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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

2019

Open to Public Inspection

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

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 $ 1,427,035,121

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**	13
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 2019 (Part V, line 2a)	**5**	5,208
6	Total number of volunteers (estimate if necessary)	**6**	525
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 39	**7b**	

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	2,631,049	4,466,807
9	Program service revenue (Part VIII, line 2g)	753,234,896	866,025,605
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	18,883,649	128,104,012
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	55,812,005	3,542,630
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	830,561,599	1,002,139,054
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	994,686	1,429,434
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)	423,646,413	459,720,034
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶748,218		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	359,935,505	372,574,003
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	784,576,604	833,723,471
19	Revenue less expenses. Subtract line 18 from line 12	45,984,995	168,415,583

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,047,605,572	1,206,976,077
21	Total liabilities (Part X, line 26)	406,838,923	435,183,665
22	Net assets or fund balances. Subtract line 21 from line 20	640,766,649	771,792,412

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

****** 2020-11-11
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: See Additional Data)	(Expenses $	459,059,507	including grants of $	1,429,434)	(Revenue $ 592,440,987)
4b	(Code: See Additional Data)	(Expenses $	74,200,102	including grants of $	)	(Revenue $ 55,705,844)
4c	(Code: See Additional Data)	(Expenses $	72,772,757	including grants of $	)	(Revenue $ 100,842,149)
4d	Other program services (Describe in Schedule O.)	(Expenses $	83,414,830	including grants of $	)	(Revenue $ 120,460,286)
4e	**Total program service expenses ▶**		689,447,196			

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	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
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
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 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) 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, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a		No
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b		No
c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? *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	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		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	455		
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	

Part V Statements Regarding Other IRS Filings and Tax Compliance *(continued)*

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**	5,208		
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**	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**	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**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
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**	13		
	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**	Yes	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?			**5**		No
6	Did the organization have members or stockholders?			**6**		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.

See instructions for the order in which to list the persons above.

☐ 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) ▶								10,222,791		1,310,190

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 ▶ 788

			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	39,089,955
MAYO CLINIC LABORATORIES 200 SW FIRST STREET ROCHESTER, MN 55905	LAB SERVICES	3,148,911
CENTRAL OREGON MRI LLC PO BOX 6059 BEND, OR 97708	MRI services	5,382,150
BEND ANESTHESIOLOGY GROUP 150 W CIVIC CENTER DR STE 200 SANDY, UT 84070	ANESTHESIOLOGY	3,061,710
CENTRAL OR PATHOLOGY CONSULTANTS 1348 NE CUSHING DRIVE STE 200 BEND, OR 97701	DIAGNOSTIC SERVICES	1,612,274

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 ▶ 47

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	1,853,624			
	e Government grants (contributions)	1e	242,302			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,370,881			
	g Noncash contributions included in lines 1a - 1f: $	1g	27,346			
	h **Total.** Add lines 1a-1f . . . . . ▶		4,466,807			
Program Service Revenue		Business Code				
	2a St. Charles Bend	900099	592,440,987	592,440,987		
	b St. Charles Madras	900099	43,052,711	43,052,711		
	c St. Charles Medical Group	621110	55,705,844	55,705,844		
	d St. Charles Prineville	900099	42,811,129	42,811,129		
	e St. Charles Redmond	900099	100,842,149	100,842,149		
	f All other program service revenue.		31,172,785	31,172,785		
	g **Total.** Add lines 2a–2f. . . . . ▶	866,025,605				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		7,623,822			7,623,822
	4 Income from investment of tax-exempt bond proceeds ▶		0			
	5 Royalties . . . . . ▶		0			
		(i) Real	(ii) Personal			
	6a Gross rents	6a 123,491				
	b Less: rental expenses	6b 4,522				
	c Rental income or (loss)	6c 118,969				
	d Net rental income or (loss) . . . . . ▶			118,969		118,969
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	7a 527,252,956	17,780,608			
	b Less: cost or other basis and sales expenses	7b 424,553,374				
	c Gain or (loss)	7c 102,699,582	17,780,608			
	d Net gain or (loss) . . . . . ▶			120,480,190		120,480,190
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	8a				
	b Less: direct expenses . . .	8b				
	c Net income or (loss) from fundraising events . . ▶			0		
	9a Gross income from gaming activities. See Part IV, line 19 . . .	9a				
	b Less: direct expenses . . .	9b				
	c Net income or (loss) from gaming activities . . ▶			0		
	10a Gross sales of inventory, less returns and allowances . .	10a 599,690				
	b Less: cost of goods sold . .	10b 338,171				
	c Net income or (loss) from sales of inventory . . ▶			261,519	261,519	
	Miscellaneous Revenue	Business Code				
	11a Healthcare JV Income	900099	1,249,830	1,249,830		
	b Patient Account Interest	900099	848,795	848,795		
	c Service Fees	900099	544,367	544,367		
	d All other revenue		519,150	519,150		
	e **Total.** Add lines 11a–11d . . . . . ▶		3,162,142			
	12 **Total revenue.** See instructions . . . . . ▶		1,002,139,054	869,449,266		128,222,981

