW PRIORITY" OF THE HEALTH NEEDS IS A MAJOR CONCERN IN OUR COMMUNITY AS IN VIOLENCE, THE HOSPITAL HAS DECIDED NOT TO ADDRESS THIS AREA AS OUR GOVERNMENT PROGRAMS ARE ASSISTING CITIZENS TO PROVIDE BASIC NEEDS, FOOD, SHELTER, ETC WE WILL SUPPORT THEIR ENDEAVORS WHENEVER POSSIBLE

**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
SCHEDULE H, PART V, SECTION B, LINE 15E	MEMORIAL MEDICAL CENTER (FACILITY 3) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE - OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE SCHEDULE H, PART V, SECTION B, LINES 16A, 16B, & 16C MEMORIAL MEDICAL CENTER (FACILITY 3) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE MEMORIAL MEDICAL CENTER WEBSITE AT <a href="http://www.memorialmedicalcenter.org/about/financial-assistance.html">HTTP //WWW MEMORIALMEDICALCENTER ORG/ABOUT/FINANCIAL-ASSISTANCE HTML</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 16J	MEMORIAL MEDICAL CENTER (FACILITY 3) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ON AN ANNUAL BASIS SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE SCHEDULE H, PART V, SECTION B, LINE 22D MEMORIAL MEDICAL CENTER (FACILITY 3) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1 501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT

**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
REPORTING FACILITY SUTTER TRACY COMMUNITY HOSPITAL	<p>SCHEDULE H, PART V, SECTION B, LINE 3E SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) IN CONDUCTING ITS MOST RECENT CHNA, SUTTER TRACY COMMUNITY HOSPITAL DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA (HSA) COMMUNITY INPUT WAS PROVIDED BY A BROAD RANGE OF RESIDENTS AND LEADERS THROUGH A COMMUNITY SURVEY, KEY INFORMANT INTERVIEWS, AND FOCUS GROUPS A COMMUNITY SURVEY WAS ADMINISTERED TO 2,927 RESIDENTS OF SAN JOAQUIN COUNTY IN THE PARTICIPANT'S SELF-IDENTIFIED DOMINANT LANGUAGE (ENGLISH OR SPANISH) OR VERBALLY IN OTHER LANGUAGES (HMONG OR CAMBODIAN) APPROXIMATELY 10% OF SURVEYS WERE ADMINISTERED IN SPANISH THE SURVEY WAS AVAILABLE ONLINE AND IN A PAPER VERSION AMONG ALL RESPONDENTS, 19 2% WERE UNDER AGE 25 AND 7 2% WERE OVER AGE 60 RESPONDENTS WERE 71 7% FEMALE, 43 0% IDENTIFIED AS LATINO, AND 26 6% SPOKE SPANISH AT HOME A TOTAL OF 34 INDIVIDUALS IDENTIFIED BY THE CORE PLANNING GROUP AS HAVING VALUABLE KNOWLEDGE, INFORMATION, AND EXPERTISE WERE INTERVIEWED INTERVIEWEES INCLUDED REPRESENTATIVES FROM THE LOCAL PUBLIC HEALTH DEPARTMENT, AS WELL AS LEADERS, REPRESENTATIVES, AND MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, MINORITY POPULATIONS, AND THOSE WITH A CHRONIC DISEASE OTHER INDIVIDUALS FROM VARIOUS SECTORS WITH EXPERTISE IN LOCAL HEALTH NEEDS WERE ALSO CONSULTED TO MAXIMIZE RESOURCES AND STRENGTHEN RELATIONSHIPS, ALL INTERVIEWS WERE CONDUCTED BY MEMBERS OF THE CORE PLANNING GROUP FOR A COMPLETE LIST OF INDIVIDUALS WHO PROVIDED INPUT, SEE APPENDIX F FOR A SUMMARY OF KEY THEMES RELATED TO HEALTH NEEDS THAT AROSE FROM THESE INTERVIEWS, SEE APPENDIX E ADDITIONALLY, 29 FOCUS GROUPS WERE CONDUCTED THROUGHOUT THE COUNTY, REACHING 348 RESIDENTS TO MAXIMIZE RESOURCES AND LEVERAGE RELATIONSHIPS WITH COMMUNITY GROUPS AND RESIDENTS, THESE GROUPS WERE FACILITATED BY LOCAL VOLUNTEERS WHO HAD BEEN TRAINED BY MIG STAFF COMMUNITY PARTNERS PROVIDED INVALUABLE ASSISTANCE IN RECRUITING AND ENROLLING FOCUS GROUP PARTICIPANTS INDIVIDUALS WHO PARTICIPATED IN FOCUS GROUPS INCLUDED LEADERS, REPRESENTATIVES, OR MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, CHRONICALLY DISEASED, AND MINORITY POPULATIONS PARTICIPANTS ALSO REPRESENTED A BREADTH OF GEOGRAPHIC REGIONS, RACIAL/ETHNIC SUBPOPULATIONS, AND AGE CATEGORIES FOR MORE INFORMATION ABOUT SPECIFIC POPULATIONS REACHED IN FOCUS GROUPS, SEE APPENDIX F FOR A SUMMARY OF KEY THEMES RELATED TO HEALTH NEEDS THAT AROSE FROM THESE FOCUS GROUPS, SEE APPENDIX E THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN THE SUTTER TRACY COMMUNITY HOSPITAL'S CHNA ARE AVAILABLE AT <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN</a></p> <p>T</p>

**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
SCHEDULE H, PART V, SECTION B, LINE 6A & 6B	SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) THE SAN JOAQUIN COUNTY CHNA WAS A COLLABORATIVE EFFORT THAT INCLUDED SAN JOAQUIN'S NONPROFIT HOSPITALS AND SAN JOAQUIN COUNTY PUBLIC HEALTH SERVICES, AS WELL AS MANY PARTNER ORGANIZATIONS AND INDIVIDUALS THROUGHOUT THE COUNTY THE PROCESS WAS GUIDED BY A STEERING COMMITTEE THAT SUPPORTED AND PROVIDED INPUT ALONG THE WAY, AND WAS LED BY A CORE PLANNING GROUP THAT WAS RESPONSIBLE FOR PLANNING AND KEY DECISION-MAKING, INCLUDING PROVIDING SUBSTANTIAL ASSISTANCE IN DEVELOPING THE DATA COLLECTION INSTRUMENTS, WORKING ALONGSIDE CONSULTANTS TO COLLECT AND ANALYZE DATA, AND ULTIMATELY PRODUCE THIS REPORT CORE PLANNING GROUP MEMBERS - COMMUNITY MEDICAL CENTERS - COMMUNITY PARTNERSHIP FOR FAMILIES OF SAN JOAQUIN - DAMERON HOSPITAL ASSOCIATION - DIGNITY HEALTH-ST JOSEPH'S MEDICAL CENTER - FIRST 5 SAN JOAQUIN - HEALTH NET - HEALTH PLAN OF SAN JOAQUIN - KAISER PERMANENTE - SAN JOAQUIN COUNTY PUBLIC HEALTH SERVICES - SUTTER TRACY COMMUNITY HOSPITAL SCHEDULE H, PART V, SECTION B, LINES 7A, 7B AND 10A SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) FILING ORG WEBSITES <a href="https://www.sutterhealth.org/stch/for-patients/community-health-needs-assessment">https://www.sutterhealth.org/stch/for-patients/community-health-needs-assessment</a> OTHER WEBSITE <a href="https://www.sutterhealth.org/for-patients/community-health-needs-assessment">HTTPS://WWW.SUTTERHEALTH.ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 11	<p>SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT SUTTER TRACY COMMUNITY HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 OBESITY &amp; DIABETES 2 YOUTH GROWTH AND DEVELOPMENT 3 ECONOMIC SECURITY 4 VIOLENCE AND INJURY 5 ACCESS TO HOUSING 6 ACCESS TO MEDICAL CARE 7 MENTAL HEALTH 8 ORAL HEALTH DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY SUTTER TRACY COMMUNITY HOSPITAL IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT - EDUCATION WHEN FURTHER EVALUATING THE DISPARITIES REGARDING HIGH SCHOOL GRADUATION AND DROP-OUT RATES FOR RESIDENTS IN THE HOSPITAL'S SERVICE AREA, IT WAS FOUND THAT LOCAL RESIDENTS ARE PERFORMING BETTER THAN NEIGHBORS THROUGHOUT THE SAN JOAQUIN COUNTY IN GENERAL TRACY UNIFIED SCHOOL DISTRICT DATA NOTES A SIGNIFICANT REDUCTION IN DROP-OUT RATES AND AN INCREASE IN GRADUATION RATES WITHIN THE LAST THREE YEARS, AND METRICS ARE BETTER THAN STATE RATES BASED ON THESE FINDINGS, THERE IS NO NEED FOR THE HOSPITAL TO IMPLEMENT PLANS TO ADDRESS THIS NEED - SUBSTANCE USE ALTHOUGH THE HOSPITAL DOES NOT HAVE A SPECIFIC STRATEGY TO CONFRONT THIS HEALTH ISSUE HEAD ON, IT DOES INTEND TO INDIRECTLY ADDRESS THE PRIORITY FINDING THROUGH THE VARIOUS OTHER INTERVENTIONS AS MENTIONED IN THIS REPORT MANY OF THE STRATEGIES IN THIS PLAN LOOK TO PROVIDE WHOLE-PERSON CARE, AND WILL OFFER REFERRALS TO SUBSTANCE ABUSE RESOURCES TO INDIVIDUALS AS NECESSARY - ASTHMA/AIR QUALITY DUE TO LIMITED RESOURCES AND ABILITY TO IMPACT ENVIRONMENTAL POLICIES, THE HOSPITAL DOES NOT INTEND TO DIRECTLY ADDRESS THIS HEALTH ISSUE HOWEVER, COMMUNITY BENEFIT STAFF WILL REMAIN ENGAGED IN BUILDING AWARENESS, INCREASING PREVENTION, AND GROWING EDUCATIONAL OPPORTUNITIES THROUGH INVOLVEMENT IN THE SAN JOAQUIN COUNTY CHRONIC DISEASE AND OBESITY TASKFORCE - ASTHMA AND COPD SUBCOMMITTEE</p>

**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
SCHEDULE H, PART V, SECTION B, LINE 15E	SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE - OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE PART V, LINES 16A, 16B, & 16C SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE SUTTER TRACY COMMUNITY HOSPITAL WEBSITE AT <a href="http://www.suttertracy.org/about/financial-assistance.html">HTTP //WWW SUTTERTRACY ORG/ABOUT/FINANCIAL-ASSISTANCE HTML</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 16J	SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ON AN ANNUAL BASIS SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE SCHEDULE H, PART V, SECTION B, LINE 22D SUTTER TRACY COMMUNITY HOSPITAL (FACILITY 6) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1 501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT



**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
REPORTING FACILITY MEMORIAL HOSPITAL LOS BANOS	SCHEDULE H, PART V, SECTION B, LINE 3E MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) IN CONDUCTING ITS MOST RECENT CHNA, MEMORIAL HOSPITAL LOS BANOS DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA TO SOLICIT INPUT FROM KEY INFORMANTS, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN THE HEALTH OF THE COMMUNITY, AN ONLINE KEY INFORMANT SURVEY WAS ALSO IMPLEMENTED AS PART OF THIS PROCESS A LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY MEMORIAL HOSPITAL LOS BANOS, THIS LIST INCLUDED NAMES AND CONTACT INFORMATION FOR PHYSICIANS, PUBLIC HEALTH REPRESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS OF THE COMMUNITY OVERALL KEY INFORMANTS REPRESENTED IN THIS PROCESS WERE ASKED TO EVALUATE HEALTH NEEDS SPECIFICALLY IN THE LOS BANOS AREA KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRODUCING THE PURPOSE OF THE SURVEY AND PROVIDING A LINK TO TAKE THE SURVEY ONLINE, REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION IN ALL, 79 COMMUNITY STAKEHOLDERS TOOK PART IN THE ONLINE KEY INFORMANT SURVEY THROUGH THIS PROCESS, INPUT WAS GATHERED FROM SEVERAL INDIVIDUALS WHOSE ORGANIZATIONS WORK WITH LOW-INCOME, MINORITY POPULATIONS OR MEDICALLY UNDERSERVED POPULATIONS

**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
SCHEDULE H, PART V, SECTION B, LINE 6A	MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) MEMORIAL HOSPITAL LOS BANOS AND MERCY MEDICAL CENTER MERCED COLLABORATED ON THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT SCHEDULE H, PART V, SECTION B, LINES 7A, 7B AND 10A MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) FILING ORG WEBSITES HTTP //WWW MEMORIALLOSBANOS ORG/ABOUT/COMMUNITY-NEEDS-ASSESSMENT HTML OTHER WEBSITE HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T

**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
SCHEDULE H, PART V, SECTION B, LINE 11	<p>MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT MEMORIAL HOSPITAL LOS BANOS INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 NUTRITION, PHYSICAL ACTIVITY &amp; WEIGHT 2 ACCESS TO HEALTHCARE SERVICES 3 MENTAL HEALTH 4 DIABETES 5 INJURY AND VIOLENCE 6 IMMUNIZATION &amp; INFECTIOUS DISEASES DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI, ALONG WITH ADDITIONAL EFFORTS ON BEHALF OF MEMORIAL HOSPITAL LOS BANOS NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY MEMORIAL HOSPITAL LOS BANOS IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT - HEART DISEASE AND STROKE AT THIS TIME MHLB DOES NOT HAVE SPECIFIC STRATEGIES TO INCREASE SERVICES OR PROGRAMS TO ADDRESS THIS NEED MHLB CURRENTLY HAS PHYSICIANS AND DIAGNOSTIC SERVICES FOCUSED ON HEART DISEASE AND STROKE - SUBSTANCE ABUSE WHILE THERE IS NOT A CURRENT STRATEGY TO ADDRESS SUBSTANCE ABUSE, PROGRAMS AND/OR SERVICES OFFERED THROUGH THE MENTAL HEALTH STRATEGIES MAY ADDRESS THIS ISSUE - ORAL HEALTH THIS NEED IS CURRENTLY BEING ADDRESSED BY OTHER FACILITIES IN THE COMMUNITY - RESPIRATORY DISEASES A RELATIVELY LOW PRIORITY WAS ASSIGNED TO THIS NEED BY THE COMMUNITY - CANCER A RELATIVELY LOW PRIORITY WAS ASSIGNED TO THIS NEED AND MHLB CURRENTLY DOES NOT HAVE FACULTY WITH THE EXPERTISE TO EFFECTIVELY ADDRESS THIS NEED - DEMENTIA, INCLUDING ALZHEIMER'S DISEASE A RELATIVELY LOW PRIORITY WAS ASSIGNED TO THIS NEED - POTENTIALLY DISABLING CONDITIONS A RELATIVELY LOW PRIORITY WAS ASSIGNED TO THIS NEED SCHEDULE H, PART V, SECTION B, LINE 15E MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE-OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE SCHEDULE H, PART V, LINES 16A, 16B, &amp; 16C MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE MEMORIAL HOSPITAL LOS BANOS WEBSITE AT <a href="http://www.memoriallosbanos.org/about/financial-assistance.html">HTTP //WWW MEMORIALLOSBANOS ORG/ABOUT/FINANCIAL-ASSISTANCE HTML</a></p>

