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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018 , and ending 12-31-2018

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
St Charles Health System Inc

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
2500 NE Neff Rd

City or town, state or province, country, and ZIP or foreign postal code
BEND, OR 97701

D Employer identification number
93-0602940

E Telephone number
(541) 706-7707

G Gross receipts $ 831,908,289

F Name and address of principal officer
Sluka Joseph
2500 NE Neff Rd
BEND, OR 97701

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 ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ http //www stcharleshealthcare org/

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

L Year of formation 2001

M State of legal domicile OR

Part I Summary

1 Briefly describe the organization's mission or most significant activities
Mission In a spirit of love and compassion, better health, better care, better value Vision Creating America's healthiest community, together

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)	**3**	12
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	12
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	5,140
6	Total number of volunteers (estimate if necessary)	**6**	440
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	4,860,261	2,631,049
9	Program service revenue (Part VIII, line 2g)	735,666,203	753,234,896
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	14,352,024	18,883,649
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	54,207,350	55,812,005
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	809,085,838	830,561,599
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	2,379,095	994,686
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	418,451,096	423,646,413
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶759,085		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	346,811,147	359,935,505
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	767,641,338	784,576,604
19	Revenue less expenses Subtract line 18 from line 12	41,444,500	45,984,995

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,066,147,828	1,047,605,572
21	Total liabilities (Part X, line 26)	421,140,343	406,838,923
22	Net assets or fund balances Subtract line 21 from line 20	645,007,485	640,766,649

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

****** 2019-11-06
Signature of officer Date

Welander Jennifer SENIOR VP/CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN

Firm's name ▶ | Firm's EIN ▶

Firm's address ▶ | Phone no

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

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

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 400,541,846 including grants of $ 994,686) (Revenue $ 520,473,835)
See Additional Data

4b (Code) (Expenses $ 92,950,311 including grants of $) (Revenue $ 86,609,888)
See Additional Data

4c (Code) (Expenses $ 64,429,509 including grants of $) (Revenue $ 44,830,019)
See Additional Data

4d Other program services (Describe in Schedule O)
(Expenses $ 75,977,792 including grants of $) (Revenue $ 157,008,222)

4e **Total program service expenses ▶** 633,899,458

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**	Yes	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**		No
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	**1a**	433		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			**1c** Yes	

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	5,140		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	No
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	Yes
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	No
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**	0		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	No
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	No
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	No
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .			**9a**	No
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	No
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	No
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			**13a**	No
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a** 12		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
b	Enter the number of voting members included in line 1a, above, who are independent	**1b** 12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	**3**		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	**4**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	**5**		No
6	Did the organization have members or stockholders?	**6**		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
a	The governing body?	**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you made these available Check all that apply

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

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

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

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

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

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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

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

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

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

(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			
See Additional Data Table										

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(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			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, **Section A** ▶										
d Total (add lines 1b and 1c) ▶								8,626,397		1,087,107

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 ▶ 590

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DR BEND, OR 97701	Imaging Services	34,000,507
CSI HEALTHCARE IT PO BOX 890841 CHARLOTTE, NC 28289	IT SERVICES	5,627,924
CENTRAL OREGON MRI LLC PO BOX 6059 BEND, OR 97708	MRI services	4,776,121
BEND ANESTHESIOLOGY GROUP 150 W CIVIC CENTER DR STE 200 SANDY, UT 84070	ANESTHESIOLOGY	1,879,544
NEENAN COMPANY LLP 2607 MIDPOINT DRIVE FORT COLLONS, CO 80525	CONSTRUCTION	1,576,748

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 50

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	**1a** Federated campaigns . .	1a			
	b Membership dues . .	1b			
	c Fundraising events . .	1c			
	d Related organizations	1d	1,639,673		
	e Government grants (contributions)	1e	113,475		
	f All other contributions, gifts, grants, and similar amounts not included above	1f	877,901		
	g Noncash contributions included in lines 1a - 1f $ 14,644				
	h Total. Add lines 1a-1f . . . . . ▶		2,631,049		

Program Service Revenue		Business Code				
2a St Charles Bend		900099	520,473,837	520,473,837		
b St Charles Madras		900099	33,105,802	33,105,802		
c St Charles Medical Group		621110	44,830,019	44,830,019		
d St Charles Prineville		900099	34,033,042	34,033,042		
e St Charles Redmond		900099	86,609,888	86,609,888		
f All other program service revenue			34,182,308	34,182,308		
g Total. Add lines 2a–2f . . . . ▶			753,234,896			

Other Revenue					
3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶			18,668,388			18,668,388
4 Income from investment of tax-exempt bond proceeds ▶			0			
5 Royalties . . . . . ▶			0			
	(i) Real	(ii) Personal				
6a Gross rents	130,732					
b Less rental expenses	5,795					
c Rental income or (loss)	124,937					
d Net rental income or (loss) . . . . . ▶			124,937			124,937
	(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory	1,206,837	600				
b Less cost or other basis and sales expenses	966,997	25,179				
c Gain or (loss)	239,840	-24,579				
d Net gain or (loss) . . . . . ▶			215,261			215,261
8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . **a**						
b Less direct expenses . . . **b**						
c Net income or (loss) from fundraising events . . ▶			0			
9a Gross income from gaming activities See Part IV, line 19 . . . **a**						
b Less direct expenses . . . **b**						
c Net income or (loss) from gaming activities . . ▶			0			
10a Gross sales of inventory, less returns and allowances . . **a**	592,771					
b Less cost of goods sold . . **b**	348,719					
c Net income or (loss) from sales of inventory . . ▶			244,052	244,052		
Miscellaneous Revenue		Business Code				
11a Healthcare JV Income		900099	50,449,000	50,449,000		
b Reimbursed Salaries		446110	4,566,613	4,566,613		
c Transcription & Records		900099	354,568	354,568		
d All other revenue			72,835	72,835		
e Total. Add lines 11a–11d . . . . . ▶			55,443,016			
12 Total revenue. See Instructions . . . . . ▶			830,561,599	808,921,964		19,008,586

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) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	994,686	994,686		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	6,219,831		6,219,831	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	328,655,695	271,889,243	56,351,915	414,537
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	13,302,191	11,125,798	2,155,327	21,066
9 Other employee benefits	51,459,978	38,773,974	12,600,529	85,475
10 Payroll taxes	24,008,718	18,878,003	5,101,886	28,829
11 Fees for services (non-employees)				
a Management	0			
b Legal	1,924,328		1,924,328	
c Accounting	263,707	41,028	221,524	1,155
d Lobbying	0			
e Professional fundraising services See Part IV, line 17	0			
f Investment management fees	154,657		154,657	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	88,781,347	71,560,976	17,093,880	126,491
12 Advertising and promotion	620,683	14,956	599,914	5,813
13 Office expenses	17,741,599	15,747,629	1,983,916	10,054
14 Information technology	16,503,915	1,146,960	15,337,106	19,849
15 Royalties . .	0			
16 Occupancy	10,641,268	8,101,288	2,539,980	
17 Travel	1,098,599	861,977	223,769	12,853
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .	0			
19 Conferences, conventions, and meetings	1,863,668	958,992	900,545	4,131
20 Interest	7,535,941		7,535,941	
21 Payments to affiliates	1,810,214	488,346	1,297,351	24,517
22 Depreciation, depletion, and amortization . .	40,174,870	26,671,166	13,503,704	
23 Insurance . . .	1,958,591	36,487	1,922,104	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEDICAL SUPPLIES	114,531,320	114,239,980	291,240	100
b PROVIDER TAX EXPENSE	37,598,630	37,598,630		
c MAINTENTANCE AND REPAIRS	8,309,710	6,789,203	1,520,507	
d PATIENT SUPPORT	4,800,743	4,766,458	34,285	
e All other expenses	3,621,715	3,213,678	403,822	4,215
25 **Total functional expenses.** Add lines 1 through 24e	784,576,604	633,899,458	149,918,061	759,085
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ 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
Assets	1	Cash–non-interest-bearing		21,610,719	1	45,421,837
	2	Savings and temporary cash investments		35,994,975	2	12,190,567
	3	Pledges and grants receivable, net			3	0
	4	Accounts receivable, net		105,107,273	4	95,435,912
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	9,375
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L			6	0
	7	Notes and loans receivable, net			7	0
	8	Inventories for sale or use		14,709,178	8	15,929,662
	9	Prepaid expenses and deferred charges		8,760,164	9	8,530,701
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 710,759,841			
	b	Less accumulated depreciation	10b 349,509,424	334,194,942	10c	361,250,417
	11	Investments—publicly traded securities		484,803,689	11	473,295,544
	12	Investments—other securities See Part IV, line 11		51,122,129	12	24,083,040
	13	Investments—program-related See Part IV, line 11		-1,464,253	13	-1,395,986
	14	Intangible assets		4,504,494	14	4,520,385
	15	Other assets See Part IV, line 11		6,804,518	15	8,334,118
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,066,147,828	16	1,047,605,572
Liabilities	17	Accounts payable and accrued expenses		104,439,042	17	99,714,323
	18	Grants payable			18	
	19	Deferred revenue		1,844,031	19	2,174,307
	20	Tax-exempt bond liabilities		294,460,682	20	288,603,299
	21	Escrow or custodial account liability Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		6,360,491	23	6,366,517
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D		14,036,097	25	9,980,477
	26	**Total liabilities.** Add lines 17 through 25		421,140,343	26	406,838,923
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		645,007,485	27	640,766,649
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		645,007,485	33	640,766,649
	34	Total liabilities and net assets/fund balances		1,066,147,828	34	1,047,605,572

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	830,561,599
2	Total expenses (must equal Part IX, column (A), line 25)	2	784,576,604
3	Revenue less expenses Subtract line 2 from line 1	3	45,984,995
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	645,007,485
5	Net unrealized gains (losses) on investments	5	-41,775,503
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-8,450,328
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	640,766,649

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

Form 990 (2018)

Form 990, Part III, Line 4a:

St Charles BendSCMC-B provided services for 16,499 Inpatients, 1,685 births, 16,840 surgical cases, 43,442 Emergency Room visits, and 79,381 Other Outpatient visits in 2018 As one of the Pacific Northwest's leading regional health care facilities, St Charles Bend provides services typically found in markets many times its size For almost 100 years, St Charles Bend has taken responsibility for the health and well-being of generations of Oregonians, developing into a Level II Regional Trauma Center with specialized partnerships in heart, cancer, orthopedics and neurosurgery