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	1,429,434	1,429,434		
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, lines 15 and 16.	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	7,600,792		7,600,792	
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	362,498,533	308,066,142	54,017,595	414,796
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	14,202,648	11,652,364	2,530,898	19,386
9 Other employee benefits	52,014,645	38,801,371	13,124,942	88,332
10 Payroll taxes	23,403,416	19,209,227	4,165,621	28,568
11 Fees for services (non-employees):				
a Management	0			
b Legal	2,274,043		2,274,043	
c Accounting	480,402	221,625	258,777	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	69,445,221	61,610,579	7,711,760	122,882
12 Advertising and promotion	733,357	69,297	659,438	4,622
13 Office expenses	8,903,176	7,307,199	1,586,283	9,694
14 Information technology	16,844,184	1,355,327	15,466,652	22,205
15 Royalties	0			
16 Occupancy	10,342,419	8,014,491	2,327,928	
17 Travel	1,193,317	930,524	251,179	11,614
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	2,066,701	1,108,278	953,307	5,116
20 Interest	7,581,090	24,045	7,557,045	
21 Payments to affiliates	2,376,245	616,536	1,756,916	2,793
22 Depreciation, depletion, and amortization	42,740,946	28,184,008	14,556,938	
23 Insurance	2,140,629	84	2,140,545	
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	143,590,832	143,624,453	-33,621	
b PROVIDER TAX EXPENSE	39,822,834	39,822,834		
c MAINTENTANCE AND REPAIRS	9,343,168	7,818,473	1,524,695	
d PATIENT SUPPORT	5,495,671	5,439,328	56,343	
e All other expenses	7,199,768	4,141,577	3,039,981	18,210
25 **Total functional expenses.** Add lines 1 through 24e	833,723,471	689,447,196	143,528,057	748,218
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		45,421,837	1	28,594,863
	2	Savings and temporary cash investments		12,190,567	2	24,082,846
	3	Pledges and grants receivable, net			3	0
	4	Accounts receivable, net		95,435,912	4	99,580,678
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		9,375	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	0
	7	Notes and loans receivable, net			7	0
	8	Inventories for sale or use		15,929,662	8	16,000,309
	9	Prepaid expenses and deferred charges		8,530,701	9	11,356,981
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 828,495,802			
	b	Less: accumulated depreciation	10b 394,719,842	361,250,417	10c	433,775,960
	11	Investments—publicly traded securities		473,295,544	11	571,469,470
	12	Investments—other securities. See Part IV, line 11		24,083,040	12	5,664,113
	13	Investments—program-related. See Part IV, line 11		-1,395,986	13	1,927,944
	14	Intangible assets		4,520,385	14	4,579,946
	15	Other assets. See Part IV, line 11		8,334,118	15	9,942,967
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,047,605,572	16	1,206,976,077
Liabilities	17	Accounts payable and accrued expenses		99,714,323	17	110,066,564
	18	Grants payable			18	
	19	Deferred revenue		2,174,307	19	3,128,321
	20	Tax-exempt bond liabilities		288,603,299	20	282,456,950
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties		6,366,517	23	27,092,542
	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		9,980,477	25	12,439,288
	26	**Total liabilities.** Add lines 17 through 25		406,838,923	26	435,183,665
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		640,766,649	27	771,792,412
	28	Net assets with donor restrictions			28	
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		640,766,649	32	771,792,412
	33	Total liabilities and net assets/fund balances		1,047,605,572	33	1,206,976,077