**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
SCHEDULE H, PART V, SECTION B, LINE 16J	MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITALS SERVICE AREA DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY ON AN ANNUAL BASIS SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE SCHEDULE H, PART V, SECTION B, LINE 22D MEMORIAL HOSPITAL LOS BANOS (FACILITY 11) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1 501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT

**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
REPORTING FACILITY STANISLAUS SURGICAL HOSPITAL	SCHEDULE H, PART V, SECTION B, LINE 2 STANISLAUS SURGICAL HOSPITAL (FACILITY 12) SUTTER VALLEY HOSPITALS ACQUIRED A 20% MEMBERSHIP INTEREST IN STANISLAUS SURGICAL HOSPITAL, LLC ON APRIL 1, 2016 PREVIOUSLY, THE HOSPITAL OPERATED AS A PARTNERSHIP WITHOUT TAX-EXEMPT OWNERSHIP SCHEDULE H, PART V, SECTION B, LINE 15E STANISLAUS SURGICAL HOSPITAL (FACILITY 12) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE - OTHER PATIENTS MAY SUBMIT CHARITY CARE APPLICATIONS TO THE COLLECTIONS SUPERVISOR SCHEDULE H, PART V, LINES 16A, 16B, & 16C STANISLAUS SURGICAL HOSPITAL (FACILITY 12) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE STANISLAUS SURGICAL HOSPITAL WEBSITE AT <a href="https://stanislaussurgical.com/financial-assistance">HTTPS //STANISLAUSSURGICAL COM/FINANCIAL-ASSISTANCE</a>

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
SCHEDULE H, PART V, SECTION B, LINE 16J	STANISLAUS SURGICAL HOSPITAL (FACILITY 12) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA (ENGLISH & SPANISH) DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED THE FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS POSTED IN SEVERAL PROMINENT LOCATIONS WITHIN THE HOSPITAL, INCLUDING, BUT NOT LIMITED TO THE BILLING OFFICE, ADMISSIONS OFFICE, AND PATIENT WAITING AREA THE HOSPITAL PROVIDES PATIENTS, IN A TIMELY MANNER, A COPY OF THE FINANCIAL ASSISTANCE POLICY UPON REQUEST

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 INFUSION THERAPY CENTER 11710 EDUCATION STREET AUBURN, CA 95602	OUTPATIENT SERVICES
1 WOUND CAREOSTOMY DEPARTMENT 11775 EDUCATION STREET AUBURN, CA 95602	OUTPATIENT SERVICES
2 URGENT CARE 11795 EDUCATION STREET AUBURN, CA 95603	OUTPATIENT SERVICES
3 INFUSION SERVICES 2020 SUTTER PLACE DAVIS, CA 95616	OUTPATIENT SERVICES
4 CARDIAC REHABILITATION 2030 SUTTER PLACE DAVIS, CA 95616	OUTPATIENT SERVICES
5 SUTTER AMADOR WOMEN'S SERVICES 100 MISSION BLVD JACKSON, CA 95642	OUTPATIENT SERVICES
6 DIABETES EDUCATION CLINIC 200 MISSION BLVD JACKSON, CA 95642	OUTPATIENT SERVICES
7 SUTTER SLEEP DISORDERS CENTER 1411 SECRET RAVINE PARKWAY STE 150 ROSEVILLE, CA 95661	OUTPATIENT SERVICES
8 OUTPATIENT SURGERY DEPARTMENT FOUR MEDICAL PLAZA ROSEVILLE, CA 95661	OUTPATIENT SERVICES
9 WOUND CARE CENTER ONE MEDICAL PLAZA ROSEVILLE, CA 95661	OUTPATIENT SERVICES
10 CHILDREN'S OUTPATIENT SERVICE CENTER 1625 STOCKTON BLVD SACRAMENTO, CA 95819	OUTPATIENT SERVICES
11 AMBULATORY SURGERY CENTER 2725 CAPITOL AVENUE SACRAMENTO, CA 95816	OUTPATIENT SERVICES
12 OUTPATIENT SERVICE CENTER 2800 L STREET SACRAMENTO, CA 95816	OUTPATIENT SERVICES
13 FORT SUTTER SURGERY CENTER 2801 K STREET SACRAMENTO, CA 95816	OUTPATIENT SERVICES
14 SUTTER CENTER FOR PSYCHIATRY 7919 FOLSOM BLVD STE 100 SACRAMENTO, CA 95826	OUTPATIENT 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)
<b>16</b> SUTTER CANCER CENTER 100 HOSPITAL DRIVE VALLEJO, CA 94589	OUTPATIENT SERVICES
<b>1</b> ROSEVILLE ENDOSCOPY CENTER 4 MEDICAL PLAZA ROSEVILLE, CA 95661	OUTPATIENT SERVICES
<b>2</b> SUTTER AMADOR SURGERY CENTER 223 CLINTON RD JACKSON, CA 95642	OUTPATIENT SERVICES
<b>3</b> SUTTER PIONEER HEALTH CENTER 24685 HIGHWAY 88 PIONEER, CA 95666	OUTPATIENT SERVICES
<b>4</b> SUTTER REHABILITATION INSTITUTE 6 MEDICAL PLAZA ROSEVILLE, CA 95661	OUTPATIENT SERVICES
<b>5</b> SUTTER PLYMOUTH HEALTH CENTER 9279 LOCUST STREET PLYMOUTH, CA 95669	OUTPATIENT SERVICES
<b>6</b> MHLB RURAL HEALTH CLINIC 1253 WEST I STREET LOS BANOS, CA 93635	RURAL HEALTH CLINIC
<b>7</b> MEMORIAL SURGERY CENTER 1401 SPANOS COURT MODESTO, CA 95355	OUTPATIENT SERVICES
<b>8</b> SUTTER TRACY HOSPITAL IMAGING CENTER 1530 BESSIE AVENUE SUITE 109 TRACY, CA 95376	OUTPATIENT SERVICES



Schedule I  
(Form 990)

Department of the  
Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY HOSPITALS

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public  
Inspection

Employer identification number  
94-1156621

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 . . . . .

112

3

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

11

**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
SCHEDULE I, PART I, LINE 2	PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS IN ORDER TO CLOSELY MONITOR EFFICIENCY AND EFFECTIVENESS, THE COMMUNITY BENEFIT FUNCTION OUTLINES MEASURABLE REPORTING (QUARTERLY, SIX-MONTH AND/OR YEAR-END), PROGRAM AND FUNDING REQUIREMENTS IN A MEMORANDUM OF UNDERSTANDING (MOU), BUSINESS SERVICES AGREEMENT (BSA), OR JOINT VENTURE AGREEMENT FOR EACH INVESTMENT MADE WITH A COMMUNITY PARTNER WHERE IT IS DETERMINED NECESSARY, ADDITIONAL EFFORTS ARE MADE TO MONITOR EFFECTIVENESS AND EFFICIENCY OF INVESTMENTS, WHICH COULD INCLUDE - QUARTERLY MEETINGS WITH COMMUNITY PARTNERS - E-MAIL AND TELEPHONIC COMMUNICATIONS WITH COMMUNITY PARTNERS - CONTINUED DIALOGUE WITH INVOLVED HOSPITAL STAFF AND COMMUNITY PARTNERS THROUGHOUT DURATION OF PROGRAM - SITE VISITS WITH COMMUNITY PARTNERS - BI-ANNUAL "OUTCOMES" SURVEY (6-MONTH AND/OR YEAR-END OUTCOMES) - REVIEW OF HOSPITAL USAGE AND PATIENT LEVEL DATA - COLLECTION OF PATIENT STORIES AND NARRATIVES - COLLABORATIVE DISCUSSIONS AROUND AD-HOC SUCCESSES AND CHALLENGES THAT ARISE - REPORTING TO INCLUDE YEAR-END FINANCIAL SUMMARY THAT COMPARES ACTUAL EXPENDITURES TO THE FUNDED PROJECT'S BUDGET, INDICATING ANY UNUSED AMOUNT OF GRANT FUNDS AT THE END OF EACH YEAR/REPORTING PERIOD, COMMUNITY BENEFIT ANALYZES FULL-YEAR DATA TO ENSURE COMMUNITY PARTNERS MET THE OBJECTIVES OUTLINED IN THE MOU OR BSA IF THE COMMUNITY PARTNERS DID NOT REACH THE ANTICIPATED OUTCOMES, COMMUNITY BENEFIT WORKS TO UNDERSTAND WHAT CIRCUMSTANCES PREVENTED THE ORGANIZATION FROM MEETING THE GOALS TO HELP IDENTIFY WAYS TO IMPROVE OR PERHAPS RE-EVALUATE WHAT SUCCESS OF THIS PROGRAM LOOKS LIKE, AND MAKES THE DETERMINATION TO CONTINUE OR TERMINATE FUNDING

Additional Data

Software ID:  
Software Version:  
EIN: 94-1156621  
Name: SUTTER VALLEY HOSPITALS