Form 990, Part III, Line 4b:

St Charles RedmondSCMC-R provided services for 2,750 inpatients, 495 births, 3,900 surgical cases, 21,976 Emergency Room visits, and 29,387 Other Outpatient Visits in 2018 At St Charles Redmond, the patient experience remains at the center of all we do and each patient is empowered to play an active role in his or her own care and healing Surgeries are performed in four of Oregon's newest and most advanced surgical suites Patients and their families enjoy the comfort of state-of-the-art patient rooms Everyone receives the level of care that is expected of a leading regional health care facility

Form 990, Part III, Line 4c:

St Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Charles Health System These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care SCMG provided over 213,500 visits in Bend clinics, 70,400 visits in Redmond clinics, 7,800 visits in the Sisters clinic, 28,800 visits in Prineville clinics, 6,000 in the Madras clinics and 5,900 in La Pine clinics in 2018 SCMG also operates an immediate care clinic to provide low-cost urgent care services to the community, the immediate care clinic provided services for more than 24,200 patient visits in 2018

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Gardner Mack Director	15 00 0 00	X						19,000	0	0
Sayeg Thomas Director	5 00 0 00	X						23,750	0	0
Schuette Dan Chairman	30 00 0 00	X		X				28,500	0	0
DeGroot Shawn Director	5 00 0 00	X						19,000	0	0
Dempsey Dennis Vice Chair	20 00 0 00	X		X				23,750	0	0
Downer Doug Director	15 00 0 00	X						23,750	0	0
Askari Sanaz MD Director	6 00 0 00	X						19,000	0	0
Van Pelt Greg Director	4 00 0 00	X						23,750	0	0
Buehler Knute MD Director	0 00 0 00	X						0	0	0
Haase Megan Director	10 00 0 00	X						19,000	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Orlikoff James Director	5 00 0 00	X						19,000	0	0
Gordon Steve Director	4 00 0 00	X						23,750	0	0
Sluka Joseph President	50 00 1 00			X				799,821	0	135,590
Welander Jennifer Senior VP/CFO	45 00 5 00			X				404,061	0	70,763
Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	60 00 1 00				X			458,318	0	84,231
Adams Aaron CEO Bend & Redmond	50 00 0 00				X			297,575	0	40,296
Steinke Pamela SVP Quality/CNE	50 00 0 00				X			328,245	0	67,021
Weinsheim John PRESIDENT SCMG	50 00 0 00				X			239,433	0	59,116
Brickhouse Jeremiah SVP/CIO	60 00 0 00				X			374,876	0	65,362
Guyn Jim MD SVP Population Health	40 00 1 00				X			396,807	0	45,311

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			
Stevens Carla SR Director Periop & Cardiovascular	50 00 0 00				X			188,115	0	24,393
Simmons Iman SVP COO	50 00 0 00				X			353,619	0	77,723
Powell Michael CHIEF PHARMACY OFFICER	50 00 0 00				X			208,225	0	39,166
Pennavaria Laura CHIEF MEDICAL OFFICER, SCMG	50 00 0 00				X			284,902	0	26,754
Berry Rebecca VP Human Resources	50 00 0 00				X			269,500	0	57,434
Marchiando Rod SVP Improvement & Strategy	50 00 0 00				X			277,785	0	64,970
Robinson Debra CNO Bend	50 00 0 00				X			203,475	0	34,691
Vlessis Angelo MD Physician	50 00 0 00					X		757,606	0	37,224
Slater Matthew MD Physician	50 00 0 00					X		679,685	0	33,017
Reed Richard MD Physician	50 00 0 00					X		610,736	0	41,850

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			
McLellan Bruce MD Physician	50 00 0 00					X		614,482	0	38,517
Rafael Allen MD Physician	50 00 0 00					X		636,881	0	43,678

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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.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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

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

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

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

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

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

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

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

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

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

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

10 ☐ An organization that normally receives (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

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

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

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

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

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

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

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

f Enter the number of supported organizations _____

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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170 (b)(1)(A)(ix)**

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2017 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2018** (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from **2017** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2018.** 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—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *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*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *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*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *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)*	1		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**

- **a** ☐ The organization satisfied the Activities Test Complete **line 2** below
- **b** ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- **c** ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

			Yes	No
2	Activities Test **Answer (a) and (b) below.**			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *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*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *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*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard*	3b		

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

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

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

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

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

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

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**) See instructions	
9 Distributable amount for 2018 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-2018**	**(iii) Distributable Amount for 2018**
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, 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 2018 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 2019.** Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

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

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493310033509

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

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

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

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

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

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

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

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

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☑ No

4a Was a correction made? ☐ Yes ☑ No

b If "Yes," describe in Part IV

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

	(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds If none, enter -0-	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
1					
2					
3					
4					
5					
6					

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a If zero or less, enter -0-		
i Subtract line 1f from line 1c If zero or less, enter -0-		

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

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2015	**(b)** 2016	**(c)** 2017	**(d)** 2018	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?	Yes		
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		42,424
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		49,508
j	Total Add lines 1c through 1i			91,932
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

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

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

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

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

Part IV Supplemental Information

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

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

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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

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

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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 7/25/06, 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? ☐ Yes ☐ No

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

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

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

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other

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

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

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

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

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

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	4,902,009	4,527,217	4,475,381	4,564,921	3,495,960
b Contributions . . .	2,440	2,577	2,517	51,375	1,027,077
c Net investment earnings, gains, and losses	-127,411	573,516	236,984	-29,698	138,332
d Grants or scholarships . . .	51,407	179,114	161,937	90,396	75,764
e Other expenditures for facilities and programs . . .					
f Administrative expenses	23,477	22,187	25,728	20,821	20,684
g End of year balance	4,702,154	4,902,009	4,527,217	4,475,381	4,564,921

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

- a Board designated or quasi-endowment ▶ 23 000 %
- b Permanent endowment ▶ 61 000 %
- c Temporarily restricted endowment ▶ 16 000 %

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

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

	Yes	No
(i) unrelated organizations	3a(i)	No
(ii) related organizations	3a(ii) Yes	
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	3b Yes	

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		10,157,008		10,157,008
b Buildings		353,261,494	171,989,939	181,271,555
c Leasehold improvements		6,219,615	3,486,694	2,732,921
d Equipment		267,219,267	162,332,800	104,886,467
e Other		73,902,457	11,699,991	62,202,466
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* . . ▶				361,250,417

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

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

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) JOINT VENTURES	-1,395,986	C
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
COST REPORT SETTLEMENT EST LIABILITIES	2,200,382
LEASE LIABILITY	1,354,045
PROF LIAB INSURANCE	6,268,000
RAC LIABILITY	158,050
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	9,980,477

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

Supplemental Information

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

Supplemental Information

Return Reference	Explanation
Part X FIN48 Footnote	The audited financial statements contain the following footnote Accounting principles gen erally accepted in the United States of America require SCHS' management to evaluate tax p ositions taken by the Corporation and recognize a tax liability (or asset) if the Corporat ion has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS Management has analyzed tax positions taken by the Corporation and has concluded that as of December 31, 2018, there are no uncertain positions taken or exp ected to be taken that would require recognition of a liability (or asset) or disclosure i n the financial statements The Corporation is subject to routine audits by taxing jurisdi ctions, however, there are currently no audits for any tax periods in progress The Corpor ation's management believes it is no longer subject to income tax examinations for years p rior to 2015

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		38,804	19,525,161		19,525,161	2 490 %
b Medicaid (from Worksheet 3, column a)		159,651	201,119,185	136,591,187	64,527,998	8 220 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		198,455	220,644,346	136,591,187	84,053,159	10 710 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		8,922	547,725		547,725	0 070 %
f Health professions education (from Worksheet 5)			927,069	292,894	634,175	0 080 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			36,375		36,375	
i Cash and in-kind contributions for community benefit (from Worksheet 8)			1,122,065		1,122,065	0 140 %
j **Total.** Other Benefits		8,922	2,633,234	292,894	2,340,340	0 290 %
k **Total.** Add lines 7d and 7j		207,377	223,277,580	136,884,081	86,393,499	11 000 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			268,336		268,336	0 030 %
9 Other						
10 Total			268,336		268,336	0 030 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	183,159,605
6	Enter Medicare allowable costs of care relating to payments on line 5	6	214,278,744
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-31,119,139
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	Cascade Medical Imaging LLC	CT, Mammography and Other	70 000 %		30 000 %
2	Central Oregon Magnetic Res	Magnetic Resonance Imaging	33 300 %		66 700 %
3	Heart Center of the Cascade	Owns & manages a medical bu	50 000 %		50 000 %
4	Cascade SurgiCenter LLC	Outpatient surgery	50 000 %		50 000 %
5	Institute of the Cascades L	Administration & Marketing	50 000 %		50 000 %
6	Cascade Medical Buildings L	Owns & manages a medical bu	50 000 %		50 000 %
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

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

4

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group St Charles Bend

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) http //www stcharleshealthcare org/			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) http //www stcharleshealthcare org/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		No
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

St Charles Bend

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
b	☑ The FAP application form was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
c	☑ A plain language summary of the FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

St Charles Bend

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

St Charles Bend

Name of hospital facility or letter of facility reporting group

		Yes	No
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? **23**		No
	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? **24**		No
	If "Yes," explain in Section C		

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)

Name of hospital facility or letter of facility reporting group St Charles Redmond

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) http //www stcharleshealthcare org/			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) http //www stcharleshealthcare org/ **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

St Charles Redmond

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
b	☑ The FAP application form was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
c	☑ A plain language summary of the FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

St Charles Redmond

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

St Charles Redmond

Name of hospital facility or letter of facility reporting group

		Yes	No
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? **23**		No
	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? **24**		No
	If "Yes," explain in Section C		

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)

Name of hospital facility or letter of facility reporting group St Charles Prineville

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) http //www stcharleshealthcare org/			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
If "Yes" (list url) http //www stcharleshealthcare org/ **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