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	1,002,139,054
2	Total expenses (must equal Part IX, column (A), line 25)	2	833,723,471
3	Revenue less expenses. Subtract line 2 from line 1	3	168,415,583
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	640,766,649
5	Net unrealized gains (losses) on investments	5	-27,939,820
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	-9,450,000
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	771,792,412

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: 19009920
Software Version: 2019v5.0
EIN: 93-0602940
Name: St Charles Health System Inc

Form 990, Part III, Line 4a:

St. Charles BendSCMC-B provided services for 16,903 Inpatients, 1,955 births, 17,169 surgical cases, 44,954 Emergency Room visits, and 92,378 Other Outpatient visits in 2019. 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 100 years, St. Charles Bend has taken responsibility for the health and well-being of generations of Oregonians, developing into a Level II Regional Trauma Center with specialized partnerships in heart, cancer, orthopedics and neurosurgery.

Form 990, Part III, Line 4b:

St. Charles Medical Group (SCMG)SCMG is a group of medical clinics owned and operated by St. Charles Health System. These clinics are located throughout the region and provide outpatient services such as cancer care, OB/GYN, pulmonary care, sleep disorder resources, heart services and primary care. SCMG provided over 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 two immediate care clinics to provide low-cost urgent care services to the community; the immediate care clinics provided services for more than 22,500 patient visits in 2019.

Form 990, Part III, Line 4c:

St. Charles RedmondSCMC-R provided services for 2,421 inpatients, 228 births, 4,747 surgical cases, 22,328 Emergency Room visits, and 31,678 Other Outpatient Visits in 2019. At St. Charles Redmond, the patient experience remains at the center of all we do and each patient is empowered to play an active role in his or her own care and healing. Surgeries are performed in four of Oregon's newest and most advanced surgical suites. Patients and their families enjoy the comfort of state-of-the-art patient rooms. Everyone receives the level of care that is expected of a leading regional health care facility.

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Sluka Joseph President	50.00 1.00			X				862,342	0	149,018
Slater Matthew MD Physician	50.00 0.00							863,422	0	33,020
Martin William MD Physician	50.00 0.00							720,467	0	53,801
Rafael Allen MD Physician	50.00 0.00							720,243	0	43,896
Laughlin James MD Physician	50.00 0.00							697,134	0	43,872
Vlessis Angelo MD Physician	50.00 0.00							670,255	0	34,579
Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	40.00 0.00							510,422	0	90,304
Simmons Iman SVP COO	40.00 0.00							433,597	0	84,161
Welander Jennifer Senior VP/CFO	45.00 5.00			X				425,085	0	58,800
Guyn Jim MD SVP Population Health	40.00 0.00							428,903	0	45,624

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			
Steinke Pamela SVP Quality/CNE	40.00 0.00							351,612	0	90,643
Pfister Robert SVP Chief Quality and Safety Physic	40.00 0.00							365,425	0	64,016
Brickhouse Jeremiah SVP/CIO	50.00 0.00							322,309	0	73,035
Adams Aaron CEO Bend & Redmond	40.00 0.00							315,484	0	76,129
Marchiando Rod SVP Improvement & Strategy	40.00 0.00							308,142	0	73,542
Berry Rebecca VP Human Resources	60.00 0.00							289,547	0	65,407
Binder Darren SVP Chief Legal & Risk Officer	50.00 0.00							262,028	0	36,221
Pennavaria Laura CHIEF MEDICAL OFFICER, SCMG	40.00 0.00							225,601	0	32,627
Robinson Debra CNO Bend	40.00 0.00							205,058	0	34,645
Powell Michael CHIEF PHARMACY OFFICER	50.00 0.00							196,432	0	38,707

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			
Shields Todd VP Hospital Administor Prineville	40.00 0.00							173,004	0	36,901
Stevens Carla SR Director Periop & Cardiovascular	40.00 0.00							192,414	0	14,638
Golda David VP Hospital Administor Madras	40.00 0.00							161,866	0	36,604
Reedy James CNO Redmond	40.00 0.00							195,499	0	0
Askari Sanaz MD Director	5.00 0.00	X						71,500	0	0
Schuette Dan Director	25.00 0.00	X						30,000	0	0
Sayeg Thomas Director	5.00 0.00	X						25,000	0	0
Dempsey Dennis Director	15.00 0.00	X						25,000	0	0
Downer Doug Director	5.00 0.00	X						25,000	0	0
Van Pelt Greg Director	5.00 0.00	X						25,000	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			
Gordon Steve Director	5.00 0.00	X						25,000	0	0
Gardner Mack Director	5.00 0.00	X						20,000	0	0
DeGroot Shawn Director	5.00 0.00	X						20,000	0	0
Haase Megan Vice Chair	5.00 0.00	X		X				20,000	0	0
Orlikoff James Chairman	5.00 0.00	X		X				20,000	0	0
Terhes John MD Director	5.00 0.00	X						10,000	0	0
Schmid Corey Director	5.00 0.00	X						10,000	0	0