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
WELLSPACE HEALTH 777 12TH ST STE 250 SACRAMENTO, CA 95814	94-1713704	501(C)(3)	3,948,419				GENERAL SUPPORT
HEALTHY COMMUNITY FORUM FOR GREATER SAC 8928 VOLUNTEER LN STE 220 SACRAMENTO, CA 95826	68-0377256	501(C)(3)	1,285,935				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PLACER COUNTY HEALTH & HUMAN SERVICES DEPT 3091 COUNTY CENTER DR STE 290 AUBURN, CA 95603		GOVT	1,029,998				GENERAL SUPPORT
SACRAMENTO STEPS FORWARD 1331 GARDEN HWY STE 100 SACRAMENTO, CA 95833	27-4907397	501(C)(3)	625,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNICARE HEALTH CENTERS PO BOX 1260 DAVIS, CA 95617	94-2188574	501(C)(3)	460,000				GENERAL SUPPORT
HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CA 1215 K ST STE 800 SACRAMENTO, CA 95814	94-1533644	501(C)(6)	368,045				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GONOODLE INC 209 10TH AVE SO STE 350 NASHVILLE, TN 37203	20-3456491		350,912				GENERAL SUPPORT
COMMUNITY MEDICAL CENTERS INC PO BOX 779 STOCKTON, CA 95201	94-2437106	501(C)(3)	342,277				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NEHEMIAH COMMUNITY REINVESTMENT FUND INC 640 BERCUT DR STE A SACRAMENTO, CA 95811	68-0365842	501(C)(3)	334,000				GENERAL SUPPORT
CITY OF ROSEVILLE 311 VERNON ST ROSEVILLE, CA 95678	94-6000409	GOVT	250,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LINKING EDUCATION AND ECONOMIC DEVELOPMENT 1410 ETHAN WY SACRAMENTO, CA 95825	68-0287387	501(C)(3)	250,000				GENERAL SUPPORT
SACRAMENTO NATIVE AMERICAN HEALTH CTR INC 2020 J ST SACRAMENTO, CA 95811	20-4287737	501(C)(3)	250,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CITY OF DAVIS 23 RUSSELL BLVD DAVIS, CA 95616	94-6000319	GOVT	232,990				GENERAL SUPPORT
UNITED WAY OF STANISLAUS COUNTY PO BOX 3066 MODESTO, CA 95353	94-1212129	501(C)(3)	205,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SAN JOAQUIN COUNTY OF PUBLIC HEALTH SERVICES 1601 E HAZELTON AVE STOCKTON, CA 95205	94-6108640	GOVT	200,000				GENERAL SUPPORT
SENIORS FIRST 12183 LOCKSLEY LN STE 205 AUBURN, CA 95602	68-0430154	501(C)(3)	195,250				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN HEART ASSOCIATION INC 7272 GREENVILLE AVE DALLAS, TX 75231	13-5613797	501(C)(3)	197,310				GENERAL SUPPORT
Sacramento Downtown Partnership Inc 980 NINTH ST STE 400 SACRAMENTO, CA 95814	68-0270320	501(C)(6)	180,550				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY PARTNERSHIP FOR FAMILIES PO BOX 1569 STOCKTON, CA 95201	68-0475602	501(C)(3)	178,086				GENERAL SUPPORT
GOLDEN VALLEY HEALTH CENTERS FOUNDATION 737 W CHILDS AVE MERCED, CA 95341	47-4773124	501(C)(3)	164,976				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HAVEN WOMENS CENTER 619 13TH ST STE 1 MODESTO, CA 95354	94-2499361	501(C)(3)	156,734				GENERAL SUPPORT
UNITED WAY OF MERCED COUNTY INC 658 W MAIN ST MERCED, CA 95340	94-2633265	501(C)(3)	136,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LA CLINICA DE LA RAZA 1515 FRUITVALE AVE OAKLAND, CA 94601	94-1744108	501(C)(3)	134,893				GENERAL SUPPORT
SHADY CREEK OUTDOOR EDUCATION FOUNDATION 970 KLAMATH LN YUBA CITY, CA 95993	68-0239809	501(C)(3)	125,672				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED STATES FUND FOR UNICEF 101 MONTGOMERY ST SUITE 625 SAN FRANCISCO, CA 94104	13-1760110	501(C)(3)	125,000				GENERAL SUPPORT
CENTER FOR HUMAN SERVICES 1700 MCHENRY VILLAGE WY STE 11 MODESTO, CA 95350	94-1725620	501(C)(3)	110,250				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SACRAMENTO METROPOLITAN CHAMBER COMMERCE ONE CAPITOL MALL STE 300 SACRAMENTO, CA 95814	94-0824600	501(C)(6)	105,000				GENERAL SUPPORT
STANISLAUS BUSINESS ALLIANCE 1010 TENTH ST STE 1400 MODESTO, CA 95354	20-5186517	501(C)(3)	100,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GATHERING INN 201 BERKELEY AVE ROSEVILLE, CA 95678	84-1657746	501(C)(3)	90,520				GENERAL SUPPORT
SECOND HARVEST FOOD BANK-SAN JOAQUIN & STANIS 704 E INDUSTRIAL PARK DR MANTECA, CA 95337	68-0376587	501(C)(3)	90,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MERCED COUNTY BEHAV HEALTH & RECOVERY SVCS PO BOX 2087 MERCED, CA 95344		GOVT	86,836				GENERAL SUPPORT
BOYS AND GIRLS CLUB OF TRACY 753 W LOWELL AVE TRACY, CA 95376	68-0028682	501(C)(3)	83,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MCHENRY HOUSE TRACY FAMILY SHELTER 757 A ST TRACY, CA 95376	68-0123612	501(C)(3)	80,000				GENERAL SUPPORT
CATHOLIC CHARITIES OF DIOCESE OF STOCKTON 1106 NO EL DORADO ST STOCKTON, CA 95202	94-1629114	501(C)(3)	76,250				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CALIFORNIA STATE UNIVERSITY STANISLAUS FNDN ONE UNIVERSITY CIR TURLOCK, CA 95382	77-0492209	501(C)(3)	75,000				GENERAL SUPPORT
TRACY COMMUNITY CONNECTIONS CENTER PO BOX 1215 TRACY, CA 95378	47-5483883	501(C)(3)	69,243				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SOLANO COALITION FOR BETTER HEALTH 1 HARBOR DR STE 270 SUISUN CITY, CA 94585	94-3189914	501(C)(3)	60,000				GENERAL SUPPORT
TOURO UNIVERSITY 1310 CLUB DR VALLEJO, CA 94592	13-3838740	501(C)(3)	60,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SAINT MARYS DINING ROOM 545 W SONORA ST STOCKSTON, CA 95203	94-2687280	501(C)(3)	53,845				GENERAL SUPPORT
BOYS AND GIRLS CLUB OF STANISLAUS COUNTY 422 MCHENRY AVE MODESTO, CA 95350	45-5034180	501(C)(3)	51,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNEE2 INC 1852 W 11TH ST STE 564 TRACY, CA 95376	77-0549779	501(C)(3)	51,500				GENERAL SUPPORT
CROCKER ART MUSEUM ASSOCIATION 216 O ST SACRAMENTO, CA 95814	94-2552486	501(C)(3)	50,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
DENTISTS ORGANIZED FOR VETERANS 35 QUAIL CT STE 304 WALNUT CREEK, CA 94596	46-4819872	501(C)(3)	50,000				GENERAL SUPPORT
MENTAL HEALTH AMERICA OF CALIFORNIA 2035 HURLEY WY STE 290 SACRAMENTO, CA 95825	94-1393424	501(C)(3)	50,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MODESTO UNION GOSPEL MISSION 1400 YOSEMITE BLVD MODESTO, CA 95354	94-6102833	501(C)(3)	50,000				GENERAL SUPPORT
PEACH TREE HEALTHCARE 1114 YUBA ST STE 144 MARYSVILLE, CA 95901	68-0371679	501(C)(3)	50,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SHANES INSPIRATION 15213 BURBANK BLVD SHERMAN OAKS, CA 91411	95-4760497	501(C)(3)	50,000				GENERAL SUPPORT
VALLEY VISION INC 2320 BROADWAY SACRAMENTO, CA 95818	94-3214572	501(C)(3)	48,831				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GIVE EVERY CHILD A CHANCE 322 SUN WEST PL MANTECA, CA 95337	68-0399384	501(C)(3)	47,198				GENERAL SUPPORT
YOLO COUNTY CHILDRENS ALLIANCE 600 A ST STE Y DAVIS, CA 95616	68-0526185	501(C)(3)	42,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY 1720 SO AMPHLETT BLVD STE 220 SAN MATEO, CA 94402	94-1170350	501(C)(3)	41,500				GENERAL SUPPORT
AMBULATORY SURGERY ACCESS 1119 MARKET ST STE 400 SAN FRANCISCO, CA 94103	94-3180356	501(C)(3)	40,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HELPING OTHERS PROVIDE ENCOURAGEMENT MINISTRIES PO BOX 841 MANTECA, CA 95336	68-0235846	501(C)(3)	40,000				GENERAL SUPPORT
ROSEVILLE CHAMBER OF COMMERCE 650 DOUGLAS BLVD ROSEVILLE, CA 95678	94-1079379	501(C)(6)	40,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YOLO COMMUNITY CARE CONTINUUM PO BOX 1101 DAVIS, CA 95617	94-2623205	501(C)(3)	40,000				GENERAL SUPPORT
SACRAMENTO ASIAN PACIFIC CHAMBER COMMERCE 2331 ALHAMBRA BLVD STE 100 SACRAMENTO, CA 95817	68-0306606	501(C)(6)	39,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
STANISLAUS COUNTY OFFICE OF EDUCATION 1100 H ST MODESTO, CA 95354	94-6002388	GOVT	38,500				GENERAL SUPPORT
COMMUNITY SERVICE EDUCATION 5380 ELVAS AVE SACRAMENTO, CA 95819	23-7003581	501(C)(3)	38,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WOMENS CENTER OF SAN JOAQUIN COUNTY 620 NO SAN JOAQUIN ST STOCKTON, CA 95202	94-2341360	501(C)(3)	38,000				GENERAL SUPPORT
LATINO LEADERSHIP COUNCIL INC 2945 BELL RD STE 274 AUBURN, CA 95603	27-0970476	501(C)(3)	37,500				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
INTERNATIONAL STUDENT TOURS 5080 ROBERT J MATHEWS PKWY EL DORADO HILLS, CA 95762	91-1915695		34,390				GENERAL SUPPORT
MAKE A WISH FOUNDATION 1401 Halyard Dr 130 W SACRAMENTO, CA 95691	68-0027351	501(C)(3)	32,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CENTER FOR HEALTHCARE DECISIONS INC 955 UNIVERSITY AVE STE C SACRAMENTO, CA 95825	68-0441958	501(C)(3)	30,000				GENERAL SUPPORT
COALITION TRACY CITIZENS TO ASSIST HOMELESS 21055 SOUTH CORRAL HOLLOW ROAD TRACY, CA 95304	90-0532767	501(C)(3)	30,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GOSPEL CENTER RESCUE MISSION INC 445 SO SAN JOAQUIN ST STOCKTON, CA 95203	94-1375835	501(C)(3)	30,000				GENERAL SUPPORT
SOW A SEED COMMUNITY FOUNDATION 35 E 10TH ST STE D1 TRACY, CA 95376	11-3821058	501(C)(3)	30,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNIVERSITY OF THE PACIFIC 3601 PACIFIC AVE STOCKTON, CA 95211	94-1156266	501(C)(3)	30,000				GENERAL SUPPORT
SALVATION ARMY 286 SUTTER ST AUBURN, CA 95603	94-1156347	501(C)(3)	29,750				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MARCH OF DIMES PO BOX 1657 WILKESBARRE, PA 18703	13-1846366	501(C)(3)	27,500				GENERAL SUPPORT
CRISTO REY HIGH SCHOOL SAC WORK STUDY 6200 MCMAHON DR SACRAMENTO, CA 95824	41-2191660	501(C)(3)	26,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ALLIANCE FOR COMMUNITY TRANSFORMATIONS PO BOX 2075 MARIPOSA, CA 95338	77-0272319	501(C)(3)	25,000				GENERAL SUPPORT
EMERGENCY FOOD BANK 7 W SCOTTS AVE STOCKTON, CA 95203	68-0002165	501(C)(3)	25,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TIDES FOUNDATION 1014 TORNEY AVE SAN FRANCISCO, CA 94129	51-0198509	501(C)(3)	25,000				GENERAL SUPPORT
YUBA SUTTER CHAMBER OF COMMERCE 519 D ST MARYSVILLE, CA 95901	94-1731239	501(C)(6)	25,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GENERAL CONFERENCE OF SEVENTH DAY ADVENTIST 12225 ROCK CREEK RD AUBURN, CA 95603	68-0260677	501(C)(3)	24,895				GENERAL SUPPORT
CITY OF SACRAMENTO CONVENTION CENTER 1030 15TH ST SACRAMENTO, CA 95814	94-6000410	GOVT	20,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIERRA FOREVER FAMILIES 138 NEW MOHAWK RD STE 200 NEVADA CITY, CA 95959	68-0002878	501(C)(3)	20,000				GENERAL SUPPORT
SYLVAN EDUCATIONAL FOUNDATION 605 SYLVAN AVE MODESTO, CA 95350	77-0307373	501(C)(3)	20,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN LEADERSHIP FORUM MOUNTAIN VALLEY 6507 4TH AVE STE 400 SACRAMENTO, CA 95817	91-1792774	501(C)(3)	17,500				GENERAL SUPPORT
KEATON RAPHAEL MEMORIAL FOR NEUROBLASTOMA 2260 DOUGLAS BLVD STE 150 ROSEVILLE, CA 95661	68-0406980	501(C)(3)	17,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CALIFORNIA MUSEUM FOR HISTORY WOMEN & ARTS 1020 O ST SACRAMENTO, CA 95814	94-3015670	501(C)(3)	15,000				GENERAL SUPPORT
FRIENDS OF SUTTERS FORT 2701 L ST SACRAMENTO, CA 95816	94-2608741	501(C)(3)	15,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
KVIE INC 2030 W EL CAMINO AVE SACRAMENTO, CA 95833	94-1421463	501(C)(3)	15,000				GENERAL SUPPORT
SACRAMENTO LOAVES AND FISHES 1351 NO C ST SACRAMENTO, CA 95811	68-0189897	501(C)(3)	15,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WEAVE INC 1900 K ST SACRAMENTO, CA 95811	94-2493158	501(C)(3)	15,000				GENERAL SUPPORT
YOLO CRISIS NURSERY INC 1477 DREW AVE STE 103 DAVIS, CA 95618	47-1006055	501(C)(3)	15,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TRACY VOLUNTEER CAREGIVERS INC 101 BERVERDOR AVE TRACY, CA 95376	77-0618493	501(C)(3)	13,900				GENERAL SUPPORT
CITY OF LOS BANOS 645 7TH ST LOS BANOS, CA 93635	94-6000363	GOVT	13,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PLACER COMMUNITY FOUNDATION PO BOX 9207 AUBURN, CA 95604	20-1485011	501(C)(3)	13,500				GENERAL SUPPORT
STOCKTON UNIFIED SCHOOL DIST 931 E MAGNOLIA ST STOCKTON, CA 95202	94-6002661	GOVT	13,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LIGHTHOUSE COUNSELING & FAMILY RESOURCE CTR 427 A ST STE 400 LINCOLN, CA 95648	35-2252834	501(C)(3)	12,500				GENERAL SUPPORT
DELTA COLLEGE FOUNDATION 5151 PACIFIC AVE STOCKTON, CA 95207	23-7367633	501(C)(3)	12,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HOLISTIC APPROACH TO RECOVERY & TRANSITION INC 35 10TH ST STE D TRACY, CA 95376	46-2324389	501(C)(3)	12,000				GENERAL SUPPORT
SIERRA COLLEGE FOUNDATION 5100 SIERRA COLLEGE BLVD ROCKLIN, CA 95677	23-7241877	501(C)(3)	10,150				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN DIABETES ASSOCIATION 2451 CRYSTAL DR STE 900 ARLINGTON, VA 22202	13-1623888	501(C)(3)	10,000				GENERAL SUPPORT
CALIFORNIA PRIMARY CARE ASSOC 1215 K ST STE 700 SACRAMENTO, CA 95814	94-3215565	501(C)(3)	10,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ELK GROVE CHAMBER OF COMMERCE 9401 E STOCKTON BLVD STE 125 ELK GROVE, CA 95624	94-1483392	501(C)(6)	10,000				GENERAL SUPPORT
GREATER SACRAMENTO AREA ECONOMIC COUNCIL 400 CAPITOL MALL BLVD STE 2520 SACRAMENTO, CA 95814	46-5517841	501(C)(3)	10,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HABITAT FOR HUMANITY WESTSIDE MERCED COUNTY INC PO BOX 1421 LOS BANOS, CA 93635	20-1497263	501(C)(3)	10,000				GENERAL SUPPORT
MERCED COUNTY SPRING FAIR HERITAGE FOUNDATION 403 F ST LOS BANOS, CA 93635	94-6000521	501(C)(3)	10,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PLACER BREAST CANCER ENDOWMENT PO BOX 564 ROSEVILLE, CA 95678	27-0690037	501(C)(3)	10,000				GENERAL SUPPORT
SACRAMENTO REG COALITION TO END HOMELESSNESS 1331 GARDEN HWY STE 101 SACRAMENTO, CA 95833	46-3175193	501(C)(3)	10,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SACRAMENTO REG FAMILY JUSTICE CENTER FNDN PO BOX 276551 SACRAMENTO, CA 95827	46-4522608	501(C)(3)	10,000				GENERAL SUPPORT
VOLUNTEERS OF AMERICA NORTHERN CA & NEVADA 1900 POINT WEST WY STE 270 SACRAMENTO, CA 95815	94-6001984	501(C)(3)	10,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
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HOWARD TRAINING CENTER 1424 STONUM RD MODESTO, CA 95351	94-6033763	501(C)(3)	9,100				GENERAL SUPPORT
SUTTER YUBA HOMELESS CONSORTIUM PO BOX 3642 YUBA CITY, CA 95992	46-2438264	501(C)(3)	9,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YUBA SUTTER-LODI PINK OCTOBER 871 E ONSTOTT RD YUBA CITY, CA 95991	20-1530007	501(C)(3)	8,500				GENERAL SUPPORT
COMMUNITY HOSPICE INC 4368 SPYRES WY MODESTO, CA 95356	94-2638213	501(C)(3)	8,000				GENERAL SUPPORT