St Charles Prineville

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
b	☑ The FAP application form was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
c	☑ A plain language summary of the FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

St Charles Prineville

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

St Charles Prineville

Name of hospital facility or letter of facility reporting group

		Yes	No
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? **23**		No
	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? **24**		No
	If "Yes," explain in Section C		

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)

Name of hospital facility or letter of facility reporting group St Charles Madras

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) http //www stcharleshealthcare org/			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url) http //www stcharleshealthcare org/			
a			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		No
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

St Charles Madras

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 0000 % and FPG family income limit for eligibility for discounted care of 400 0000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☐ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	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	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
b	☑ The FAP application form was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
c	☑ A plain language summary of the FAP was widely available on a website (list url) http //www stcharleshealthcare org/For-P			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

St Charles Madras

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

St Charles Madras

Name of hospital facility or letter of facility reporting group

		Yes	No
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? **23**		No
	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? **24**		No
	If "Yes," explain in Section C		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

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

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

Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

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Form and Line Reference	Explanation
Part I, Line 7 - Explanation of Costing Methodology	The costing methodology used was derived from SCHS's financial systems, which address all hospital-based patient segments and other services provided A cost-to-charge ratio from the financial systems was used to calculate the cost of Financial Assistance in line 7a Numbers reported in column (b) in lines 7a and 7b refer to the number of patient encounters
Part III, Line 2 - Methodology Used To Estimate Bad Debt Expense	When SCHS provides care to patients, it does not require collateral, however, itmaintains an estimated allowance for doubtful accounts The primary collection risksrelate to uninsured patient accounts and patient accounts for which the primaryinsurance payor has paid, but patient responsibility amounts (generally deductiblesand copayments) remain outstanding The reserves against accounts receivable is estimated based primarily upon SCHS historical collection experience, the age of the patient's account, management's estimate of the patient's economic ability to pay, and the effectiveness of collection efforts Patient accounts receivable balances are routinely reviewed in conjunction with historical collection rates and other economic conditions that might ultimately affect the collectability of patientaccounts when considering the adequacy of the amounts recorded in the allowance for doubtful accounts Actual write offs have historically been within management'sexpectations Bad debt expense for the year ended December 31, 2018 was not significant, therefore there is no bad debt reported

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Form and Line Reference	Explanation
Part III, Line 3 - Methodology of Estimated Amount & Rationale for Including in Community Benefit	SCHS currently has no reasonable way to track or estimate the amount of bad debt expense attributable to charity care, and accordingly this line has been left blank
Part III, Line 4 - Bad Debt Expense	See page 15, footnote 4 "Net Patient Service Revenue", in the attached Audited Financial Statements

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part III, Line 8 - Explanation Of Shortfall As Community Benefit	As a response to efforts to improve the health and quality of life of people living in the community, SCHS provided $31,119,139 in unreimbursed services to patients enrolled in traditional Medicare programs SCHS believes that the Medicare shortfall should be treated as a community benefit since it has a clear mission to serving and improving the health status of the elderly If SCHS should cease to exist, this shortfall would have to be absorbed by another health care provider Costs are from the Medicare Cost Report, but none of these costs are being claimed as a community benefit in Part I, line 7 Our community benefit report shows a Medicare shortfall of $65,433,239 which differs from the shortfall of $31,119,139 reported in Part III Section B because Part III Section B includes only those costs allowed in the Medicare Cost Report which excludes the Medicare Advantage shortfall, this shortfall is included in our annual community benefit report
Part III, Line 9b - Provisions On Collection Practices For Qualified Patients	Collection policies are the same for all patients Every effort will be made to identify patients who may need financial assistance at the earliest point during the patients experience with St Charles Patients may be identified as a candidate for financial assistance at any time before, during or after services are delivered If at any point during the collection process documentation or information is received that indicates the patient may be eligible for our financial assistance program, the account will be reviewed by our financial assistance team for presumptive eligibility If the responsible party does not respond to statements, letters or phone calls within 120 days of billing the patient balance due, St Charles will run all accounts through charity advisor software and the probability of payment will be determined electronically If the probability of payment is low, the encounter will be written off to free care

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI, Line 2 - Needs Assessment	St Charles Health System (SCHS) assesses the needs of each of our communities in many different ways other than the facility community health needs assessments SCHS partners with Healthy Communities Institute (HCI) to purchase a dashboard of each community and population risk profiling data that is continuously updated, accessible to the community, easy to understand and directly embeddable in our existing website This information helps SCHS to keep a finger on the pulse of each population's many health indicators, helping us to continually assess each community's needs, positive changes and/or opportunities for improvement This information can be found at http //www stcharleshealthcare org/Healthy-Communities/CHNA Each year St Charles also produces the St Charles Health System Annual Report This report is comprised of a summary of each of the following Community BenefitTotalsFinancial OverviewDays cash on handOperating marginExcess marginOperating ExpensesFull time employee countEach health system facility (St Charles Bend, St Charles Redmond, St Charles Prineville and St Charles Madras) BirthsDischargesIn-patient casesOut-patient casesEmergency visitsSt Charles Medical GroupPatient visits for each clinicsThe 2017-18 Annual Report is posted online on the St Charles Health System website at https //www stcharleshealthcare org/About-Us/Reports This report and the primary data collected for its creation let us know what the trends are for different hospital stays, conditions and out-patient visits, helping to decide what services we offer and where the needs are St Charles also plays a significant role in local, regional and State groups in order to stay abreast of the newest information, trends, health data and best practices SCHS has representation on the Central Oregon Health Council (COHC), the governance entity over the region's Coordinated Care Organization, PacificSource Community Solutions, County Commissions, patients, community members, local medical clinics and the regional dental clinic also participate in the COHC BY PARTICIPATING ON THIS COUNCIL, ST CHARLES IS ABLE TO WORK WITH THE EXPERTS IN EACH OF THE THREE COUNTIES TO HEAR FIRSTHAND HOW EACH COMMUNITY IS DOING AND WHAT THEIR HEALTH NEEDS ARE ST CHARLES ALSO SITS ON DIFFERENT COMMITTEES FOR THE OREGON ASSOCIATION FOR HOSPITALS AND HEALTH SYSTEMS (OAHHS) AND LOCAL NON-PROFITS BEING PART OF THESE GROUPS HELPS ST CHARLES TO BETTER UNDERSTAND THE NEEDS OF OUR COMMUNITIES WHILE ALSO LEARNING HOW TO BETTER COLLECT, TRACK, REPORT AND IMPROVE UPON COLLECTED INFORMATION
Part VI, Line 3 - Patient Education of Eligibility for Assistance	The Financial assistance program policy is posted on the SCHS website Financial Counselors and registration staff in our facilities & primary care clinics offer financial assistance to patients, both upon request and when patients are uninsured SCHS works to identify patients who may qualify for coverage through the following government programs (uninsured patients seen in our Emergency departments & those admitted to all of our facilities are automatically referred to a Financial Counseling Patient Advocate) Cobra (these are referred to Financial Counselors)Crime Victims AssistanceEmergency Medicaid for Aliens Medicaid for pregnant women and children Medicaid, Medicare Supplemental Security Income (SSI)Temporary Aid for Needy Families (TANF) VeteransOur Financial Counseling Patient Advocate will work with these individuals through the process of qualifying for coverage or denial of coverage from all applicable government programs Patients working with the Financial Counseling Patient Advocate have their accounts put on hold from collections Patients will be referred to the SCHS Financial Assistance Department for follow-up

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Form and Line Reference	Explanation
Part VI, Line 4 - Community Information	Deschutes County (St Charles Bend and St Charles Redmond) Information taken from United States Census Bureau(https //www census gov/quickfacts/fact/table/deschutescountyoregon/PST045217) unless otherwise noted URBANLAND AREA IN SQUARE MILES (2010) 3,018POPULATION (2017 ESTIMATE) 186,875POPULATION (2017) UNDER 5 YEARS 5 2% UNDER 18 YEARS 20 5% 65 YEARS AND OVER 19 4% FEMALE 50 6%HOUSEHOLDS (2013-2017) 69,631PERSONS PER HOUSEHOLD (2013-2017) 2 50MEDIAN HOUSEHOLD INCOME (2013-2017) $59,152PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2013-2017) 12 1%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2013-2017) 93 5%POPULATION BY RACE (2017) WHITE ALONE, NOT HISPANIC 94 4% HISPANIC OR LATINO 8 0% TWO OR MORE RACES 2 6% AMERICAN INDIAN AND ALASKA NATIVE ALONE 1 1% ASIAN ALONE 1 2% BLACK OR AFRICAN AMERICAN ALONE 5% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 2%HEALTH CARE PROVIDER ASSETS IN DESCHUTES COUNTY (OUTSIDE OF ST CHARLES BEND AND REDMOND) MOSAIC MEDICAL CLINIC, (BEND AND REDMOND) (FQHC) LYNCH COMMUNITY CLINIC (SCHOOL-BASED HEALTH CENTER PARTNERSHIP BETWEEN MOSAIC MEDICAL, REDMOND SCHOOL DISTRICT AND DESCHUTES COUNTY) ENSWORTH COMMUNITY SCHOOL-BASED HEALTH CENTER (PARTNERSHIP BETWEEN MOSAIC MEDICAL, BEND-LAPINE SCHOOL DISTRICT AND DESCHUTES COUNTY) BEND MEMORIAL CLINIC, (BEND, REDMOND AND SISTERS) HIGH LAKES HEALTH CARE (BEND, REDMOND AND SISTERS) CROOK COUNTY (ST CHARLES PRINEVILLE) INFORMATION TAKEN FROM UNITED STATES CENSUS BUREAU(https //www census gov/quickfacts/fact/table/crookcountyoregon/PST045217) UNLESS OTHERWISE NOTED RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2010) 2,979POPULATION (2017 ESTIMATE) 23,123POPULATION (2017) UNDER 5 YEARS 5 4% UNDER 18 YEARS 19 6% 65 YEARS AND OVER 24 5% FEMALE 50 3%HOUSEHOLDS (2013-2017) 9,330PERSONS PER HOUSEHOLD (2013-2017) 2 3MEDIAN HOUSEHOLD INCOME (2013-2017) $41,777PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2013-2017) 15 3%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2013-2017) 87 9%POPULATION BY RACE (2016) WHITE ALONE, NOT HISPANIC 94 8% HISPANIC OR LATINO 7 8% TWO OR MORE RACES 2 3% AMERICAN INDIAN AND ALASKA NATIVE ALONE 1 7% ASIAN ALONE 0 7% BLACK OR AFRICAN AMERICAN ALONE 0 5% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 1%HEALTH CARE PROVIDER ASSETS IN CROOK COUNTY (OUTSIDE OF ST CHARLES PRINEVILLE) MOSAIC MEDICAL (FQHC)CROOK KIDS CLINIC (SCHOOL-BASED HEALTH CENTER PARTNERSHIP BETWEEN MOSAIC MEDICAL AND CROOK COUNTY SCHOOL DISTRICT) JEFFERSON COUNTY (ST CHARLES MADRAS) INFORMATION TAKEN FROM UNITED STATES CENSUS BUREAU(https //www census gov/quickfacts/fact/table/jeffersoncountyoregon/PST045217) UNLESS OTHERWISE NOTED RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2010) 1,781POPULATION (2017 ESTIMATE) 23,758POPULATION (2016) UNDER 5 YEARS 6 6% UNDER 18 YEARS 23 6% 65 YEARS AND OVER 19 0% FEMALE 48 4%HOUSEHOLDS (2013-2017) 7,628PERSONS PER HOUSEHOLD (2013-2017) 2 9MEDIAN HOUSEHOLD INCOME (2013-2017) $48,469PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2013-2017) 20 9%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2013-2017) 85 7%POPULATION BY RACE (2017) WHITE ALONE, NOT HISPANIC 75 1% HISPANIC OR LATINO 19 8% TWO OR MORE RACES 3 3% AMERICAN INDIAN AND ALASKA NATIVE ALONE 19 0% ASIAN ALONE 1 0% BLACK OR AFRICAN AMERICAN ALONE 1 4% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 3%HEALTH CARE PROVIDER ASSETS IN JEFFERSON COUNTY (OUTSIDE OF ST CHARLES MADRAS) MOSAIC MEDICAL (FQHC)CONFEDERATED TRIBES OF WARM SPRINGS MADRAS MEDICAL GROUP
Part VI, Line 4 - Community Building Activities	Our community building activities focused on workforce development activities which support the community by offering the expertise and resources of our hospital systems caregivers for the betterment of the community Specifically these programs address community-wide workforce issues, potentially providing health care workers to promote the health of the community