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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 instructions and the latest information.**

OMB No. 1545-0047

2019

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) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15**

16a **33 1/3% support test—2019.** 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—2018.** 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—2019.** 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—2018.** 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2019.** 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—2018.** 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)

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *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 2019 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-2019**	**(iii) Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, 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 2019. 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 2020.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID: 19009920
Software Version: 2019v5.0
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: 93493316059650

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

2019

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.		

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

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-.		
i Subtract line 1f from line 1c. If zero or less, enter -0-.		

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(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?	Yes		792,368
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		69,046
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		33,486
j	Total. Add lines 1c through 1i			894,900
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 instructions and the latest information.

OMB No. 1545-0047

2019

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	4,702,154	4,902,009	4,527,217	4,475,381	4,564,921
b Contributions	325	2,440	2,577	2,517	51,375
c Net investment earnings, gains, and losses	728,943	-127,411	573,516	236,984	-29,698
d Grants or scholarships	113,389	51,407	179,114	161,937	90,396
e Other expenditures for facilities and programs					
f Administrative expenses	22,880	23,477	22,187	25,728	20,821
g End of year balance	5,295,153	4,702,154	4,902,009	4,527,217	4,475,381

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

- a Board designated or quasi-endowment ▶ 62.000 %
- b Permanent endowment ▶ 29.000 %
- c Temporarily restricted endowment ▶ 9.000 %

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
3a(i) (i) unrelated organizations		No
3a(ii) (ii) related organizations	Yes	
3b b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	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		474,265,953	190,385,722	283,880,231
c Leasehold improvements		7,857,114	5,241,411	2,615,703
d Equipment		296,194,576	181,748,594	114,445,982
e Other		40,021,151	17,344,115	22,677,036
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				433,775,960

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	1,927,944	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	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	12,439,288

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: 19009920
Software Version: 2019v5.0
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, 2019, 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 2016.

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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

2019

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)		36,466	18,366,400		18,366,400	2.200 %
b Medicaid (from Worksheet 3, column a)		179,522	196,356,056	155,951,194	40,404,862	4.850 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		215,988	214,722,456	155,951,194	58,771,262	7.050 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).		32,691	710,438		710,438	0.090 %
f Health professions education (from Worksheet 5)		2,105	845,509	384,611	460,898	0.060 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)		485	51,642		51,642	0.010 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)		49	1,861,335		1,861,335	0.220 %
j **Total.** Other Benefits		35,330	3,468,924	384,611	3,084,313	0.380 %
k **Total.** Add lines 7d and 7j		251,318	218,191,380	156,335,805	61,855,575	7.430 %

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		205,134	317,125		317,125	0.040 %
9 Other						
10 Total		205,134	317,125		317,125	0.040 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2		
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	196,255,423
6	Enter Medicare allowable costs of care relating to payments on line 5	6	248,041,457
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-51,786,034
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				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? **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 19			
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 19			
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
- b ☑ The FAP application form was widely available on a website (list url): http://www.stcharleshealthcare.org
- c ☑ A plain language summary of the FAP was widely available on a website (list url): http://www.stcharleshealthcare.org
- 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 (if not, describe in Section C)			
b ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
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 19			
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 19			
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 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			
b	☑ The FAP application form was widely available on a website (list url): http://www.stcharleshealthcare.org			
c	☑ A plain language summary of the FAP was widely available on a website (list url): http://www.stcharleshealthcare.org			
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 (if not, describe in Section C)			
b ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
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 19			
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 19			
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 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			
b	☑ The FAP application form was widely available on a website (list url): http://www.stcharleshealthcare.org			
c	☑ A plain language summary of the FAP was widely available on a website (list url): http://www.stcharleshealthcare.org			
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 (if not, describe in Section C)			
b ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
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 19			
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 19			
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 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
- b ☑ The FAP application form was widely available on a website (list url): http://www.stcharleshealthcare.org
- c ☑ A plain language summary of the FAP was widely available on a website (list url): http://www.stcharleshealthcare.org
- 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 (if not, describe in Section C)			
b ☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
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, 20a, 20b, 20c, 20d, 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.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
Part I, Line 7 - Explanation of Costing Methodology	The costing methodology used was derived from SCHS's financial systems, which address all hospital-based patient segments and other services provided. A cost-to-charge ratio from the financial systems was used to calculate the cost of Financial Assistance in line 7a. Numbers reported in column (b) in lines 7a and 7b refer to the number of patient encounters.
Part 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 as net patient revenues. Actual write offs have historically been within management'sexpectations.