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
NATIONAL MEDICAL FELLOWSHIPS 347 5TH AVE STE 510 NEW YORK, NY 10016	01-0963657	501(C)(3)	8,000				GENERAL SUPPORT
CHILD ABUSE PREVENTION COUNCIL SACRAMENTO 4700 ROSEVILLE RD STE 102 NORTH HIGHLANDS, CA 95660	94-2833431	501(C)(3)	7,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GREATER SACRAMENTO URBAN LEAGUE 3725 MARYSVILLE BLVD SACRAMENTO, CA 95838	94-1686314	501(C)(3)	7,500				GENERAL SUPPORT
HEALTH COMMUNICATION RESEARCH INSTITUTE INC 5025 J ST STE 311 SACRAMENTO, CA 95819	68-0195121	501(C)(3)	7,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MODESTO CITY SCHOOLS 426 LOCUST ST MODESTO, CA 95351	77-0195326	GOVT	7,500				GENERAL SUPPORT
NORTHERN CALIFORNIA WORLD TRADE CENTER ONE CAPITOL MALL STE 300 SACRAMENTO, CA 95814	91-1811449	501(C)(3)	7,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SACRAMENTO BLACK CHAMBER OF COMMERCE FNDN 5770 FREEPORT BLVD STE 44 SACRAMENTO, CA 95822	95-4818928	501(C)(3)	7,500				GENERAL SUPPORT
DAVIS CHAMBER OF COMMERCE 604 THIRD ST DAVIS, CA 95616	94-0420636	501(C)(6)	7,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HEALTHY AGING ASSOCIATION 121 DOWNEY AVE STE 102 MODESTO, CA 95354	77-0546574	501(C)(3)	6,500				GENERAL SUPPORT
SOIL BORN FARMS URBAN AGRICULTURE PROJECT PO BOX 661175 SACRAMENTO, CA 95866	20-0774693	501(C)(3)	6,500				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EDUCATION FOUNDATION OF STANISLAUS COUNTY 1100 H ST MODESTO, CA 95354	94-2906392	501(C)(3)	6,400				GENERAL SUPPORT
SACRAMENTO KINGS FOUNDATION ONE SPORTS PKWY SACRAMENTO, CA 95834	68-0249718	501(C)(3)	6,000				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MIDTOWN SACRAMENTO PBID CORPORATION 1401 21ST ST STE A SACRAMENTO, CA 95811	46-1549378	501(C)(6)	5,500				GENERAL SUPPORT
KIDS FIRST 124 MAIN ST ROSEVILLE, CA 95678	68-0195225	501(C)(3)	5,200				GENERAL SUPPORT

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BETHEL PENTECOSTAL CHURCH OF GOD 415 I ST LOS BANOS, CA 93635	26-0347826	501(C)(3)	5,062				GENERAL SUPPORT



**Schedule J**  
(Form 990)

**Compensation Information**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

**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](http://www.irs.gov/form990).**

Name of the organization  
SUTTER VALLEY HOSPITALS

Employer identification number  
94-1156621

**Part I Questions Regarding Compensation**

	Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input checked="" type="checkbox"/> Tax indemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                 </div> <div> <input checked="" type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </div> </div>		
<b>b</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	
<b>2</b> 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	
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Compensation committee  <input checked="" type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                 </div> <div> <input type="checkbox"/> Written employment contract  <input checked="" type="checkbox"/> Compensation survey or study  <input checked="" type="checkbox"/> Approval by the board or compensation committee                 </div> </div>		
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: <div style="margin-left: 20px;"> <b>a</b> Receive a severance payment or change-of-control payment?  <b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?  <b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?                 </div> If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4a Yes 4b Yes 4c No	
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: <div style="margin-left: 20px;"> <b>a</b> The organization?  <b>b</b> Any related organization?                 </div> If "Yes," on line 5a or 5b, describe in Part III.	5a No 5b No	
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: <div style="margin-left: 20px;"> <b>a</b> The organization?  <b>b</b> Any related organization?                 </div> If "Yes," on line 6a or 6b, describe in Part III.	6a No 6b No	
<b>7</b> 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 Yes	
<b>8</b> 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	
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

[illegible]

**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
SCHEDULE J, PART I, LINE 1A	TAX INDEMNIFICATION STANDARD POLICY FOR ALL SUTTER HEALTH EMPLOYEES IS THAT NON-CASH GIFTS AND AWARDS ARE GROSSED-UP FOR TAX PURPOSES. THE AMOUNT OF THE GROSS-UP IS ADDED TO THE EMPLOYEE'S WAGES AND TAXED ACCORDINGLY. HOUSING ALLOWANCE: TWO (2) INDIVIDUALS, MIKE COHILL AND MITCH HANNA, RECEIVED A HOUSING ALLOWANCE. THE BENEFIT WAS REPORTED AS TAXABLE COMPENSATION ON THEIR W-2S.
SCHEDULE J, PART I, LINE 3	SUPPLEMENTAL COMPENSATION INFORMATION: THE CEO OF THIS ORGANIZATION IS AN EMPLOYEE OF SUTTER HEALTH, A RELATED TAX-EXEMPT ORGANIZATION. THE COMPENSATION COMMITTEE OF THE SUTTER HEALTH BOARD OF DIRECTORS RETAINS ULTIMATE DISCRETIONARY AUTHORITY OVER ALL ELEMENTS OF COMPENSATION TO ASSURE THAT ORGANIZATIONAL PURPOSES ARE APPROPRIATELY SERVED. THE COMPENSATION COMMITTEE USES CREDIBLE DATA SOURCES AND MAINTAINS AN OBJECTIVE "ARMS LENGTH" DECISION-MAKING PROCESS, ENSURING THE INTEGRITY OF SUTTER'S EXECUTIVE PROGRAMS AND CONSISTENCY WITH THE ORGANIZATION'S OVERALL MISSION. SEE SCHEDULE O NARRATIVE FOR PART VI, LINE 15 FOR A FULL DESCRIPTION OF THE COMPENSATION APPROVAL PROCESS COMPLETED BY SUTTER HEALTH. SCHEDULE J, PART I, LINE 4A SEVERANCE PAYMENTS: FARAAZ YOUSEF RECEIVED SEVERANCE PAYMENTS OF \$187,345.
SCHEDULE J, PART I, LINE 4B	NONQUALIFIED RETIREMENT PLAN: THE PURPOSE OF THE NONQUALIFIED RETIREMENT PLAN IS TO PROVIDE SUTTER HEALTH EXECUTIVES WITH A COMPETITIVE RETIREMENT BENEFIT CONSISTENT WITH SUTTER HEALTH'S OVERALL COMPENSATION PHILOSOPHY FOR ALL EMPLOYEES. CONTRIBUTIONS ARE DESIGNED TAKING INTO CONSIDERATION LOST RETIREMENT BENEFITS THAT WOULD OTHERWISE BE OBTAINED THROUGH THE QUALIFIED PENSION PLAN. SUTTER'S PLANS ARE DESIGNED CONSISTENT WITH COMPETITIVE INDUSTRY PRACTICES. THE RETIREMENT PLAN FOR SUTTER HEALTH EMPLOYEES IS A COMBINATION OF 403(B) EMPLOYER MATCH CONTRIBUTIONS AND QUALIFIED PENSION PLAN BENEFITS. SUTTER HEALTH EXECUTIVES ARE GENERALLY INELIGIBLE FOR EMPLOYER MATCH CONTRIBUTIONS. TO ENSURE A COMPETITIVE RETIREMENT BENEFIT AND TO ADDRESS THE SHORTFALLS DESCRIBED ABOVE, SUTTER HEALTH MAKES AN ANNUAL CONTRIBUTION TO A NON-QUALIFIED 457(F) PLAN FOR ITS EXECUTIVES. THE FORMULA HAS TWO PARTS: (1) 4% TO 7% OF BASE SALARY (COMMENSURATE WITH MANAGEMENT LEVEL), PLUS (2) A CONTRIBUTION STARTING AT 5% (BASED UPON TENURE) FOR ELIGIBLE EARNINGS BEYOND THE IRS DEFINITION OF INCLUDIBLE COMPENSATION ("PENSION PAY CAP"). THE LATTER OF WHICH IS DESIGNED TO HELP RESTORE LOST PENSION BENEFITS FORFEITED UNDER THE QUALIFIED PENSION PLAN FOR EARNINGS OVER THE PENSION PAY CAP LIMIT. CONTRIBUTIONS ARE ALSO MADE FOR A SMALL GROUP OF SENIOR LEVEL EXECUTIVES WHOSE ESTIMATED RETIREMENT BENEFIT (SOCIAL SECURITY PLUS QUALIFIED PLAN BENEFITS PLUS 457(F)) FALLS BELOW 50% - 65% OF FINAL 4-YEAR AVERAGE BASE SALARY WHEN RETIRING AT AGE 65 WITH 22.5 YEARS OF SERVICE. TARGET BENEFIT LEVELS ARE DISCOUNTED FOR YEARS OF SERVICE LESS THAN 22.5 AT AGE 65. UNLIKE SUTTER HEALTH'S QUALIFIED PENSION PLAN WHERE EMPLOYEE BENEFITS ARE GUARANTEED (I.E., A DEFINED BENEFIT), SUTTER'S NON-QUALIFIED PLAN BENEFITS ARE NOT GUARANTEED BY SUTTER HEALTH. INVESTMENT RISK IS BORNE BY PARTICIPANTS AND BENEFITS ARE NOT PROTECTED SHOULD SUTTER HEALTH BECOME INSOLVENT. THE FOLLOWING INDIVIDUALS RECEIVED 457(F) NON-QUALIFIED PAYMENTS DURING THE YEAR: MICHAEL COHILL - \$250,804; MITCH HANNA - \$44,536; JOHN MESIC, MD - \$57,040; THOMAS BLINN - \$107,492.
SCHEDULE J, PART I, LINE 7	NON-FIXED PAYMENTS SPOT AWARDS ARE INFREQUENTLY USED TO REWARD EMPLOYEES. THERE ARE NO SPECIFIC GUIDELINES FOR THE AMOUNT OF THE SPOT AWARD BUT THE AMOUNT TENDS TO NOT EXCEED 5% TO 10% OF GROSS ANNUAL SALARY. ANNUAL INCENTIVE PLAN (AIP): THE PURPOSE OF THE PLAN IS TO FOCUS EXECUTIVES ON SPECIFIC, SHORTER-TERM GOALS THAT ARE CRITICAL TO THE ACHIEVEMENT OF AFFILIATE, OPERATING UNIT AND SYSTEM-WIDE OBJECTIVES THAT DRIVE OVERALL ORGANIZATION PERFORMANCE. A PORTION OF THE PLAN AWARD IS DISCRETIONARY IN THAT THE SUPERVISOR MAY ADD UP TO 5% TO THE AWARD PROVIDED THE TOTAL AWARD (FORMULA PORTION PLUS DISCRETIONARY) DOES NOT EXCEED THE MAXIMUM ESTABLISHED FOR ANY GIVEN EXECUTIVE. LONG TERM PERFORMANCE PLANS: SUTTER HEALTH ALSO EMPLOYS A LONG TERM PERFORMANCE PLAN WHICH IS DESIGNED TO FOCUS ON LONGER TERM STRATEGIC OBJECTIVES OF THE ORGANIZATION. SUTTER'S LONG TERM PERFORMANCE PLAN APPROACH IS A COMBINATION OF BOTH LONGER TERM MEASURES OF ORGANIZATION SUCCESS AND KEY ORGANIZATION STRATEGIES WHICH REQUIRE THE COMBINED EFFORT OF ALL LEADERSHIP TO ACHIEVE SUCCESS. SUTTER USES A COMMON FATE APPROACH IN THAT ALL LONG TERM PERFORMANCE PLAN PARTICIPANTS ARE MEASURED AGAINST THE SAME, ORGANIZATION-WIDE CRITERIA VS. INDIVIDUAL EFFORTS. THIS FOSTERS A COMMON PURPOSE ACROSS LEADERSHIP AND A SHARED SENSE OF ACCOUNTABILITY FOR THE OVERALL SUCCESS OF SUTTER HEALTH. TO ENSURE THAT EXTRAORDINARY EFFORTS BY INDIVIDUALS CAN BE RECOGNIZED AND THAT ACTIONS OF LEADERSHIP ARE CONSISTENT WITH SUPPORTING SUTTER HEALTH'S OVERALL MISSION, VISION, AND VALUES, SUTTER'S LONG TERM PERFORMANCE PLAN APPROACH ALSO INCORPORATES A COMBINATION OF CEO AND SUTTER HEALTH COMPENSATION COMMITTEE DISCRETION. IN SOME CASES, THE SUTTER HEALTH COMPENSATION COMMITTEE HAS DELEGATED AUTHORITY TO THE PRESIDENT & CEO TO MODIFY INDIVIDUAL AWARDS WITHIN LIMITS THAT HAVE BEEN PRE-APPROVED BY THE SUTTER HEALTH COMPENSATION COMMITTEE. THIS INCLUDES BOTH THE REDUCTION AND INCREASE OF AWARD AMOUNTS. SUCH MODIFICATIONS GENERALLY DO NOT EXCEED +/- 20% AND ARE EMPLOYED JUDICIOUSLY. IN ALL CASES, THE COMPENSATION COMMITTEE OF THE BOARD DETERMINES ACHIEVEMENT OF ORGANIZATION GOALS AND MAKES FINAL AWARD DETERMINATION WHICH MAY RESULT IN A REDUCTION OF AWARD IF APPROPRIATE. ALL SENIOR EXECUTIVE AWARDS ARE REVIEWED FOR COMPENSATION REASONABLENESS AND APPROVED BY THE COMPENSATION COMMITTEE PRIOR TO PAYMENT.