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part VI, Line 5 - Promotion of Community Health	SCHS provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy SCHS criteria for the determination of charity care include the patientsor other responsible partysannual household income, number of people in the home and amount claimed on taxes, credit history, existing medical debt obligations and other indicators of the patients ability to pay Generally, those individuals with an annual household income at or less than 250% of the Federal Poverty Guidelines (the Guidelines) qualify for charity care under SCHS policy In addition, SCHS provides discounts on a sliding scale to those individuals with an annual household income of between 250% and 400% of the Guidelines Since SCHS does not pursue collection of amounts determined to qualify as charity care, those amounts are not reported as net patient service revenue Because Madras Prineville and La Pine are located in medically underserved areas (MUAs), the resources used for provider recruitment in those communities are counted as community benefit St Charles also allows nursing students, high school students and other providers to partake in job-shadowing with our paid caregivers to help them complete their course work and/or earn credits, without restrictions related to future employment The St Charles Health System Board of Directors is comprised of members from all communities served by the systemBend, Redmond, Prineville and Madras, etc allowing for diverse views and leadership related to promoting the health of the community Various community classes are offered at each campus, including Trauma Nurses Talk Tough, Childbirth Education, Diabetes-Health Heart Education, etc In order to continue to promote health in the community and eliminate barriers, scholarships are available for those who are unable to pay but would still like to participate in any of these classes Being the only health care system in Central Oregon, many non-profit community organizations come to St Charles needing funds and other donations, such as in-kind support During 2018, St Charles facility caregivers provided thousands of hours of in-kind support to these organizations who share in St Charles vision of Creating Americas healthiest community, together In-kind support activities include but are not limited to membership on non-profit community organization boards, below fair market value rent fees, free cleaning and landscaping services and hours spent coordinating events promoting health improvement for vulnerable and low-income community members
Part VI, Line 7 - States Filing of Community Benefit Report	OR

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	St Charles Bend 2500 NE NEFF RD BEND, OR 97701	X	X					X			
2	St Charles Redmond 1253 NW CANAL BLVD REDMOND, OR 97756	X	X					X			
3	St Charles Prineville 384 SE COMBS FLAT RD PRINEVILLE, OR 97754	X	X			X		X			
4	St Charles Madras 470 NE A ST MADRAS, OR 97741	X	X			X		X			

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

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

Form and Line Reference	Explanation
Facility St Charles Bend - Part V, Section B, Line 5	Methodologyprimary researchTHE CHNA WAS CONDUCTED USING MANY FORMS OF DATA COLLECTION AND ANALYSIS INCLUDING THE FOLLOWING PRIMARY RESEARCH SURVEYS DHM RESEARCH CONDUCTED TELEPHONE INTERVIEWS OF APPROXIMATELY 700 RESIDENTS THROUGHOUT THE FOUR COMMUNITIES (BEND, REDMOND, PRINEVILLE AND MADRAS) SERVED BY A ST CHARLES FACILITY TO DETERMINE THE HEALTH-RELATED PRIORITIES OF THE POPULATION RESIDING IN CENTRAL OREGON THE SURVEY WAS DESIGNED TO ESTABLISH A BASELINE OF IMPORTANCE, PRIORITIES AND NEEDS AROUND HEALTH AND WELLNESS, INCLUDING ACCESS, QUALITY AND COST COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, DESCHUTES COUNTY HEALTH SERVICES, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, CENTRAL OREGON COMMUNITY COLLEGE, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE

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

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

Form and Line Reference	Explanation
Facility St Charles Madras - Part V, Section B, Line 5	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research Surveys DHM Research conducted telephone interviews of approximately 700 residents throughout the four communities (Bend, Redmond, Prineville and Madras) served by a St Charles facility to determine the health-related priorities of the population residing in Central Oregon The survey was designed to establish a baseline of importance, priorities and needs around health and wellness, including access, quality and cost Community stakeholder interviews The St Charles Health System Community Benefit department conducted meetings and discussions with local community stakeholders that included, but is not limited to, representatives from each countys public health department The interviewees included persons with special knowledge or expertise in public health and persons who represent the medically underserved and vulnerable populations throughout the Central Oregon region, including the St Charles defined communities The majority of these took place at either the interviewees location, the St Charles Community Benefit department office or by email/phone, between the months of January and September of 2016 The recommendations from these organizations were compiled and considered while selecting the significant health needs for the local communities Participants included representatives from WEBCo, Jefferson County Public Health Department, Saving GraceImagine Life without Violence, PacificSource Community Solutions, Lets Talk Diversity, Madras CHIP, Central Oregon Health Council, Family Resource Center, Better Together, Central Oregon Community College, MountainStar Family Relief Nursery and Warm Springs Prevention Team

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

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

Form and Line Reference	Explanation
Facility St Charles Prineville - Part V, Section B, Line 5	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research SURVEYS DHM RESEARCH CONDUCTED TELEPHONE INTERVIEWS OF APPROXIMATELY 700 RESIDENTS THROUGHOUT THE FOUR COMMUNITIES (BEND, REDMOND, PRINEVILLE AND MADRAS) SERVED BY A ST CHARLES FACILITY TO DETERMINE THE HEALTH-RELATED PRIORITIES OF THE POPULATION RESIDING IN CENTRAL OREGON THE SURVEY WAS DESIGNED TO ESTABLISH A BASELINE OF IMPORTANCE, PRIORITIES AND NEEDS AROUND HEALTH AND WELLNESS, INCLUDING ACCESS, QUALITY AND COST COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, CROOK COUNTY HEALTH DEPARTMENT, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE

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
Facility St Charles Redmond - Part V, Section B, Line 5	Methodologyprimary researchThe CHNA was conducted using many forms of data collection and analysis including the following primary research Surveys DHM Research conducted telephone interviews of approximately 700 residents throughout the four communities (Bend, Redmond, Prineville and Madras) served by a St Charles facility to determine the health-related priorities of the population residing in Central Oregon The survey was designed to establish a baseline of importance, priorities and needs around health and wellness, including access, quality and cost COMMUNITY STAKEHOLDER INTERVIEWS THE ST CHARLES HEALTH SYSTEM COMMUNITY BENEFIT DEPARTMENT CONDUCTED MEETINGS AND DISCUSSIONS WITH LOCAL COMMUNITY STAKEHOLDERS THAT INCLUDED, BUT IS NOT LIMITED TO, REPRESENTATIVES FROM EACH COUNTYS PUBLIC HEALTH DEPARTMENT THE INTERVIEWEES INCLUDED PERSONS WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND PERSONS WHO REPRESENT THE MEDICALLY UNDERSERVED AND VULNERABLE POPULATIONS THROUGHOUT THE CENTRAL OREGON REGION, INCLUDING THE ST CHARLES DEFINED COMMUNITIES THE MAJORITY OF THESE TOOK PLACE AT EITHER THE INTERVIEWEES LOCATION, THE ST CHARLES COMMUNITY BENEFIT DEPARTMENT OFFICE OR BY EMAIL/PHONE, BETWEEN THE MONTHS OF JANUARY AND SEPTEMBER OF 2016 THE RECOMMENDATIONS FROM THESE ORGANIZATIONS WERE COMPILED AND CONSIDERED WHILE SELECTING THE SIGNIFICANT HEALTH NEEDS FOR THE LOCAL COMMUNITIES PARTICIPANTS INCLUDED REPRESENTATIVES FROM WEBCO, DESCHUTES COUNTY HEALTH SERVICES, PACIFICSOURCE COMMUNITY SOLUTIONS, CENTRAL OREGON HEALTH COUNCIL, FAMILY RESOURCE CENTER, BETTER TOGETHER, CENTRAL OREGON COMMUNITY COLLEGE, MOUNTAINSTAR FAMILY RELIEF NURSERY AND SAVING GRACEIMAGINE LIFE WITHOUT VIOLENCE