Additional Data

Software ID:  
Software Version:  
EIN: 94-1156621  
Name: SUTTER VALLEY HOSPITALS

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				
1James Conforti President SH Valley Area	(i)	0	0	0	0	0	0	0
	(ii)	772,743	795,319	359,215	404,353	23,671	2,355,301	693,304
1Peter Hull MD Trustee/CME, SVH	(i)	0	0	0	0	0	0	0
	(ii)	330,846	0	6,052	54,347	17,797	409,042	0
2Sarah Krevans President & CEO, Sutter Health	(i)	0	0	0	0	0	0	0
	(ii)	1,681,729	2,410,475	222,583	1,926,153	25,705	6,266,645	1,297,143
3Paige Terra CFO SH, Valley Area	(i)	0	0	0	0	0	0	0
	(ii)	487,027	344,752	30,209	122,753	19,848	1,004,589	168,849
4Penny Westfall CHIEF LEGAL OFC SH VALLEY AREA	(i)	0	0	0	0	0	0	0
	(ii)	396,471	303,172	37,288	103,703	8,460	849,094	151,555
5Doug Archer ADMIN, MEMORIAL HOSP LOS BANOS	(i)	0	0	0	0	0	0	0
	(ii)	249,818	109,378	9,923	46,745	17,027	432,891	46,990
6John W Boyd CEO, Mental Health Services	(i)	0	0	0	0	0	0	0
	(ii)	375,190	268,901	22,371	100,021	11,961	778,444	123,923
7Pat Brady CEO, SRMC (PART-YEAR)	(i)	0	0	0	0	0	0	0
	(ii)	502,456	381,210	90,885	88,653	20,343	1,083,547	263,919
8David Cheney CEO, SMCS (part-year)	(i)	0	0	0	0	0	0	0
	(ii)	495,566	25,000	7,191	87,486	10,449	625,692	0
9Michael Cohill CEO, SMCS (part-year)	(i)	0	0	0	0	0	0	0
	(ii)	137,463	759,945	294,524	85,084	2,014	1,279,030	348,360
10Grant Davies CEO, Valley Area Hospitals	(i)	0	0	0	0	0	0	0
	(ii)	664,382	618,289	78,987	206,353	23,200	1,591,211	319,997
11Abhishek Dosi CEO, SSMC	(i)	0	0	0	0	0	0	0
	(ii)	214,953	0	5,420	37,581	15,272	273,226	0
12Mitch Hanna CEO, SCH & SAFH	(i)	0	0	0	0	0	0	0
	(ii)	356,945	296,126	99,497	121,003	19,776	893,347	125,400
13Daryn Kumar CEO, MMC	(i)	0	0	0	0	0	0	0
	(ii)	446,434	318,346	44,919	59,253	16,493	885,445	181,233
14Jennifer Maher CEO, SRMC (PART-YEAR)	(i)	0	0	0	0	0	0	0
	(ii)	296,211	211,027	9,413	78,053	12,004	606,708	76,920
15Anne Platt CEO, Sutter Amador Hospital	(i)	0	0	0	0	0	0	0
	(ii)	290,635	238,472	33,520	83,553	16,055	662,235	126,753
16David Thompson CEO, STCH & MHLB	(i)	0	0	0	0	0	0	0
	(ii)	383,852	338,931	52,723	116,203	20,030	911,739	184,035
17Bnan Alexander VP, Strgy & Bus Dev, SH Valley	(i)	0	0	0	0	0	0	0
	(ii)	301,244	262,886	27,854	70,170	12,526	674,680	122,719
18Asit Gokli MD CMO, SH Valley Area	(i)	0	0	0	0	0	0	0
	(ii)	490,684	382,157	190,374	123,953	16,568	1,203,736	350,744
19John Mesic MD PHYSICIAN EXEC, SH VALLEY AREA	(i)	0	0	0	0	0	0	0
	(ii)	593,467	474,561	76,351	178,953	16,357	1,339,689	208,320

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				
<b>21</b> Faraaz Yousuf COO, SUTTER MED CTR SACRAMENTO	(i)	0	0	0	0	0	0	0
	(ii)	137,463	163,628	232,433	29,507	7,547	570,578	93,865
<b>1</b> Philip Yu MD CME, SUTTER TRACY COMM HOSP	(i)	0	0	0	0	0	0	0
	(ii)	328,111	155,241	6,442	65,953	17,272	573,019	47,880
<b>2</b> Jeff Sprague SVP & CFO, SVH FINANCE ADMIN	(i)	0	0	0	0	0	0	0
	(ii)	724,980	778,891	144,710	564,953	20,977	2,234,511	471,045
<b>3</b> Thomas Blinn CEO, SH VALLEY AREA FOUNDATION	(i)	0	0	0	0	0	0	0
	(ii)	14,705	503,421	205,050	35,557	1,961	760,694	224,760
<b>4</b> Terry Glubka CEO, SSCD	(i)	0	0	0	0	0	0	0
	(ii)	427,609	341,771	57,584	130,378	15,632	972,974	190,026
<b>5</b> Carrie Owen-Plietz FORMER CEO, SUTTER MED CTR SAC	(i)	0	0	0	0	0	0	0
	(ii)	0	0	159,228	0	438	159,666	0
<b>6</b> Thomas Ream II REG CIO SUTTER VALLEY HOSPITLS	(i)	0	0	0	0	0	0	0
	(ii)	0	85,500	67,519	0	438	153,457	57,000
<b>7</b> Janet Wagner CEO, MILLS PENINSULA DIVISION	(i)	0	0	0	0	0	0	0
	(ii)	425,597	374,580	69,687	148,603	17,719	1,036,186	222,740

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service  
Name of the organization  
SUTTER VALLEY HOSPITALS

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number

94-1156621

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 CHFFA 2008A	52-1643828	13033F2L3	05-14-2008	329,041,638	REFUNDING 5/1/07, 04 & 02		X		X		X
B CSCDA 2011A	68-0164610	1307952Q9	02-10-2011	271,589,951	CONSTRUCT & EQUIP FACILITY		X		X		X
C CSCDA 2011C	68-0164610	1307954U8	12-22-2011	38,777,964	REFUNDING - 1999		X		X		X
D CHFFA 2011D	52-1643828	13033LVW4	12-22-2011	331,759,643	CONSTRUCT & REFUNDING		X		X		X

Part II		Proceeds							
		A		B		C		D	
1	Amount of bonds retired . . . . .	153,305,000		0		0		0	
2	Amount of bonds legally defeased . . . . .	118,730,000		0		0		0	
3	Total proceeds of issue . . . . .	329,041,638		276,420,623		38,777,964		334,684,174	
4	Gross proceeds in reserve funds . . . . .	0		0		0		0	
5	Capitalized interest from proceeds . . . . .	0		0		0		0	
6	Proceeds in refunding escrows . . . . .	0		0		0		0	
7	Issuance costs from proceeds . . . . .	0		0		0		0	
8	Credit enhancement from proceeds . . . . .	0		0		0		0	
9	Working capital expenditures from proceeds . . . . .	0		0		0		0	
10	Capital expenditures from proceeds . . . . .	0		276,420,623		0		145,589,174	
11	Other spent proceeds . . . . .	329,041,638		0		38,777,964		189,095,000	
12	Other unspent proceeds . . . . .	0		0		0		0	
13	Year of substantial completion . . . . .			2014				2014	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue? . . . . .	X			X	X		X	
15	Were the bonds issued as part of an advance refunding issue? . . . . .		X		X		X		X
16	Has the final allocation of proceeds been made? . . . . .	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X		X		X	

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

Part III

Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b>	Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X		X		X		X	
<b>b</b>	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
<b>c</b>	Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X		X		X
<b>d</b>	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?								
<b>4</b>	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . ▶	1 800 %		0 960 %		0 500 %		0 710 %	
<b>5</b>	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶	0 430 %		0 010 %		0 %		0 010 %	
<b>6</b>	Total of lines 4 and 5 . . . . .	2 230 %		0 970 %		0 500 %		0 720 %	
<b>7</b>	Does the bond issue meet the private security or payment test? . . .		X		X		X		X
<b>8a</b>	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X		X		X
<b>b</b>	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
<b>c</b>	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .		X		X		X		X
<b>9</b>	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X		X		X		X	

Part IV

Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b>	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . .		X		X		X		X
<b>2</b>	If "No" to line 1, did the following apply? . . . .								
<b>a</b>	Rebate not due yet? . . . . .		X		X		X		X
<b>b</b>	Exception to rebate? . . . . .		X		X		X		X
<b>c</b>	No rebate due? . . . . .	X		X		X		X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b>	Is the bond issue a variable rate issue? . . . . .		X		X		X		X
<b>4a</b>	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
<b>b</b>	Name of provider . . . . .	0		0		0		0	
<b>c</b>	Term of hedge . . . . .								
<b>d</b>	Was the hedge superintegrated? . . . . .								
<b>e</b>	Was the hedge terminated? . . . . .								

**Part IV Arbitrage** (Continued)

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
<b>b</b> Name of provider . . . . .	0		0		0		0	
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . .	X		X		X		X	

**Part V Procedures To Undertake Corrective Action**

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

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

Return Reference	Explanation
SCHEDULE K	THE ORGANIZATIONS SOLE CORPORATE MEMBER IS A CONDUIT BORROWER OF TAX-EXEMPT BOND ISSUES THAT ALLOCATES PORTIONS OF EACH ISSUE TO CERTAIN SUBSIDIARY ORGANIZATIONS, INCLUDING THE ORGANIZATION THE OUTSTANDING BOND LIABILITY ALLOCATED TO THIS ORGANIZATION IS REPORTED ON FORM 990, PART X, BALANCE SHEET, AND PART VI HEREIN WITH THE EXCEPTION OF THIS PORTION OF PART VI, THE SCHEDULE K FOR THIS ORGANIZATION IS REPORTING INFORMATION FOR THE ENTIRE BOND ISSUE



Return Reference	Explanation
<p>SCHEDULE K, PART I-1, COLUMN (E)</p>	<p>THE FILING ORGANIZATION RECEIVED BOND PROCEEDS IN THE AMOUNTS OF \$213,941,683 FROM THE 2008A ISSUE, \$271,589,951 FROM THE 2011A ISSUE, \$25,952,489 FROM THE 2011C ISSUE, AND \$59,991,527 FROM THE 2011D ISSUE THE DIFFERENCE BETWEEN THE ISSUE PRICE REPORTED IN PART I, COLUMN (E) AND THE PROCEEDS OF ISSUE IN PART II, LINE 3 IS DUE TO INVESTMENT EARNINGS SCHEDULE K, PART I-2, COLUMN (E) THE FILING ORGANIZATION RECEIVED BOND PROCEEDS IN THE AMOUNTS OF \$132,681,869 FROM THE 2012A ISSUE, \$46,787,671 FROM THE 2015A ISSUE, \$190,388,783 FROM THE 2016B ISSUE, AND \$266,365,544 FROM THE 2017A ISSUE THE DIFFERENCE BETWEEN THE ISSUE PRICE REPORTED IN PART I, COLUMN (E) AND THE PROCEEDS OF ISSUE IN PART II, LINE 3 IS DUE TO INVESTMENT EARNINGS SCHEDULE K, PART I-1, LINE B, COLUMN (F) (CHFFA 2008A) THE REFUNDING OCCURRED VIA THE REPAYMENT OF A DRAW ON A TAXABLE LINE OF CREDIT, DRAWN IN SEVERAL INSTALLMENTS BETWEEN APRIL 7 AND APRIL 11, 2008, USED TO REFUND THE 2007, 2004 AND 2002 ISSUES THE REFUNDED BONDS ISSUED IN 2007 WERE USED TO REFUND BONDS ISSUED IN 1991 AND 1995 THE REFUNDED BONDS ISSUED IN 2004 WERE USED FOR EXPANSION THE REFUNDED BONDS ISSUED IN 2002 WERE USED TO REFUND BONDS ISSUED IN 1992, WHICH WERE USED TO REFUND BONDS ISSUED IN 1985, 1986 AND 1987 SCHEDULE K, PART II, LINE 7 ISSUANCE COSTS WERE FUNDED THROUGH EQUITY CONTRIBUTIONS SCHEDULE K, PART IV, LINE 2C THE REBATE COMPUTATIONS WERE PERFORMED FOR BOND CHFFA 2008A ON 6/21/2013, BOND CSCDA 2011A ON 3/15/2016, BOND CSCDA 2011C ON 1/13/2016, AND BOND CHFFA 2011D ON 1/13/2016</p>

Schedule K  
(Form 990)

Department of the Treasury  
Internal Revenue Service  
Name of the organization  
SUTTER VALLEY HOSPITALS

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number

94-1156621

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 CSCDA 2012A	68-0164610	1307956K8	07-11-2012	132,681,869	REFUNDING 2002		X		X		X
B CHFFA 2015A	52-1643828	13032UAR9	11-12-2015	204,061,105	REFUND 2005A & 1995 CERTIFICATES		X		X		X
C CHFFA 2016B	52-1643828	13032UDW5	08-17-2016	901,627,093	REFUND 2003AB, 2005BC & 2007A	X			X		X
D CHFFA 2017A	52-1643828	13032UNY0	07-06-2017	496,319,743	Refund 2004CD,2008BC,Partial 2008A	X			X		X

Part II

Proceeds

		A		B		C		D	
1	Amount of bonds retired . . . . .	0		0		0		0	
2	Amount of bonds legally defeased . . . . .	0		0		0		0	
3	Total proceeds of issue . . . . .	132,681,869		204,061,105		902,923,938		496,319,743	
4	Gross proceeds in reserve funds . . . . .	0		0		0		0	
5	Capitalized interest from proceeds . . . . .	0		0		0		0	
6	Proceeds in refunding escrows . . . . .	0		0		0		0	
7	Issuance costs from proceeds . . . . .	0		0		0		0	
8	Credit enhancement from proceeds . . . . .	0		0		0		0	
9	Working capital expenditures from proceeds . . . . .	0		0		0		0	
10	Capital expenditures from proceeds . . . . .	0		0		0		0	
11	Other spent proceeds . . . . .	132,681,869		204,061,105		902,923,938		496,319,743	
12	Other unspent proceeds . . . . .	0		0		0		0	
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			X		X
15	Were the bonds issued as part of an advance refunding issue? . . . .		X		X	X		X	
16	Has the final allocation of proceeds been made? . . . . .	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X		X		X	

Part III

Private Business Use

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

**Part III Private Business Use** (Continued)

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X		X		X		X	
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X		X		X
<b>d</b> 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?								
<b>4</b> 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 . . . . ▶	0 170 %		0 250 %		0 380 %		1 580 %	
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶	0 010 %		0 %		0 %		0 380 %	
<b>6</b> Total of lines 4 and 5 . . . . .	0 180 %		0 250 %		0 380 %		1 960 %	
<b>7</b> Does the bond issue meet the private security or payment test? . . .		X		X		X		X
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X		X		X
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .		X		X		X		X
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X		X		X		X	

**Part IV Arbitrage**

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . .		X		X		X		X
<b>2</b> If "No" to line 1, did the following apply? . . . .								
<b>a</b> Rebate not due yet? . . . . .	X		X		X		X	
<b>b</b> Exception to rebate? . . . . .		X		X		X		X
<b>c</b> No rebate due? . . . . .		X		X		X		X
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .		X		X		X		X
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
<b>b</b> Name of provider . . . . .	0		0		0		0	
<b>c</b> Term of hedge . . . . .								
<b>d</b> Was the hedge superintegrated? . . . . .								
<b>e</b> Was the hedge terminated? . . . . .								