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

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

Form and Line Reference	Explanation
Facility St Charles Bend - Part V, Section B, Line 6a	St Charles Redmond, St Charles Madras, St Charles Prineville

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

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

Form and Line Reference	Explanation
Facility St Charles Madras - Part V, Section B, Line 6a	St Charles Bend, St Charles Redmond, St Charles Prineville

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

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

Form and Line Reference	Explanation
Facility St Charles Prineville - Part V, Section B, Line 6a	St Charles Bend, St Charles Redmond, St Charles Madras

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
Facility St Charles Redmond - Part V, Section B, Line 6a	St Charles Bend, St Charles Madras, St Charles Prineville

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
Facility St Charles Bend - Part V, Section B, Line 11	The significant health needs selected for the St Charles Bend facility were prioritized a s such 1 Social determinants of healtha Education and healthb Housingc Jobs2 Behavioral he alth identification and awarenessa Substance abuseb Suicide prevention3 Timely access to h ealth care4 Physical healtha Oral healthb Diabetes5 Eating healthy/nutrition/wellnessAfter careful consideration, St Charles Bend selected suicide prevention as its priority for t he 2017-2019 regional health implementation strategy Suicide, death resulting from intenti onal use of force against oneself, is one of the most persistent public health problems in the state of Oregon On average, two Oregonians die every day from suicide it is the seco nd leading cause of death among people 15 to 34 years of age and the eighth leading cause of death overall in Oregon The rate of suicide in our state has been increasing since the year 2000 Oregon ranks in the top 10 among states for suicide incidence and has suicide rates similar to the national trend, only higher One in six teenagers have had serious th oughts of suicide in the last year Approximately 25 percent of suicides occurred among ve terans The financial cost of suicide in Oregon is also enormous In 2013 alone, self-infl icted injury hospitalization charges exceeded $54 million and the estimate of total lifeti me cost of suicide in the state was more than $677 million In 2016, 33 people committed s uicide in Deschutes County Behavioral health problems, relationship issues with intimate partners, physical health problems and financial trouble/loss of job were the most reporte d factors surrounding suicide incidents St Charles Bend representatives feel that suicid e prevention is a health need that is severe in Oregon and Deschutes County and that toget her with our partners we have a strong ability to make a positive change Many local organ izations are working to address this need and we believe St Charles can capitalize on the energy that surrounds the subject St Charles Health System is using the Robert Wood Joh nson Foundation County Health Rankings to measure the success of its 10-year goal of becom ing the first, second and third ranked counties in the state of Oregon Suicide falls unde r the Injury deaths section of the rankings along with motor vehicle traffic accidents, po isoning, falls and homicide with a firearm By increasing suicide prevention efforts, we w ould not only be improving the health of the communities we serve, educating our populatio ns and enhancing our partnerships, we would also be in alignment with the health systems s trategic plan and its goals The following are the significant health needs identified in t he St Charles Bend CHNA that will not be addressed in this implementation strategy Social determinants of healthEducation and HealthHousingJobsBehavioral health identification and awarenessSubstance abusePhysical healthOral healthDiabetesEating healthy/nutrition/wellne ssIn order to achieve real imp

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
Facility St Charles Bend - Part V, Section B, Line 11	rovement, it was determined that this plan would only focus on severe issues that the orga nization felt it had the most ability to impact, had community partners available to colla borate with and needs that would further its strategic goal of becoming one of the top thr ee counties in Oregon per the Robert Wood Johnson Foundations County Health Rankings By s electing one priority, a more focused effort can be made by the caregivers at St Charles Bend, in collaboration with local partners, to improve the health of those the health syst em serves Although the other needs listed above are important, they were not selected for this RHIS With limited resources available, the St Charles Bend team felt it was import ant not to take on too much in order to tackle the selected issue from all angles and have laser-focused energy around improving suicide prevention efforts in our region It is imp ortant to note that even though the other needs werent selected as priorities, work in the se areas will continue Each of the needs is an area of focus both internally within St C harles departments and by external partners

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
Facility St Charles Madras - Part V, Section B, Line 11	The significant health needs selected for the St Charles Madras facility were prioritized as such 1 Social determinants of healtha Health and educationb Jobsc Housing2 Timely acce ss to health care3 Behavioral health identification and awarenessa Substance abuseb Suicid e prevention4 Eating healthy/nutrition/wellness5 Physical Healtha Diabetesb Oral healthAft er careful consideration, St Charles Madras selected suicide prevention as its priority f or the 2017-2019 regional health implementation strategy Suicide, death resulting from int entional use of force against oneself, is one of the most persistent public health problem s in the state of Oregon On average, two Oregonians die every day from suicideit is the s econd leading cause of death among people 15-34 years of age and the 8th leading cause of death overall in Oregon The rate of suicide in our state has been increasing since the ye ar 2000 Oregon ranks in the top 10 among states for suicide incidence and has suicide rat es similar to the national trend, only higher One in six teenagers have had serious thoug hts of suicide in the last year Approximately 25 percent of suicides occurred among veter ans The financial cost of suicide in Oregon is also enormous In 2013 alone, self-inflict ed injury hospitalization charges exceeded $54 million and the estimate of total lifetime cost of suicide in our state was over $677 million In 2016 alone, three people committed suicide in Jefferson County Between 2003 and 2012, the county suicide rate was 15 7 per 1 00,000 Behavioral health problems, relationship issues with intimate partners, physical h ealth problems and financial trouble/loss of job were the most reported factors surroundin g suicide incidents St Charles Madras representatives feel that suicide prevention is a health need that is severe in Oregon and Jefferson County and that together with our partn ers, we have a strong ability to impact Many local organizations are working to address t his need and there is a lot of energy around the subject at this time, something that can capitalized on St Charles Health System is using the County Health Rankings to measure t he success of our 10-year goal of becoming the first, second and third ranked counties in the state of Oregon Suicide falls under the Injury deaths section of the Robert Wood John son Foundation County Health Rankings & Roadmaps (County Health Rankings), along with moto r vehicle traffic, poisoning, falls and homicide with a firearm By increasing suicide pre vention efforts, we would not only be improving the health of the communities we serve, ed ucating our populations and enhancing our partnerships, we would also be in alignment with the health systems strategic plan and its goals The following are the significant health needs identified in the St Charles Madras CHNA that will not be addressed in this impleme ntation strategy Social determinants of healthHealth and educationJobsHousingTimely access to health careBehavioral heal

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
Facility St Charles Madras - Part V, Section B, Line 11	th identification and awarenessSubstance abuseEating healthy/nutrition/wellnessPhysical He althDiabetesOral healthIn order to achieve real improvement, it was determined that this p lan would only focus on severe issues that the organization felt it had the most ability t o impact, had community partners available to collaborate with and needs that would furthe r its strategic goal of becoming one of the top three counties in Oregon per the Robert Wo od Johnson Foundations County Health Rankings By selecting one priority, a more focused e ffort can be made by the caregivers at St Charles Madras, in collaboration with local par tners, to improve the health of those the health system serves Although the other needs l isted above are important, they were not selected for this RHIS With limited resources av ailable, the St Charles Madras team felt it was important not to take on too much in orde r to tackle the selected issue from all angles and have laser-focused energy around improv ing suicide prevention efforts in our region It is important to note that even though the other needs werent selected as priorities, work in these areas will continue Each of the needs is an area of focus both internally within St Charles departments and by external partners

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
Facility St Charles Prineville - Part V, Section B, Line 11	The significant health needs selected for the St Charles Prineville facility were priorit ized as such 1 Social determinants of healtha Education and healthb Housingc Jobs2 Timely access to health care3 Eating healthy/nutrition/wellness4 Behavioral health identification and awarenessa Substance abuseb Suicide prevention5 Physical healtha Oral healthb Diabete sAfter careful consideration, St Charles Prineville selected suicide prevention as its pr iority for the 2017-2019 regional health implementation strategy Suicide, death resulting from intentional use of force against oneself, is one of the most persistent public health problems in the state of Oregon On average, two Oregonians die every day from suicideit is the second leading cause of death among people 15-34 years of age and the 8th leading c ause of death overall in Oregon The rate of suicide in our state has been increasing sinc e the year 2000 Oregon ranks in the top 10 among states for suicide incidence and has sui cide rates similar to the national trend, only higher One in six teenagers have had serio us thoughts of suicide in the last year Approximately 25 percent of suicides occurred amo ng veterans The financial cost of suicide in Oregon is also enormous In 2013 alone, self -inflicted injury hospitalization charges exceeded $54 million and the estimate of total l ifetime cost of suicide in our state was over $677 million In 2016 alone, seven people co mmitted suicide in Crook County Between 2003 and 2012, the county suicide rate was 19 3 p er 100,000, which was about the same level as the state average, and the highest rate of t he three counties in the tri-county region Behavioral health problems, relationship issue s with intimate partners, physical health problems and financial trouble/loss of job were the most reported factors surrounding suicide incidents St Charles Prineville representa tives feel that suicide prevention is a health need that is severe in Oregon and Crook Cou nty and that together with our partners, we have a strong ability to impact Many local or ganizations are working to address this need and there is a lot of energy around the subje ct at this time, something that can capitalized on St Charles Health System is using the County Health Rankings to measure the success of our 10-year goal of becoming the first, second and third ranked counties in the state of Oregon Suicide falls under the Injury de aths section of the Robert Wood Johnson Foundation County Health Rankings & Roadmaps (Coun ty Health Rankings), along with motor vehicle traffic, poisoning, falls and homicide with a firearm By increasing suicide prevention efforts, we would not only be improving the he alth of the communities we serve, educating our populations and enhancing our partnerships , we would also be in alignment with the health systems strategic plan and its goals The f ollowing are the significant health needs identified in the St Charles Prineville CHNA th at will not be addressed in th

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
Facility St Charles Prineville - Part V, Section B, Line 11	is implementation strategy Social determinants of healthEducation and healthHousingJobsTim ely access to health careEating healthy/nutrition/wellnessBehavioral health identification and awarenessSubstance abusePhysical healthOral healthDiabetesIn order to achieve real im provement, it was determined that this plan would only focus on severe issues that the org anization felt it had the most ability to impact, had community partners available to coll aborate with and needs that would further its strategic goal of becoming one of the top th ree counties in Oregon per the Robert Wood Johnson Foundations County Health Rankings By selecting one priority, a more focused effort can be made by the caregivers at St Charles Prineville, in collaboration with local partners, to improve the health of those the heal th system serves Although the other needs listed above are important, they were not selec ted for this RHIS With limited resources available, the St Charles Prineville team felt it was important not to take on too much in order to tackle the selected issue from all an gles and have laser-focused energy around improving suicide prevention efforts in our regi on It is important to note that even though the other needs werent selected as priorities , work in these areas will continue Each of the needs is an area of focus both internally within St Charles departments and by external partners

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
Facility St Charles Redmond - Part V, Section B, Line 11	The significant health needs selected for the St Charles Redmond facility were prioritize d as such 1 Social determinants of healtha Education and healthb Jobsc Housing2 Timely acc ess to health care3 Eating healthy/nutrition/wellness4 Behavioral health identification an d awarenessa Substance abuseb Suicide prevention5 Physical healtha Oral healthb Diabetes After careful consideration, St Charles Redmond selected suicide prevention as its priori ty for the 2017-2019 regional health implementation strategy Suicide, death resulting from intentional use of force against oneself, is one of the most persistent public health pro blems in the state of Oregon On average, two Oregonians die every day from suicideit is t he second leading cause of death among people 15-34 years of age and the 8th leading cause of death overall in Oregon The rate of suicide in our state has been increasing since th e year 2000 Oregon ranks in the top 10 among states for suicide incidence and has suicide rates similar to the national trend, only higher One in six teenagers have had serious t houghts of suicide in the last year Approximately 25 percent of suicides occurred among v eterans The financial cost of suicide in Oregon is also enormous In 2013 alone, self-inf licted injury hospitalization charges exceeded $54 million and the estimate of total lifet ime cost of suicide in our state was over $677 million In 2016 alone, 33 people committed suicide in Deschutes County Between 2003 and 2012, the county suicide rate was 18 6 per 100,000, which was about the same level as the state average Behavioral health problems, relationship issues with intimate partners, physical health problems and financial trouble /loss of job were the most reported factors surrounding suicide incidents St Charles Red mond representatives feel that suicide prevention is a health need that is severe in Orego n and Deschutes County and that together with our partners, we have a strong ability to im pact Many local organizations are working to address this need and there is a lot of ener gy around the subject at this time, something that can capitalized on St Charles Health System is using the County Health Rankings to measure the success of our 10-year goal of b ecoming the first, second and third ranked counties in the state of Oregon Suicide falls under the Injury deaths section of the Robert Wood Johnson Foundation County Health Rankin gs & Roadmaps (County Health Rankings), along with motor vehicle traffic, poisoning, falls and homicide with a firearm By increasing suicide prevention efforts, we would not only be improving the health of the communities we serve, educating our populations and enhanci ng our partnerships, we would also be in alignment with the health systems strategic plan and its goals The following are the significant health needs identified in the St Charles Redmond CHNA that will not be addressed in this implementation strategy Social determinan ts of healthEducation and heal

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
Facility St Charles Redmond - Part V, Section B, Line 11	thJobsHousingTimely access to health careEating healthy/nutrition/wellnessBehavioral healt h identification and awarenessSubstance abusePhysical healthOral healthDiabetesIn order to achieve real improvement, it was determined that this plan would only focus on severe iss ues that the organization felt it had the most ability to impact, had community partners a vailable to collaborate with and needs that would further its strategic goal of becoming o ne of the top three counties in Oregon per the Robert Wood Johnson Foundations County Heal th Rankings By selecting one priority, a more focused effort can be made by the caregiver s at St Charles Redmond, in collaboration with local partners, to improve the health of t hose the health system serves Although the other needs listed above are important, they w ere not selected for this RHIS With limited resources available, the St Charles Redmond team felt it was important not to take on too much in order to tackle the selected issue f rom all angles and have laser-focused energy around improving suicide prevention efforts i n our region It is important to note that even though the other needs werent selected as priorities, work in these areas will continue Each of the needs is an area of focus both internally within St Charles departments and by external partners

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
Facility St Charles Bend - Part V, Section B, Line 16j	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

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

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

Form and Line Reference	Explanation
Facility St Charles Madras - Part V, Section B, Line 16j	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

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

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

Form and Line Reference	Explanation
Facility St Charles Prineville - Part V, Section B, Line 16j	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

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

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

Form and Line Reference	Explanation
Facility St Charles Redmond - Part V, Section B, Line 16j	A REFERENCE TO THE FINANCIAL ASSISTANCE PROGRAM WAS INCLUDED ON BILLING STATEMENTS AS WELL AS VOICE MESSAGING ON CUSTOMER SERVICE PHONE LINES & PROMPTS

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
1	Cascade Medical Imaging 1460 NE Medical Center Dr Bend, OR 97701	Diagnostic Imaging Clinic
1	St Charles Cancer Center Bend 2500 NE Neff Road Bend, OR 97701	Outpatient Cancer Center
2	Central Oregon Magnetic Resonance Imaging 1460 NE Medical Center Dr Bend, OR 97701	MRI Center
3	St Charles Heart & Lung Specialists 2500 NE Neff Rd Bend, OR 97701	Cardiothoracic Surgery
4	Cascade SurgiCenter 2200 NE Neff Rd 100 Bend, OR 97701	Surgery Center
5	Sage View Psychiatric Center 1885 NE Purcell Blvd Bend, OR 97701	Mental Health Services
6	Redmond Surgical Specialists 1245 NW 4th Street Redmond, OR 97756	Surgical Specialists
7	St Charles Family Care Redmond 211 NW Larch Ave Redmond, OR 97756	Primary Care Clinic
8	St Charles Family Care Prineville 384 SE Combs Flat Road Prineville, OR 97754	Rural Health Clinic
9	St Charles Center for Womens Health Redmond 340 NW 5th Street Ste 101 Redmond, OR 97756	OB/GYN Clinic
10	St Charles Family Care Bend East 2965 NE Conners Ave Ste 127 Bend, OR 97701	Primary Care Clinic
11	St Charles Family Care Bend South 61250 SE Coombs Place Bend, OR 97701	Primary Care Clinic
12	St Charles Hospice 2500 NE Neff Rd Bend, OR 97754	Hospice Care
13	St Charles Trauma & Acute Care 2500 NE Neff Rd Bend, OR 97701	Trauma and & Surgical Services
14	St Charles Wound Care & Ostomy Clinic 2600 NE Neff Rd Bend, OR 97701	Wound & Ostomy Care

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
16	St Charles Immediate Care South 61250 SE Coombs Place Bend, OR 97702	Urgent Care Clinic
1	St Charles Sleep Center Bend 2042 Williamson Ct Bend, OR 97701	Sleep Lab
2	Behavioral Health Bend 2542 Courtney Dr Bend, OR 97701	Behavioral Health Clinic
3	St Charles Sleep Center Redmond 655 NW Jackpine Ave Redmond, OR 97756	Sleep Lab
4	St Charles Neonatology 2500 NE Neff Rd Bend, OR 97701	Neonatal Intensive Care Unit
5	St Charles Family Care Madras 480 NE A St Madras, OR 97741	Primary Care Clinic
6	St Charles Pulmonary Clinic Bend 2500 NE Neff Rd Bend, OR 97701	Lung Clinic
7	St Charles Anticoagulation Clinic Bend 2275 NE Doctors Drive Bend, OR 97701	Anticoag Clinic
8	St Charles Immediate Care East 2600 NE Neff Rd Bend, OR 97701	Immediate Care Clinic
9	St Charles Family Care Sisters 630 Arrowleaf Trail Sisters, OR 97759	Primary Care Clinic
10	St Charles Rheumatology 2965 NE Connors Ave Bend, OR 97701	Rheumatology Clinic
11	St Charles Paliative Care 2500 NE Neff Rd Bend, OR 97701	Paliative Care Clinic
12	St Charles Preoperative Medicine 2500 NE Neff Rd Bend, OR 97701	Comprehensive Care for Surgery Patients
13	St Charles Imaging Redmond 211 NW Larch Ave Redmond, OR 97756	Imaging Services
14	St Charles Family Care Clinic La Pine 51600 Hunnington Rd La Pine, OR 97739	PRIMARY CARE CLINIC

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
31	St Charles Pulmonary Clinic Redmond 655 NW Jackpine Ave Redmond, OR 97756	Lung Clinic
1	Sisters School Based Health Clinic 1680 W McKimmey Butte Rd Sisters, OR 97759	School Based Clinic
2	St Charles Infectious Disease 2965 NE Conners Ave Suite 127 Bend, OR 97701	Infectious Disease Clinic
3	Sisters Diagnostic Radiology 630 N Arrowleaf Trail Sisters, OR 97759	Radiology
4	St Charles Imaging Bend East 2500 NE Neff Road Bend, OR 97701	Imaging Services
5	St Charles Imaging Services La Pine 51600 Hunnington Rd La Pine, OR 97739	IMAGING SERVICES
6	Behavioral Health Redmond 916 SW 17th St Suite 202 Redmond, OR 97756	Behavioral Health Clinic
7	St Charles Anticoagulation Clinic Redmond 244 NW Kingwood Ave Redmond, OR 97756	Anticoag Clinic
8	St Charles Surgical Specialists Prineville 384 SE Combs Flat Road Prineville, OR 97754	Surgical Specialists
9	St Charles Surgical Specialists Madras 480 NE A Street Madras, OR 97741	Surgical Specialists
10	St Charles Lab Clinic Madras 470 NE A Street Madras, OR 97741	Outpatient Lab
11	St Charles Lab Services Bend East 547 NE Bellvue Suite 105 Bend, OR 97701	Outpatient Lab
12	St Charles Cancer Center Redmond 1541 NW Canal Redmond, OR 97756	Outpatient Cancer Center
13	St Charles Lab Clinic Redmond 1553 NW Canal Blvd Redmond, OR 97756	Lab Services
14	St Charles Sisters Lab Services 630 N Arrowleaf Trail Sisters, OR 97759	Outpatient Lab