**Part IV Arbitrage** (Continued)

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
<b>b</b> Name of provider . . . . .	0		0		0		0	
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . .	X		X		X		X	

**Part V Procedures To Undertake Corrective Action**

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

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

Schedule L  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Transactions with Interested Persons

► Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.  
► Attach to Form 990 or Form 990-EZ.  
► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2017

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Name of the organization  
SUTTER VALLEY HOSPITALS

Employer identification number  
94-1156621

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

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

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

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

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

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

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

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

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) MICHAEL NEWELL	SEE PART V	110,565	SEE PART V		No
(2) HELEN THOMPSON	SEE PART V	16,401	SEE PART V		No
(3) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	3,187,201	INDPNDT CONTRACTOR ARRANGEMENT		No
(4) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	332,943	INDPNDT CONTRACTOR ARRANGEMENT		No

**Part V Supplemental Information**

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

Return Reference	Explanation
SCHEDULE L, PART IV	DESCRIPTION OF BUSINESS TRANSACTIONS WITH INTERESTED PERSONS THE SPOUSE OF TRUSTEE MICHAEL NEWELL IS A RN AT SUTTER DAVIS HOSPITAL WHICH IS PART OF SVH THE DAUGHTER OF TRUSTEE HELEN THOMSON IS A RN AT SUTTER CENTER FOR PSYCHIATRY WHICH IS PART OF SVH

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](http://www.irs.gov/form990)

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization  
SUTTER VALLEY HOSPITALS

Employer identification number  
94-1156621

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 . . . . .	X	1	25,794	FMV
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .				
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ► ( ) . . . . .				
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

Yes

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 M, PART I, COLUMN (B)	COLUMN (B) REPRESENTS THE NUMBER OF CONTRIBUTIONS RECEIVED



**SCHEDULE O**  
(Form 990 or 990-EZ)

Department of the Treasury  
~~Internal Revenue Service~~

Name of the organization  
SUTTER VALLEY HOSPITALS

**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](http://www.irs.gov/form990).

OMB No 1545-0047

**2017**

**Open to Public  
Inspection**

**Employer identification number**

94-1156621

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 1 AND PART III, LINE 1	MISSION STATEMENT MISSION - WE ENHANCE THE HEALTH AND WELL-BEING OF PEOPLE IN THE COMMUNITIES WE SERVE, THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTH CARE SERVICES VISION - SUTTER HEALTH LEADS THE TRANSFORMATION OF HEALTH CARE TO ACHIEVE THE HIGHEST LEVELS OF QUALITY, ACCESS AND AFFORDABILITY VALUES - EXCELLENCE AND QUALITY, CARING AND COMPASSION, HONESTY AND INTEGRITY, TEAMWORK, COMMUNITY AND AFFORDABILITY

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>PROGRAM SERVICE ACCOMPLISHMENTS SUTTER VALLEY HOSPITALS SUTTER VALLEY HOSPITALS SERVES S ACRAMENTO, PLACER, AMADOR, EL DORADO, NEVADA, YOLO, SOLANO, YUBA, SUTTER, STANISLAUS, MERC ED, AND SAN JOAQUIN COUNTIES WITH COMPREHENSIVE HEALTH CARE WE STRIVE TO PROVIDE ACCESS T O PRIMARY CARE PHYSICIANS AND SPECIALTY SERVICES IN EACH OF OUR COMMUNITIES, AND HAVE A NE TWORK OF MORE THAN 1,800 PHYSICIANS REGIONALLY AND MORE THAN 5,500 PHYSICIANS THROUGHOUT T HE SUTTER HEALTH SYSTEM EFFECTIVE MAY 1, 2017, SUTTER CENTRAL VALLEY HOSPITALS, A RELATED TAX-EXEMPT AFFILIATE OF SUTTER HEALTH, WHICH INCLUDES MEMORIAL MEDICAL CENTER, MEMORIAL H OSPITAL LOS BANOS, AND SUTTER TRACY COMMUNITY HOSPITAL, MERGED INTO SUTTER VALLEY HOSPITAL S SUTTER VALLEY HOSPITALS PROVIDES MORE THAN \$900 MILLION IN CHARITY CARE AND COMMUNITY B ENEFITS AND HAD A TOTAL OF 363,534 PATIENT DAYS IN 2017 SUTTER VALLEY HOSPITALS IS COMPRI SED OF THE FOLLOWING HOSPITALS SUTTER AUBURN FAITH HOSPITAL IS LICENSED FOR 64 ACUTE BEDS , AND IS ACCREDITED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIO NS IT IS MEDICARE CERTIFIED AND ACCEPTS MOST PRIVATE INSURANCE PLANS SUTTER AUBURN FAITH HOSPITAL'S MISSION IS TO SERVE THE HEALTHCARE NEEDS OF AUBURN AND THE SURROUNDING FOOTHIL L COMMUNITIES THROUGH PARTNERSHIPS WITH PHYSICIANS, PAYORS, OTHER HEALTH AND HUMAN SERVIC ES AGENCIES AND WITH OUR EMPLOYEES AND VOLUNTEER LEADERSHIP, SUTTER AUBURN FAITH HOSPITAL SEEKS TO PROVIDE A CONTINUUM OF HEALTH AND WELLNESS SERVICES TO ASSURE A HIGH QUALITY OF L IFE FOR THE PEOPLE LIVING IN OUR SERVICE AREA SUTTER AMADOR HOSPITAL IS A 52-BED ACUTE CA RE HOSPITAL LOCATED IN JACKSON, CALIFORNIA, APPROXIMATELY 55 MILES SOUTHEAST OF SACRAMENTO IN AMADOR COUNTY THE HOSPITAL WAS ESTABLISHED IN THE MID-1800S AND BECAME AFFILIATED WIT H SUTTER HEALTH IN 1993 SUTTER AMADOR HOSPITALS MISSION IS TO ENHANCE THE HEALTH AND WELL -BEING OF THE RESIDENTS IN THE COMMUNITIES SERVED BY PROVIDING COORDINATED, EFFECTIVE, AFF ORDABLE AND ACCESSIBLE HEALTH AND WELLNESS SERVICES SUTTER AMADOR HOSPITAL CONTINUOUSLY S TRIVES TO IDENTIFY THE HEALTH CARE NEEDS OF THESE COMMUNITIES AND RESPONDS BY PROVIDING HE ALTH AND WELLNESS SERVICES CONSISTENT WITH THE STATED VALUES AND VISION OF THE HOSPITAL S UTTER DAVIS HOSPITAL IS A TWO-STORY 90,000 SQUARE FOOT ACUTE CARE HOSPITAL LICENSED FOR 48 BEDS THAT SERVES THE HEALTH CARE NEEDS OF RESIDENTS LIVING IN DAVIS, DIXON, WOODLAND AND WINTERS THE FACILITY IS LOCATED IN THE WESTERN-MOST SECTION OF THE CITY OF DAVIS AT THE C ORNER OF HIGHWAY 113 AND COVELL BOULEVARD SUTTER DAVIS IS ACCREDITED BY THE JOINT COMMISS ION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS IT IS MEDICARE CERTIFIED AND ACCEPTS MOST PRIVATE INSURANCE PLANS AS A NOT-FOR-PROFIT HOSPITAL, SUTTER DAVIS ALSO DONATES MANY COMMUNITY SERVICES SUTTER MEDICAL CENTER OF SACRAMENTO MEDICAL CAMPUS INCLUDES TWO ACUT E CARE HOSPITALS ANDERSON LUCCHETTI WOMENS AND CHILDRENS CENTER AND OSE ADAMS MEDICAL PAVI LION, ALONG WITH TWO BUILDINGS</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>DEDICATED TO DOCTORS OFFICES AND OTHER CARE FOUND IN AN OUTPATIENT SETTING BY LOCATING A LL PRIMARY AND SPECIALTY CARE SERVICES IN A CENTRAL LOCATION WITH CONVENIENT FREEWAY ACCES S, PATIENTS AND FAMILIES NOW GAIN FASTER AND EASIER ACCESS TO NEEDED MEDICAL SERVICES THE 242-BED ANDERSON LUCCHETTI WOMEN'S AND CHILDREN'S CENTER IS A 10-STORY ACUTE-CARE HOSPITA L WHERE PATIENTS AND THEIR FAMILIES CAN OBTAIN THE HIGHEST LEVEL OF NEONATAL AND PEDIATRIC INTENSIVE CARE SERVICES, PEDIATRIC CARDIAC, NEUROSURGERY AND CANCER SERVICES, AND HIGH-RI SK AND CONVENTIONAL MATERNITY SERVICES IT REPLACES SUTTER MEMORIAL HOSPITAL AS "SACRAMENT O'S BABY HOSPITALIS HOME TO THE SUTTER CHILDRENS CENTER, SACRAMENTO, A COMPREHENSIVE CHILD RENS HOSPITAL INSIDE THE WOMENS AND CHILDRENS CENTER AMONG THE FEATURES OF THE WOMENS AND CHILDRENS CENTER - ALL PRIVATE ROOMS, INCLUDING THOSE FOR NEW MOMS AND OUR PEDIATRIC PAT IENTS THE ROOMS HAVE FURNITURE THAT CONVERTS INTO BEDS FOR FAMILIES TO STAY OVERNIGHT WIT H THEIR LOVED ONES - A LIFE- SAVING HELISTOP ATOP THE BUILDING ADJACENT TO THE CAPITAL CIT Y FREEWAY WILL ALLOW FOR THE QUICK AND SAFE TRANSPORT OF PREEMIES AND OTHER SICK BABIES AS WELL AS OTHER PATIENTS - MOTHERS WHO HAVE GIVEN BIRTH ARE TREATED TO SPACIOUS SUITES WIT H 8TH-FLOOR VIEWS OF THE CITYS SKYLINE AND THE FOOTHILLS - THE NEONATAL INTENSIVE CARE UN IT FEATURES 61 BEDS FOR OUR TINIEST AND SICKEST BABIES IN A SETTING THAT LOOKS LIKE HOME A ND ALLOWS FAMILIES TO BE MORE INVOLVED IN THE BABIES' CARE - FACILITIES THAT INCLUDE WASH ERS AND DRYERS AND A KITCHEN FOR FAMILIES WHO HAVE EXTENSIVE STAYS OSE ADAMS MEDICAL PAVI LION THE 281-BED OSE ADAMS MEDICAL PAVILION WAS PREVIOUSLY KNOWN AS SUTTER GENERAL HOSPITA L WHILE THE OUTER SHELL OF THE OSE ADAMS MEDICAL PAVILION REMAINS MUCH THE SAME WITH AN E XPANSION IN THE SOUTHEAST CORNER TO FACILITATE THE DEDICATED PEDIATRIC EMERGENCY DEPARTMEN T AND OTHER SERVICES THE TRANSFORMATION OF THE HOSPITAL INCLUDES MAJOR ENHANCEMENTS TO ALL FIVE FLOORS WITH EMPHASIS ON FIVE MAIN SERVICES EMERGENCY MEDICINE, CARDIOVASCULAR, NEUR OSCIENCES, ORTHOPEDICS AND ONCOLOGY THE UPDATED THIRD FLOOR CONTAINS 24 OPERATING SUITES FOR INPATIENT SURGERIES IT IS THE NEW HOME FOR THE SUTTER HEART &amp; VASCULAR INSTITUTE, WHI CH BEGAN AT SUTTER MEMORIAL HOSPITAL WITH THE REGIONS FIRST OPEN-HEART SURGERIES IN THE LA TE 1950S AND EARLY 1960S OSE ADAMS MEDICAL PAVILION HAS SIX NEW HEART CATHETERIZATION LAB S AND HYBRID SUITES, AND FOUR SPECIALIZED OPERATING ROOMS DEDICATED TO HEART SURGERY ONE S ET UP SOLELY FOR PEDIATRIC HEART PATIENTS BECAUSE OF THE COMPLEX BRAIN AND OTHER SURGERIE S AND PROCEDURES, THE OSE ADAMS MEDICAL PAVILION HOUSES 10 SPECIALLY DESIGNED, PRIVATE OBS ERVATION BEDS ON THE FIFTH FLOOR THESE OBSERVATION UNITS WILL CONTAIN STATE-OF-THE-ART EQ UIPMENT DEDICATED TO THE SPECIALIZED CARE OF SUTTER NEUROSCIENCE INSTITUTE PATIENTS SUTTE R ROSEVILLE MEDICAL CENTER (SRMC) WAS ESTABLISHED IN 1952 AND AFFILIATED WITH SUTTER HEALT H IN MAY 1993 IN 1997, SUTTER</p>