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

Name and address	Type of Facility (describe)
46 St Charles Redmond School Based Health Clinic 675 SW Rimrock Way Redmond, OR 97756	School Based Health Clinic

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Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☑ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 33

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of 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

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BEND LAPINE SCHOOL DISTRICT 520 NW Wall St BEND, OR 97703	93-6000393	QUASI GOVERNMENTAL	10,000	0			School Connectedness, empathy & inc
BESTCARE TREATMENT SERVICES PO Box 1710 REDMOND, OR 97756	93-1269087	501(C)(3)	15,000	0			Treatment & prevention of addiction

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BETHLEHEM INN 3705 N HWY 97 BEND, OR 97701	93-1323419	501(C)(3)	10,000	0			HOMELESS SHELTER AND SERVICES
BOYS & GIRLS CLUB OF BEND 500 NW WALL STREET BEND, OR 97701	93-1127536	501(C)(3)	8,100	0			ENABLE YOUNG PEOPLE TO REACH THEIR

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CENTRAL OREGON HEALTH COUNCIL 760 NW York Drive BEND, OR 97703	46-0534726	501(C)(3)	19,892	0			Improve Healthcare Delivery
Citizens4Community PO Box 2193 SISTERS, OR 97759	81-1022094	501(C)(3)	6,100	0			Community Welfare

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CO COMMUNITY COLLEGE 2600 NW COLLEGE WAY BEND, OR 97701	93-0505827	QUASI GOVERNMENTAL	22,025	0			COLLEGE NURSING PROGRAM
CO COUNCIL ON AGING 373 NE Greenwood Ave BEND, OR 97701	93-0661229	501(C)(3)	10,000	0			Suicide Prevention & Basic Needs

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CO INTERGOVERNMENTAL COUNCIL 334 NE Hawthorne Ave BEND, OR 97756	93-0620261	QUASI GOVERNMENTAL	75,000	0			Community health system grant
CO VETERANS RANCH 65920 61st St BEND, OR 97703	37-1755279	501(C)(3)	11,000	0			IMPROVE QUALITY OF LIFE FOR VETS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CROOK COUNTY 300 NE Third Rm 23 PRINEVILLE, OR 97754	93-6002290	CROOK COUNTY	8,350	0			VARIOUS PROGRAMS
DESCHUTES COUNTY HEALTH DEPT 2577 NE COURTNEY DRIVE BEND, OR 97701	93-6002292	DESCHUTES COUNTY	28,560	0			COMMUNITY HEALTH

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
DESTINATION REHAB PO Box 8316 BEND, OR 97708	81-1349238	501(C)(3)	5,900	0			REHAB FOR NEURO CONDITIONS
FAMILY ACCESS NETWORK FOUND 2125 NE DAGGETT LN BEND, OR 97701	20-3534560	501(C)(3)	13,500	0			Access to basic needs for children

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
GIVING PLATE 61445 S HWY 97 S BEND, OR 97702	80-0553186	501(C)(3)	5,250	0			COMMUNITY FOOD BANK
JEFFERSON CNTY FAITH BASED 278 Southeast 8th Street MADRAS, OR 97741	46-1018517	501(C)(3)	19,000	0			COMMUNITY IMPROVEMENT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
JEFFERSON COUNTY EMS 360 SW Culver Hwy MADRAS, OR 97741	93-0941103	QUASI GOVERNMENTAL	121,496	0			Emergency Response
JERICHO ROAD PO Box 1623 REDMOND, OR 97753	56-2653566	501(C)(3)	5,700	0			SUPPORT FOR HOMELESS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
KEMPLE MEMORIAL CHILD DENTAL 1029 NW 14TH St Ste 101 BEND, OR 97701	93-1241460	501(C)(3)	10,000	0			DENTAL CARE FOR CHILDREN
KIDS CENTER 1375 NW KINGSTON AVE BEND, OR 97701	94-3169200	501(C)(3)	13,000	0			CHILD ABUSE PREVENTION & TREATMENT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MOUNTAIN STAR FAMILY RELIEF 2125 NE Daggett Ln BEND, OR 97701	42-1560891	501(C)(3)	20,000	0			Help prevent Child Abuse & Neglect
NAMI OREGON 4701 SE 42nd Ave Ste E PORTLAND, OR 97202	93-0875209	501(C)(3)	6,000	0			MENTAL ILLNESS ADVOCACY

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
OREGON CHILDRENS FOUNDATION 101 SW Market St PORTLAND, OR 97201	93-1051724	501(C)(3)	10,000	0			READING EDUCATION FOR CHILDREN
OSU CASCADES CAMPUS 1500 SW CHANDLER BEND, OR 97701	93-0620261	QUASI GOVERNMENTAL	25,000	0			STUDENT TRANSIT

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
REDMOND FIRE & RESCUE 351 NW Dogwood Ave REDMOND, OR 97756	76-0801403	QUASI GOVERNMENTAL	111,170	0			EMERGENCY RESPONSE
RIMROCK TRAILS ADOLESCENT TRE 1333 NW 9TH STREET BEND, OR 97701	93-1019081	501(C)(3)	5,225	0			DRUG & ALCOHOL TREATMENT FOR ADOLES

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SAVING GRACE 1004 NW MILWAUKEE AVE 100 BEND, OR 97701	93-0797194	501(c)(3)	15,225	0			Family Violence Abuse & Services
SISTERS PARK & REC DISTRICT PO Box 2215 SISTERS, OR 97759	47-0959421	QUASI GOVERNMENTAL	5,925	0			Recration sports & enrichment

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
ST CHARLES FOUNDATION 2500 NE Neff Rd BEND, OR 97701	94-3076293	501(C)(3)	48,305	0			To support fundraising activities
STANFORD UNIVERSITY-TRUSTEES 1265 Welch Rd MC 5415 STANDFORD, CA 94305	94-1156365	501(C)(3)	8,500	0			Perinatal Quality Care

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
VOLUNTEERS IN MEDICINE 2300 NE Neff Rd BEND, OR 97701	93-1327847	501(C)(3)	5,825	0			FREE MEDICAL CARE
WELLNESS RANCH 18602 Couch Market Road BEND, OR 97703	82-3839624	501(c)(3)	18,625	0			MENTAL HEALTH TREATMENT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
YOUTH VILLAGE PO BOX 341154 MEMPHIS, TN 38184	58-1716970	501(C)(3)	194,581	0			HELP TROUBLED CHILDREN

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate 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			
	☐ First-class or charter travel	☑ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
	☑ Compensation committee	☑ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☑ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		No

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
Part I, Line 1a Relevant information in regards to selections on 1a	

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	(I) (II)	393,961		64,357	56,247	27,984	542,549	35,932
Adams Aaron CEO Bend & Redmond	(I) (II)	259,801	15,000	22,774	23,849	16,447	337,871	
Berry Rebecca VP Human Resources	(I) (II)	213,673		55,827	35,634	21,800	326,934	
Brickhouse Jeremiah SVP/CIO	(I) (II)	223,014	83,189	68,673	38,839	26,523	440,238	
Guyn Jim MD SVP Population Health	(I) (II)	352,828	300	43,679	16,500	28,811	442,118	
Marchiando Rod SVP Improvement & Strategy	(I) (II)	220,227		57,558	36,674	28,296	342,755	
McLellan Bruce MD Physician	(I) (II)	592,418		22,064	16,500	22,017	652,999	
Pennavaria Laura CHIEF MEDICAL OFFICER, SCMG	(I) (II)	261,769	5,440	17,693		26,754	311,656	
Powell Michael CHIEF PHARMACY OFFICER	(I) (II)	176,032	7,077	25,116	12,869	26,297	247,391	
Rafael Allen MD Physician	(I) (II)	617,139		19,742	16,500	27,178	680,559	
Reed Richard MD Physician	(I) (II)	590,708	16,598	3,430	16,500	25,350	652,586	
Robinson Debra CNO Bend	(I) (II)	198,581	4,100	794	12,499	22,192	238,166	
Simmons Iman SVP COO	(I) (II)	333,790		19,829	50,702	27,021	431,342	
Slater Matthew MD Physician	(I) (II)	655,430		24,255	11,000	22,017	712,702	
Sluka Joseph President	(I) (II)	656,247		143,574	108,377	27,213	935,411	
Steinke Pamela SVP Quality/CNE	(I) (II)	271,009		57,236	44,638	22,383	395,266	21,648
Stevens Carla SR Director Periop & Cardiovascular	(I) (II)	180,608	6,833	674	11,360	13,033	212,508	
Vlessis Angelo MD Physician	(I) (II)	755,284		2,322	8,250	28,974	794,830	
Weinsheim John PRESIDENT SCMG	(I) (II)	177,604		61,829	32,295	26,821	298,549	
Welander Jennifer Senior VP/CFO	(I) (II)	309,854		94,207	48,476	22,287	474,824	

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I Bond Issues

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

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired		2,435,000		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	75,121,021	115,682,014		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds	44,185	2,226		
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	290,853	1,200,176		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	74,785,983	48,837,847		
11	Other spent proceeds		45,969,500		
12	Other unspent proceeds		19,672,264		
13	Year of substantial completion				

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?		X	X					
16	Has the final allocation of proceeds been made?		X		X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c	Are there any research agreements that may result in private business use of bond-financed property?	X		X					
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		0 600 %						
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6	Total of lines 4 and 5		0 600 %						
7	Does the bond issue meet the private security or payment test?		X	X					
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X		X					

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
Part VI	COLUMN A DIFFERENCE BETWEEN PART 1 (e) AND PART II, Line 3 IS DUE TO INTEREST EARNED ON BOND PROCEEDS PART I COL (f) PROCEEDS OF THE BOND WERE ISSUES TO PAY OR REIMBURSE THE COST OF CAPITALIZED ASSETS OF BORROWER FACILITIES AND SUPPORT THE PROVISION OF HEALTHCARE PART III, IINE 7 AS PROVIDED IN TREASURY REGULATION SECTION 1 141-4(C)(2)(i)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE ACCORDINGLY, THE AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE AMOUNT STATED IN PART III, LINE 6 THE ORGANIZATION HAS NOT UNDERTAKEN AN ANALYSIS OF THE PRIVATE SECURITY TEST WITH RESPECT TO THE BONDS, AS THE LEVEL OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS REPORTED IN PART III, LINE 6, IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF THE CODE PART IV, LINE 4(C) THE QUALIFIED HEDGE WAS TERMINATED SUBSTANTIALLY CONTEMPORANEOUSLY WITH THE ISSUE DATE OF THE BONDS, WITHIN THE MEANING OF TREASURY REGULATION, SECTION 1 148 (h)(5)(ii)(A) COLUMN B DIFFERENCE BETWEEN PART 1 (e) AND PART II, Line 3 IS DUE TO INTEREST EARNED ON BOND PROCEEDS PART I COL (f) Proceeds of the bond were used to advance refund Series 2005 Bonds, to finance capital projects, and to pay costs of issuance relating to the bonds PART III, IINE 7 AS PROVIDED IN TREASURY REGULATION SECTION 1 141-4(C)(2)(i)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE ACCORDINGLY, THE AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE AMOUNT STATED IN PART III, LINE 6 THE ORGANIZATION HAS NOT UNDERTAKEN AN ANALYSIS OF THE PRIVATE SECURITY TEST WITH RESPECT TO THE BONDS, AS THE LEVEL OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS REPORTED IN PART III, LINE 6, IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF THE CODE

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

Return Reference	Explanation
Part VI	COLUMN A DIFFERENCE BETWEEN PART 1 (e) AND PART II, Line 3 IS DUE TO INTEREST EARNED ON BOND PROCEEDS PART I COL (f) PROCEEDS OF THE BOND WERE ISSUES TO PAY OR REIMBURSE THE COST OF CAPITALIZED ASSETS OF BORROWER FACILITIES AND SUPPORT THE PROVISION OF HEALTHCARE PART III, IINE 7 AS PROVIDED IN TREASURY REGULATION SECTION 1 141-4(C)(2)(i)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE ACCORDINGLY, THE AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE AMOUNT STATED IN PART III, LINE 6 THE ORGANIZATION HAS NOT UNDERTAKEN AN ANALYSIS OF THE PRIVATE SECURITY TEST WITH RESPECT TO THE BONDS, AS THE LEVEL OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS REPORTED IN PART III, LINE 6, IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF THE CODE PART IV, LINE 4(C) THE QUALIFIED HEDGE WAS TERMINATED SUBSTANTIALLY CONTEMPORANEOUSLY WITH THE ISSUE DATE OF THE BONDS, WITHIN THE MEANING OF TREASURY REGULATION, SECTION 1 148(h)(5)(ii)(A) COLUMN B DIFFERENCE BETWEEN PART 1 (e) AND PART II, Line 3 IS DUE TO INTEREST EARNED ON BOND PROCEEDS PART I COL (f) Proceeds of the bond were used to advance refund Series 2005 Bonds, to finance capital projects, and to pay costs of issuance relating to the bonds PART III, IINE 7 AS PROVIDED IN TREASURY REGULATION SECTION 1 141-4(C)(2)(i)(B), THE AMOUNT OF PRIVATE PAYMENTS TAKEN INTO ACCOUNT UNDER THE PRIVATE PAYMENT TEST MAY NOT EXCEED THE AMOUNT OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS USE ACCORDINGLY, THE AMOUNT OF PRIVATE PAYMENTS FOR THE REPORTING PERIOD DOES NOT EXCEED THE AMOUNT STATED IN PART III, LINE 6 THE ORGANIZATION HAS NOT UNDERTAKEN AN ANALYSIS OF THE PRIVATE SECURITY TEST WITH RESPECT TO THE BONDS, AS THE LEVEL OF PRIVATE BUSINESS USE AND/OR UNRELATED TRADE OR BUSINESS REPORTED IN PART III, LINE 6, IS NOT IN EXCESS OF AMOUNTS PERMITTED UNDER SECTION 145 OF THE CODE

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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.**
▶**Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1) DR LAURA PENNAVARIA	EMPLOYEE	RECRUIT		X	10,000	2,083		No		No	Yes	
(2) DR RICHARD REED	EMPLOYEE	RECRUIT		X	10,000	6,042		No		No	Yes	
(3) DR MATTHEW SLATER	EMPLOYEE	RECRUIT		X	10,000	1,250		No		No	Yes	
Total				▶	$	9,375						

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

Part V Supplemental Information

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

Return Reference	Explanation
Schedule L, Part V Supplemental Information	Part II SCHS paid certain expenses on behalf of physicians upon employment and made further retention payments These retention payments were treated as loans, which will be forgiven as long as the physicians remain employed in good standing over the forgiveness period This method is consistent with SCHS's normal business practices The Board has delegated the authority to executive management to make such loans to physicians, the loans are reviewed by legal counsel The forgiveness of these loans, where applicable, has been reported in Form 990 Part VII and Schedule J Dr Slater and Dr Reed are current highest compensated employees Dr Pennavaria is a current key employee

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ **Attach to Form 990 or 990-EZ.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part III, Line 4d Other Program Services Description	OTHER PROGRAM SERVICES 4 Sage View mental health, Community Education and rents from affi liates OTHER PROGRAM SERVICES 5 St Charles Prineville OTHER PROGRAM SERVICES 6 St Cha rles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St Char les Health System These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart serv ices and primary care SCMG provided over 213,500 visits in Bend clinics, 70,400 visits in Redmond clinics, 7,800 visits in the Sisters clinic, 28,800 visits in Prineville clinics, 6,000 in the Madras clinics and 5,900 in La Pine clinics in 2018 SCMG also operates an i mmediate care clinic to provide low-cost urgent care services to the community, the immedi ate care clinic provided services for more than 24,200 patient visits in 2018 OTHER PROGR AM SERVICES 7 Home Health/Hospice OTHER PROGRAM SERVICES 8 Net Gain/(Loss)on sale of inv entory OTHER PROGRAM SERVICES 9 Healthcare JV Income/(Loss) OTHER PROGRAM SERVICES 10 Re imbursed Salaries OTHER PROGRAM SERVICES 11 Education Programs OTHER PROGRAM SERVICES 12 Transcription, Medical Records, Expert and Staff Fees

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15a Compensation Review & Approval Process - CEO, Top Management	SCHS utilizes an independent outside consultant to provide comparability data regarding co mpensation for the CEO and top management officials The analysis covers all elements of t otal compensation The CEO's compensation is reviewed and approved by the Board of Directo rs following a compensation review The most recent study for the CEO and top management o fficials was performed in November of 2018

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 15b Compensation Review and Approval Process for Officers and Key Employees	SCHS utilizes an independent outside consultant to provide comparability data regarding co mpensation for the Key Employees The analysis covers all elements of total compensation The compensation is reviewed by the Board of Directors following a compensation review Th e evaluation and review process is prescribed in an internal policy and the process is doc umented The most recent study for the key employees was performed in November of 2018 SCH S utilized an independent outside consultant to determine the pros and cons of establishin g board compensation In February 2010 the consultant presented its findings to the St Ch arles board governance committee advising that board members not be involved in determinin g any level of compensation for the board An external committee was selected to review th e consultants analysis along with management recommendations and agreed that compensation for the SCHS board of directors is warranted and will assist in retaining and recruiting h ighly qualified board members

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
Other Changes In Net Assets Or Fund Balances - Other Decreases	DISTRIBUTIONS PAID TO NONCONTROLLING OWNERS = -$8450328

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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

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

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1)ST CHARLES FOUNDATION 2500 NE NEFF ROAD BEND, OR 97701 94-3076293	RAISES FUNDS FOR SCHS & CMNTY PROGRAMS	OR	501(C)(3)	7	SCHS	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) CASCADE MEDICAL IMAGING LLC 1460 NE MEDICAL CENTER DRIVE BEND, OR 97701 85-0484640	IMAGING SERVICES	OR	SCHS	Related	19,267,005	17,113,297		No		Yes		70 000 %
(2) HEART CENTER OF THE CASCADES 2500 NE NEFF RD BEND, OR 97701 38-3724947	MEDICAL BUILDING	OR	NA	Related	309,011	2,074,229		No		Yes		50 000 %

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

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

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

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

			Yes	No
1	During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or**(iv)** rent from a controlled entity	1a		No
b	Gift, grant, or capital contribution to related organization(s)	1b	Yes	
c	Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d	Loans or loan guarantees to or for related organization(s)	1d	Yes	
e	Loans or loan guarantees by related organization(s)	1e		No
f	Dividends from related organization(s)	1f		No
g	Sale of assets to related organization(s)	1g		No
h	Purchase of assets from related organization(s)	1h		No
i	Exchange of assets with related organization(s)	1i		No
j	Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k	Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
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	Yes	
p	Reimbursement paid to related organization(s) for expenses	1p	Yes	
q	Reimbursement paid by related organization(s) for expenses	1q	Yes	
r	Other transfer of cash or property to related organization(s)	1r	Yes	
s	Other transfer of cash or property from related organization(s)	1s	Yes	

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

See Additional Data Table

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

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate 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		Yes	No	

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID: 18007218
Software Version: 2018v3.1
EIN: 93-0602940
Name: St Charles Health System Inc

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

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	ST CHARLES FOUNDATION	b	48,305	CASH/BOOK VALUE
(1)	ST CHARLES FOUNDATION	c	1,639,673	CASH/BOOK VALUE
(2)	ST CHARLES FOUNDATION	o	547,962	BOOK VALUE
(3)	ST CHARLES FOUNDATION	r	326,447	BOOK VALUE
(4)	CASCADE MEDICAL IMAGING LLC	j	192,276	BOOK VALUE
(5)	CASCADE MEDICAL IMAGING LLC	m	34,482,766	BOOK VALUE
(6)	CASCADE MEDICAL IMAGING LLC	p	235,082	BOOK VALUE
(7)	CASCADE MEDICAL IMAGING LLC	q	4,001,732	BOOK VALUE
(8)	CASCADE MEDICAL IMAGING LLC	s	19,754,000	CASH
(9)	HEART CENTER OF THE CASCADES	d	3,975,000	BOOK VALUE
(10)	HEART CENTER OF THE CASCADES	k	1,580,000	BOOK VALUE
(11)	HEART CENTER OF THE CASCADES	m	347,189	BOOK VALUE
(12)	HEART CENTER OF THE CASCADES	s	220,000	CASH