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>HEALTH OPENED A 172-BED FACILITY IN THE NORTHEAST AREA OF ROSEVILLE, APPROXIMATELY 20 MILES FROM DOWNTOWN SACRAMENTO. THE HOSPITAL TODAY HAS 328 BEDS AND PROVIDES RESIDENTS OF SOUTHERN PLACER AND NORTHEASTERN SACRAMENTO COUNTIES WITH COMPREHENSIVE COMMUNITY HEALTH CARE. THE FACILITY HAS AN EXPANDED HELIPAD ON-SITE FOR QUICK ACCESS TO THE HOSPITAL'S LEVEL II TRAUMA CENTER, WHICH SERVES A SEVEN-COUNTY REGION THAT INCLUDES PLACER, YOLO, NEVADA, SUTTER AND YUBA COUNTIES, AND PORTIONS OF SACRAMENTO AND EL DORADO COUNTIES. SUTTER ROSEVILLE MEDICAL CENTER'S MISSION IS TO IMPROVE THE HEALTH AND WELL-BEING OF THE PEOPLE LIVING IN THE COMMUNITIES IT SERVES. SUTTER ROSEVILLE MEDICAL CENTER STRIVES CONTINUOUSLY TO IDENTIFY THE HEALTH CARE NEEDS OF THESE COMMUNITIES AND RESPOND BY PROVIDING WELLNESS, PREVENTIVE, CURATIVE AND RESTORATIVE PROGRAMS AND SERVICES CONSISTENT WITH THE STATED VALUES AND VISION OF THE HOSPITAL. SUTTER SOLANO MEDICAL CENTER (SSMC) IS A 106 LICENSED BED ACUTE CARE HOSPITAL IN VALLEJO, CALIFORNIA, BETWEEN SACRAMENTO AND SAN FRANCISCO. THE NOT-FOR-PROFIT, COMMUNITY-BASED FACILITY IS FULLY ACCREDITED BY THE JOINT COMMISSION AND PROVIDES A FULL RANGE OF GENERAL, EMERGENCY AND MEDICAL/SURGICAL SPECIALTIES. SSMC AFFILIATED WITH SUTTER HEALTH IN 1984 ENSURING THE ABILITY TO CONTINUE PROVIDING AND IMPROVING HEALTHCARE AND WELLNESS SERVICES TO THE COMMUNITY. SUTTER SOLANO MEDICAL CENTER'S MISSION IS TO ENHANCE THE HEALTH AND WELL-BEING OF PEOPLE IN THE COMMUNITIES SERVED, THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTH CARE SERVICES. SUTTER CENTER FOR PSYCHIATRY IS A 73-BED ACUTE BEHAVIORAL MEDICINE SPECIALTY HOSPITAL THAT TREATS ADULTS, ADOLESCENTS AND CHILDREN. IT PROVIDES SERVICES TO CHILDREN FROM AGE 5 TO ELDERLY PATIENTS THROUGH A SPECTRUM OF CARE THAT ALLOWS EACH PERSON TO FIND THE LEVEL OF CARE NEEDED TO RETURN TO AN ACTIVE, HEALTHY LIFE. FAMILY MEMBERS AND SIGNIFICANT OTHERS ARE ENCOURAGED TO PARTICIPATE IN EACH PATIENT'S CARE BY TAKING PART IN EDUCATION SERVICES, THERAPY AND SUPPORT GROUPS. SCP ALSO OFFERS A CRITICAL INCIDENT DEBRIEFING TEAM TO HELP EMPLOYEES OF BUSINESSES COPE AFTER A TRAUMATIC OR VIOLENT EPISODE. SUTTER HEALTH EAP RESOURCES OFFERS CONFIDENTIAL ASSESSMENT, COUNSELING AND REFERRAL SERVICES TO EMPLOYEES OF LARGE AND SMALL BUSINESSES. SUTTER CENTER FOR PSYCHIATRY OFFERS THE ONLY INPATIENT EATING DISORDER PROGRAM IN NORTHERN CALIFORNIA. THIS NEW PROGRAM IS A SIX-BED SPECIALIZED TREATMENT PROGRAM FOR EATING DISORDER PATIENTS.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4A CONTINUED	<p>MEMORIAL MEDICAL CENTER (MMC) IS AN ACUTE CARE FACILITY LOCATED IN MODESTO, CALIFORNIA, 90 MILES SOUTH OF SACRAMENTO IN STANISLAUS COUNTY. CENTRALLY LOCATED TO SERVE OUR IMMEDIATE COUNTY AND OUTLYING AREAS, MEMORIAL WAS ESTABLISHED IN 1970. MEMORIAL MEDICAL CENTER IS CURRENTLY LICENSED FOR 423 ACUTE CARE BEDS AND IS A SUTTER HEALTH AFFILIATE. MEMORIAL HOSPITAL LOS BANOS (MHLB) IS A PRIVATE, NOT-FOR-PROFIT COMMUNITY HOSPITAL INCORPORATED UNDER CALIFORNIA LAW TO PROVIDE HEALTH CARE SERVICES WITHIN FINITE RESOURCES, TO CITIZENS OF LOS BANOS AND THE SURROUNDING GEOGRAPHICAL AREAS. WE PROVIDE HIGH QUALITY COMPASSIONATE CARE AND EXERCISE PRUDENT FISCAL RESPONSIBILITY. MHLB OPENED IN 1967 AND IS PART OF THE SUTTER CENTRAL VALLEY REGION. THE ORGANIZATION AFFILIATED WITH SUTTER HEALTH IN 1996 AND IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS. MEMORIAL HOSPITAL LOS BANOS IS CURRENTLY LICENSED FOR 40 ACUTE BEDS. SUTTER TRACY COMMUNITY HOSPITAL (STCH), SINCE 1948, CONTINUES TO BE THE ONLY FULL-SERVICE, 77 ACUTE CARE BEDS HOSPITAL WITHIN A 15-MILE RADIUS GEOGRAPHICALLY LOCATED IN TRACY, CALIFORNIA. STCH STAFF HAS THE OPPORTUNITY TO DELIVER CULTURALLY COMPETENT CARE TO THE DIVERSE POPULATION WITHIN ITS SERVICE AREA. AS A STATE-OF-THE-ART FACILITY, IT FEATURES THE LATEST MEDICAL TECHNOLOGY AND DIAGNOSTIC EQUIPMENT AND OFFERS A COMPREHENSIVE ARRAY OF INPATIENT AND OUTPATIENT SERVICES ON PAR WITH MANY LARGER, URBAN HOSPITALS. ADDITIONALLY, SUTTER TRACY IS COMMITTED TO BRINGING THE BEST AND BRIGHTEST PHYSICIANS AND THE LATEST ADVANCES IN MEDICINE TO THE COMMUNITY. IT IS AFFILIATED WITH MANY REMARKABLE, LOCAL PHYSICIANS WHO ARE AT THE FOREFRONT OF THEIR FIELD. SUTTER VALLEY HOSPITALS SERVICES INCLUDE - 24-HOUR EMERGENCY TREATMENT - ACUTE REHABILITATION - ANESTHESIOLOGY - BARIATRIC SURGERY - CANCER CARE - CARDIAC CATHETERIZATION LABORATORY - CARDIAC REHABILITATION - CARDIOPULMONARY SERVICES - CARDIOVASCULAR SERVICES - COMMUNITY BENEFIT - CONGESTIVE HEART FAILURE PROGRAM - CONTINENCE - CRITICAL CARE - DENTISTRY - DERMATOLOGY - DIABETES EDUCATION &amp; TREATMENT - DIAGNOSTIC IMAGING - DIALYSIS - DIGITAL MAMMOGRAPHY - EDUCATION RESPIRATORY THERAPY - ENDOSCOPY - FAMILY BIRTH CENTER - GASTROENTEROLOGY - HEART AND VASCULAR INSTITUTE - HOME HEALTH AND HOSPICE CARE - INFUSION THERAPY - INTENSIVE CARE - INTERNAL MEDICINE - IV THERAPY - LABORATORY - LACTATION ASSISTANCE PROGRAM - LEVEL II TRAUMA CENTER - MAJOR TRAUMA PATIENT RECEIVING CENTER - MEDICAL LIBRARY ACCESS - MODERN FAMILY BIRTHING CENTER - NEONATAL INTENSIVE CARE - NEPHROLOGY - NEUROLOGY - NUCLEAR MEDICINE - NUTRITIONAL SUPPORT SERVICES - OBSTETRICS AND PERINATAL CARE - OCCUPATIONAL MEDICINE - ONCOLOGY - OPHTHALMOLOGY - ORAL SURGERY - ORTHOPEDICS - OTOLARYNGOLOGY - OUTPATIENT SURGERY - PAIN MEDICINE - PALLIATIVE CARE - PASTORAL CARE - PATHOLOGY - PATIENT AND COMMUNITY EDUCATION - PEDIATRICS - PHARMACY - PLASTIC SURGERY - PODIATRY - PRIMARY CARE/FAMILY PRACTICE - PULMONARY REHABILITATION</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 4A CONTINUED	<p>TATION - RADIATION ONCOLOGY - RADIOLOGY - REHABILITATION / PHYSICAL THERAPY - REHABILITATION SERVICES - RESPIRATORY CARE - RESPIRATORY THERAPY - SENIOR SERVICES - SLEEP DISORDERS CENTER - SOCIAL SERVICES - SPECIALTY CARE - SPEECH THERAPY - SPIRITUAL SERVICES - SURGICAL SERVICES - SUTTER REHABILITATION INSTITUTE - TELEMETRY - TRANSFUSION MEDICINE - TRAUMA NEUROINTENSIVE CARE UNIT - UROLOGY - VNA (HOME HEALTH AND IV THERAPY) - WOMENS IMAGING CENTER - WOUND CARE SUTTER INSTITUTE FOR MEDICAL RESEARCH (SIMR) SUTTER VALLEY HOSPITALS OF SACRAMENTO SERVICE AREA IS COMMITTED TO PROVIDING THE BEST POSSIBLE HEALTHCARE TO ITS PATIENTS, AND THE SUTTER INSTITUTE FOR MEDICAL RESEARCH SUPPORTS THIS COMMITMENT BY PROVIDING RESEARCH SUPPORT AND EDUCATION PROGRAMS SIMR HAS A HISTORY OF OVER FIVE DECADES OF COMMITMENT TO MEDICAL RESEARCH SIMR HAS GAINED RECOGNITION FOR ITS INVESTIGATIVE STUDIES IN THE AREAS OF HEART, CANCER, ORTHOPEDICS, RESPIRATORY, NEUROLOGY, GI/GU AND MANY OTHER AREAS OF MEDICINE SIMRS PRIMARY OBJECTIVE IS TO HELP HEALTH PROFESSIONALS CONDUCT RESEARCH IN A CLINICAL SETTING BY PROVIDING MANAGEMENT AND ADMINISTRATIVE RESOURCES OTHERWISE UNAVAILABLE TO THE PRIVATE PRACTITIONER AT SIMR, SUTTER INVESTIGATORS RECEIVE SUPPORT IN FIVE AREAS - RESEARCH ADMINISTRATIVE SERVICES - RESEARCH SUPPORT SERVICES - CLINICAL TRIALS PROGRAM - LABORATORY RESEARCH AND TRAINING - SUTTER HEALTH CENTRAL AREA INSTITUTIONAL REVIEW COMMITTEE (IRC) COMMUNITY BENEFIT THE MEDICAL FACILITIES IN SUTTER VALLEY HOSPITALS (SVH) PLAY AN INTEGRAL ROLE IN PROVIDING DIRECT HEALTH CARE SERVICES AS WELL AS MONETARY GRANTS OR SPONSORSHIPS TO NON-PROFIT ORGANIZATIONS TO ADDRESS THE COMMUNITY HEALTH NEEDS OF VULNERABLE, UNDERINSURED, AND UNINSURED POPULATIONS IN THEIR COMMUNITIES THE COMMUNITY BENEFIT REPRESENTATIVES OF SVH WORK COLLABORATIVELY AND IN PARTNERSHIPS WITH A BROAD AND DIVERSE NETWORK OF COMMUNITY-BASED NON-PROFITS, CITY AND COUNTY AGENCIES, PHYSICIANS, AND NEIGHBORHOOD GROUPS TO IDENTIFY LOCAL NEEDS, FORMULATE COMMUNITY BENEFIT PLANS, AND TAKE APPROPRIATE FUNDING ACTIONS WHILE SBH MANAGEMENT SETS OVERALL GOALS FOR COMMUNITY BENEFITS, EACH OF THE FACILITIES MEDICAL CENTER ADMINISTRATORS ARE RESPONSIBLE FOR IDENTIFYING HOW LOCAL NEEDS ARE TO BE ADDRESSED IN FISCAL YEAR 2017, SUTTER VALLEY HOSPITALS PROVIDED A REGIONAL TOTAL OF \$124,178,142 MILLION IN COST OF SERVICES AND BENEFITS FOR THE POOR AND UNDERSERVED \$22,033,250 IN FINANCIAL ASSISTANCE, \$27,781,232 IN MEANS-TESTED PROGRAMS AND \$49,857,349 IN MEDICAID</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 1A	<p>THE AFFAIRS AND MANAGEMENT OF THE SUTTER VALLEY HOSPITALS (SVH) ARE SUPERVISED BY THE EXECUTIVE COMMITTEE WHICH HAS POWER TO TRANSACT ALL REGULAR BUSINESS OF SVH DURING THE PERIOD BETWEEN MEETINGS OF THE BOARD OF DIRECTORS THE EXECUTIVE COMMITTEE CONSISTS OF SVH'S CHAIR WHO SERVES AS CHAIR OF THE COMMITTEE, THE VICE CHAIR, THE CHAIR OF THE FINANCE AND PLANNING COMMITTEE, THE IMMEDIATE PAST CHAIR, IF HE OR SHE CONTINUES TO SERVE AS A DIRECTOR, AN ADDITIONAL DIRECTOR AND THE PRESIDENT OF SVH AT LEAST ONE COMMITTEE MEMBER IS A PHYSICIAN DIRECTOR FORM 990, PART VI, LINE 4 SIGNIFICANT CHANGES MADE TO THE ORGANIZATION'S GOVERNING DOCUMENTS MERGER INFORMATION MAY 1, 2017 SUTTER CENTRAL VALLEY HOSPITALS MERGED INTO SVH FORM 990, PART VI, LINES 6 &amp; 7A CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS THIS CORPORATION IS AN AFFILIATE OF SUTTER HEALTH, A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION SUTTER HEALTH IS THE SOLE MEMBER WITH THE RIGHT TO ELECT AT LEAST A MAJORITY OF THE MEMBERS OF THE BOARD OF DIRECTORS</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 7B	<p>CLASSES OF PERSONS, DECISIONS REQUIRING APPROVAL &amp; TYPE OF VOTING RIGHTS SUTTER HEALTH AS THE SOLE MEMBER OF THE ORGANIZATION IS ENTITLED TO EXERCISE FULLY ALL RIGHTS AND PRIVILEGES OF MEMBERS OF NONPROFIT CORPORATIONS UNDER THE CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION LAW, AND ALL OTHER APPLICABLE LAWS THE MEMBER HAS THE RIGHTS AND POWERS TO APPOINT (AND REMOVE) MEMBERS OF THE CORPORATION'S BOARD OF DIRECTORS, SUBJECT TO THE PROVISIONS OF THE BYLAWS IN ADDITION, THE MEMBER HAS THE RIGHT TO APPROVE THE FOLLOWING ACTIONS OF THE CORPORATION'S BOARD OF DIRECTORS A MERGER, CONSOLIDATION, REORGANIZATION, OR DISSOLUTION OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, B AMENDMENT OR RESTATEMENT OF THE ARTICLES OF INCORPORATION OR THE BYLAWS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, C ADOPTION OF OPERATING BUDGETS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, INCLUDING CONSOLIDATED OR COMBINED BUDGETS OF THE CORPORATION AND ALL SUBSIDIARY ORGANIZATIONS OF THE CORPORATION, D ADOPTION OF CAPITAL BUDGETS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, E AGGREGATE OPERATING OR CAPITAL EXPENDITURES ON AN ANNUAL BASIS THAT EXCEED APPROVED OPERATING OR CAPITAL BUDGETS BY A SPECIFIED DOLLAR AMOUNT TO BE DETERMINED FROM TIME TO TIME BY THE GENERAL MEMBER, F LONG-TERM OR MATERIAL AGREEMENTS INCLUDING, BUT NOT LIMITED TO, BORROWINGS, EQUITY FINANCINGS, CAPITALIZED LEASES AND INSTALLMENT CONTRACTS, AND PURCHASE, SALE, LEASE, DISPOSITION, HYPOTHECATION, EXCHANGE, GIFT, PLEDGE, OR ENCUMBRANCE OF ANY ASSET, REAL OR PERSONAL, WITH A FAIR MARKET VALUE IN EXCESS OF A DOLLAR AMOUNT TO BE DETERMINED FROM TIME TO TIME BY THE DIRECTORS OF THE GENERAL MEMBER, WHICH SHALL NOT BE LESS THAN 10% OF THE TOTAL ANNUAL CAPITAL BUDGET OF THE CORPORATION, G APPOINTMENT OF AN INDEPENDENT AUDITOR AND HIRING OF INDEPENDENT COUNSEL EXCEPT IN CONFLICT SITUATIONS BETWEEN THE GENERAL MEMBER AND THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, H THE CREATION OR ACQUISITION OF ANY SUBSIDIARY OR AFFILIATE ENTITY, I CONTRACTING WITH AN UNRELATED THIRD PARTY FOR ALL OR SUBSTANTIALLY ALL OF THE MANAGEMENT OF THE ASSETS OR OPERATIONS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, J APPROVAL OF MAJOR NEW PROGRAMS AND CLINICAL SERVICES OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY THE GENERAL MEMBER SHALL FROM TIME TO TIME DEFINE THE TERM "MAJOR" IN THIS CONTEXT, K APPROVAL OF STRATEGIC PLANS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, L ADOPTION OF QUALITY ASSURANCE POLICIES NOT IN CONFORMITY WITH POLICIES ESTABLISHED BY THE GENERAL MEMBER, M ANY TRANSACTION BETWEEN THE CORPORATION, A SUBSIDIARY OR AFFILIATE AND A DIRECTOR OF THE CORPORATION OR AN AFFILIATE OF SUCH DIRECTOR IN ADDITION, THE GENERAL MEMBER SHALL HAVE THE AUTHORITY (BY A VOTE OF NOT LESS THAN TWO-THIRDS (2/3) OF ITS BOARD), TO DECLARE A MAJOR ACTIVITY REQUIRING APPROVAL</p>



## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 11B	PROCESS USED BY MANAGEMENT &/OR GOVERNING BODY TO REVIEW FORM 990 SUTTER HEALTH HAS A CENTRALIZED TAX DEPARTMENT RESPONSIBLE FOR THE PREPARATION OF THE FORM 990 ANNUALLY THE TAX DEPARTMENT PROVIDES TRAINING AND EDUCATION TO AFFILIATE PERSONNEL WHO ASSIST THE TAX DEPARTMENT IN COLLECTING AND REVIEWING DATA TO BE REPORTED ON THE FORM 990 THE PREPARATION MATERIAL IS REVIEWED BY VARIOUS DEPARTMENTS INCLUDING TAX, FINANCE, LEGAL, AND HUMAN RESOURCES A NATIONAL ACCOUNTING FIRM PREPARES AND/OR REVIEWS THE RETURN A COMPLETED RETURN IS THEN REVIEWED BY THE TAX DEPARTMENT, THE AFFILIATE, AND THE CFO BEFORE THE RETURN IS FILED

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 12	<p>PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST EMPLOYEES ARE EDUCATED ON THE CONFLICT OF INTEREST POLICY AND THE NEED TO MAKE DISCLOSURE AS PART OF ANNUAL COMPLIANCE EDUCATION IN ADDITION, ANNUALLY A DISCLOSURE STATEMENT IS COMPLETED BY ALL DIRECTORS, OFFICERS AND KEY EMPLOYEES THAT INCLUDES AN ACKNOWLEDGEMENT THAT THEY HAVE READ THE CONFLICT OF INTEREST POLICY ON THIS STATEMENT THE INDIVIDUAL WILL LIST A WIDE RANGE OF INFORMATION WHICH INCLUDES BUSINESS RELATIONSHIPS, EMPLOYMENT RELATIONSHIPS, PROPERTY INTERESTS, AND THOSE OF RELATED PARTIES THE BOARD MAY CONSULT WITH THE OFFICE OF THE GENERAL COUNSEL AS NECESSARY IF THERE IS A POTENTIAL CONFLICT OF INTEREST RELATED TO A PARTICULAR TRANSACTION, THE INTERESTED INDIVIDUAL MUST DISCLOSE THE EXISTENCE AND NATURE OF THE RELATIONSHIP THE BOARD CHAIR MAY APPOINT A DISINTERESTED PERSON OR COMMITTEE TO INVESTIGATE THE CONFLICT UNTIL THE POTENTIAL CONFLICT IS RESOLVED, THE BOARD CHAIR (OR COMMITTEE CHAIR AS APPLICABLE) MAY REQUEST THE INDIVIDUAL TO NOT PARTICIPATE DURING RELATED PRESENTATIONS AND DISCUSSIONS IN ALL CIRCUMSTANCES INVOLVING AN ACTUAL CONFLICT, THE INTERESTED INDIVIDUAL SHALL LEAVE THE ROOM PRIOR TO THE BOARDS FINAL DISCUSSION AND VOTE</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 15	<p>PROCESS FOR DETERMINING COMPENSATION THE COMPENSATION COMMITTEE OF THE SUTTER HEALTH BOARD OF DIRECTORS RETAINS ULTIMATE DISCRETIONARY AUTHORITY OVER ALL ELEMENTS OF COMPENSATION TO ASSURE THAT ORGANIZATIONAL PURPOSES ARE APPROPRIATELY BEING SERVED THE COMPENSATION COMMITTEE USES CREDIBLE DATA SOURCES AND MAINTAINS AN OBJECTIVE "ARMS LENGTH" DECISION-MAKING PROCESS, ENSURING THE INTEGRITY OF SUTTERS EXECUTIVE PROGRAMS AND CONSISTENCY WITH THE ORGANIZATIONS OVERALL MISSION IN ORDER TO ENSURE EXTERNAL COMPETITIVENESS, NATIONAL, CALIFORNIA AND LOCAL MARKET AREA COMPENSATION DATA COMPARISONS ARE REVIEWED COMPETITIVE ANALYSIS INCLUDES (A) BASE SALARY, (B) TOTAL CASH (BASE SALARY + ANNUAL INCENTIVE), (C) TOTAL DIRECT CASH (BASE SALARY + ANNUAL INCENTIVE + LONG TERM INCENTIVE) AND (D) TOTAL REMUNERATION (BASE SALARY + ANNUAL INCENTIVE + BENEFITS AND LONG TERM INCENTIVE) THIS ANALYSIS INCLUDES COMPARABLE ORGANIZATIONS AND GEOGRAPHIC CONSIDERATIONS FOR THE MOST SENIOR EXECUTIVE POSITIONS, NATIONAL COMPARISONS FOR ORGANIZATIONS SIMILAR IN SIZE, SCOPE AND COMPLEXITY AS SUTTER HEALTH ARE MOST APPROPRIATE SINCE IT IS A NATIONAL MARKETPLACE IN WHICH SUTTER COMPETES FOR EXECUTIVE TALENT ON THE OTHER HAND, BECAUSE CALIFORNIA'S UNDERLYING COMPENSATION STRUCTURE IS HIGHER THAN NATIONAL DATA (ESPECIALLY IN THE BAY AREA), REGIONAL PAY ADJUSTMENTS MAY BE MADE OFFICERS AND KEY EMPLOYEES OF THIS ORGANIZATION UNDERGO A REVIEW AND COMPENSATION COMMITTEE APPROVAL ANNUALLY, AND SUCH APPROVAL IS RECORDED IN THE MINUTES EXECUTIVE COMPENSATION REVIEW WAS LAST COMPLETED IN DECEMBER 2017</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 19	AVAILABILITY OF GOVERNING DOCUMENTS, COI POLICY & FINANCIAL STATEMENTS THE SUTTER HEALTH SYSTEM POSTS ITS CURRENT AND PAST AUDITED FINANCIAL STATEMENTS AT SUTTERHEALTH.ORG OTHER DOCUMENTS ARE ALSO LOCATED AT THIS WEBSITE INCLUDING THE ANNUAL REPORT, MISSION STATEMENT, HISTORY, AND LINKS TO AFFILIATE WEBSITES THE GOVERNING DOCUMENTS ARE NOT AVAILABLE TO THE PUBLIC AT THIS TIME FORM 990, PART VII, SECTION A COMPENSATION OF BOARD MEMBERS THE FOLLOWING BOARD MEMBER OF THE ORGANIZATION IS A FULL-TIME EMPLOYEE (40 HOURS PER WEEK) OF SUTTER HEALTH AND THEIR SUTTER HEALTH SALARY IS REPORTED HEREIN THIS INDIVIDUAL RECEIVED NO COMPENSATION FOR THEIR SERVICE AS A BOARD MEMBER OF THIS ORGANIZATION - SARAH KREVANS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	OTHER CHANGES IN FUND BALANCE TRANSFER FROM SUTTER CENTRAL VALLEY HOSPITALS 121,960,673 K-1 ACTIVITY (441,389) PARTNERSHIP LOSS ON BOOKS (2,309,861) EQUITY TRANSFERS (NET) (302,370,400) ----- TOTAL (183,160,977)

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY HOSPITALS

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](http://www.irs.gov/form990).

OMB No 1545-0047

2017

Open to Public Inspection

Employer identification number

94-1156621

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

Part II

Identification of Related Tax-Exempt Organizations

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

See Additional Data Table

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

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

See Additional Data Table

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

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

(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
<b>(1)</b> SUTTER HEALTH DEFERRED COMP PLANS' TRUST 2200 RIVER PLAZA DRIVE SACRAMENTO, CA 95833 27-6851989	RABBI TRUST	CA	NA	TRUST				Yes	
<b>(2)</b> NORTHWOOD EUROPE TE FEEDER LP 1819 WAZEE ST 2ND FLOOR DENVER, CO 90202 98-1272216	HOLDING COMPANY	CJ	NA	C CORP				Yes	

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

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

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

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

1a

No

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

1b

No

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

1c

Yes

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

1d

No

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

No

o Sharing of paid employees with related organization(s) . . . . .

1o

No

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)

Additional Data

Software ID:  
Software Version:  
EIN: 94-1156621  
Name: SUTTER VALLEY HOSPITALS

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0088443	HEALTHCARE	CA	501(C)(3)	3	SUTTER EBH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 51-0160184	FUNDRAISING	CA	501(C)(3)	7	SUTTER EBH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2728423	FUNDRAISING	CA	501(C)(3)	7	SUTTER BH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 51-0172285	HEALTHCARE	CA	501(C)(3)	3	SUTTER EBH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2948100	HEALTHCARE	CA	501(C)(3)	10	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2290244	FUNDRAISING	CA	501(C)(3)	12A - I	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 23-7288765	FUNDRAISING	CA	501(C)(3)	7	SUTTER BH	Yes	
450 30TH STREET STE 2840 OAKLAND, CA 94609 94-2992642	UNIVERSITY	CA	501(C)(3)	2	SUTTER EBH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2594966	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-0562680	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1156581	HEALTHCARE	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1080917	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2988520	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0217870	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1196176	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2690415	HEALTHCARE	CA	501(C)(3)	12B - II	SUTTER HLTH	Yes	
2200 RIVER PLAZA DRIVE SACRAMENTO, CA 95833 94-2788907	SUPPORTING OR	CA	501(C)(3)	12C III-FI	NA		No
91-2301 FT WEAVER RD EWA BEACH, HI 96706 99-0298651	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 46-1183948	HEALTH PLAN	CA	501(C)(4)	N/A	SUTTER HLTH	Yes	
745 FORT STREET SUITE 1100 HONOLULU, HI 96813 99-0289310	INSURANCE SER	HI	501(C)(3)	12C III-FI	SUTTER HLTH	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2788906	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0040113	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2668262	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0273974	HEALTHCARE	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-6068843	HEALTHCARE	CA	501(C)(3)	10	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2948131	HEALTHCARE	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0318845	FUNDRAISING	CA	501(C)(3)	12A - I	SUTTER VH	Yes	

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



**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
SUTTER HEALTH PLAN	S	75,164,381	FMV
SUTTER WEST BAY MEDICAL FOUNDATION	P	58,039	FMV
SUTTER CENTRAL VALLEY HOSPITALS	Q	19,111,309	FMV
SUTTER INSURANCE SERVICES CORPORATION	P	15,784,748	FMV
SUTTER BAY MEDICAL FOUNDATION	P	73,333	FMV
SUTTER BAY HOSPITALS	Q	298,877	FMV
SUTTER VALLEY MEDICAL FOUNDATION	Q	1,718,673	FMV
SUTTER AUBURN FAITH HOSPITAL FOUNDATION	Q	1,432,039	FMV
SUTTER SOLANO CHARITABLE FOUNDATION	Q	234,745	FMV
SUTTER MEDICAL CENTER FOUNDATION	Q	2,395,903	FMV
TRACY HOSPITAL FOUNDATION	Q	355,353	FMV
SUTTER ROSEVILLE MEDICAL CENTER FOUNDATION	Q	975,015	FMV
MEMORIAL HOSPITAL FOUNDATION	Q	319,075	FMV
MEMORIAL MEDICAL OFFICE BUILDING PARTNERSHIP	Q	119,723	FMV
SUTTER VALLEY MEDICAL FOUNDATION	R	3,120,181	FMV
SUTTER VISITING NURSE ASSOCIATION AND HOSPICE	P	168,726	FMV
SUTTER DAVIS HOSPITAL FOUNDATION	M	392,691	FMV
SUTTER VALLEY MEDICAL FOUNDATION	K	399,108	FMV
SUTTER BAY MEDICAL FOUNDATION	C	180,000	FMV
SUTTER ROSEVILLE MEDICAL CENTER FOUNDATION	C	992,101	FMV
SUTTER MEDICAL CENTER FOUNDATION	C	5,260,274	FMV
SUTTER AUBURN FAITH HOSPITAL FOUNDATION	C	1,405,100	FMV
SUTTER DAVIS HOSPITAL FOUNDATION	C	87,675	FMV
SUTTER SOLANO CHARITABLE FOUNDATION	C	328,298	FMV
TRACY HOSPITAL FOUNDATION	C	418,043	FMV

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

<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
MEMORIAL HOSPITAL FOUNDATION	C	735,208	FMV
SUTTER VALLEY MEDICAL FOUNDATION	J	10,112,689	FMV
ROSEVILLE ENDOSCOPY CENTER LLC	J	227,754	FMV
SUTTER VISITING NURSE ASSOCIATION AND HOSPICE	J	118,488	FMV
SUTTER SOLANO CHARITABLE FOUNDATION	M	113,645	FMV
SUTTER AUBURN FAITH HOSPITAL FOUNDATION	M	465,023	FMV
SUTTER MEDICAL CENTER FOUNDATION	M	1,467,021	FMV