990 Schedule H, Supplemental Information

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 $51,786,034 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 $91,333,968 which differs from the shortfall of $51,786,034 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 is 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 is reviewed by our financial assistance team for presumptive eligibility. For a majority of the year, if the responsible party did not respond to statements, letters or phone calls within 120 days of billing the patient balance due, St. Charles ran the accounts through charity advisor software and the probability of payment was determined electronically. If the probability of payment was low, the encounter was written off to free care. On October 1st, St. Charles eliminated the charity advisory software scrub to identify the probability of payment, and subsequent write off to charity 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 many organizations from around the community. We collaborated with the Central Oregon Health Council (COHC) to establish a local community data website. The data is provide by Healthy Communities Institute (HCI) and COHC staff manages the website. The website will have dashboards of each community and population risk profiling data that is continuously updated and accessible to the community. 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.centraloregonhealthdata.org. 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 2018-19 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. 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): CobraCrime 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.

990 Schedule H, Supplemental Information

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) unless otherwise noted:URBANLAND AREA IN SQUARE MILES (2010): 3,018POPULATION (2019 ESTIMATE): 197,692POPULATION (2019): UNDER 5 YEARS: 5% UNDER 18 YEARS: 19.8% 65 YEARS AND OVER: 20.5% FEMALE: 50.5%HOUSEHOLDS (2014-2018): 72,471PERSONS PER HOUSEHOLD (2014-2018): 2.47MEDIAN HOUSEHOLD INCOME (2014-2018): $63,680PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2014-2018): 9.4%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2014-2018): 93.5%POPULATION BY RACE (2019): WHITE ALONE, NOT HISPANIC: 94.4% HISPANIC OR LATINO: 8.3% TWO OR MORE RACES: 2.8% AMERICAN INDIAN AND ALASKA NATIVE ALONE: 1.1% ASIAN ALONE: 1.3% BLACK OR AFRICAN AMERICAN ALONE: .6% 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) UNLESS OTHERWISE NOTED:RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2010): 2.971POPULATION (2019 ESTIMATE): 24,404POPULATION (2019): UNDER 5 YEARS: 5.6% UNDER 18 YEARS: 19.8% 65 YEARS AND OVER: 25.2% FEMALE: 50.4%HOUSEHOLDS (2014-2018): 9,339PERSONS PER HOUSEHOLD (2014-2018): 2.38MEDIAN HOUSEHOLD INCOME (2014-2018): $44,524PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2014-2018): 12.9%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2014-2018): 87.6%POPULATION BY RACE (2019): WHITE ALONE, NOT HISPANIC: 94.7% HISPANIC OR LATINO: 7.6% 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)UNLESS OTHERWISE NOTED: RURALMEDICALLY UNDERSERVED AREA (MUA)LAND AREA IN SQUARE MILES (2019): 1,781POPULATION (2019 ESTIMATE): 24,658POPULATION (2019): UNDER 5 YEARS: 6.3% UNDER 18 YEARS: 23.3% 65 YEARS AND OVER: 19.9% FEMALE: 48.3%HOUSEHOLDS (2014-2018): 7,892PERSONS PER HOUSEHOLD (2014-2018): 2.81MEDIAN HOUSEHOLD INCOME (2014-2018): $50,339PERCENTAGE OF PERSONS BELOW POVERTY LEVEL (2014-2018): 16%HIGH SCHOOL GRADUATE OR HIGHER, PERCENT OF PERSONS AGE 25+ (2014-2018): 86%POPULATION BY RACE (2019): WHITE ALONE, NOT HISPANIC: 75.9% HISPANIC OR LATINO: 19.9% TWO OR MORE RACES: 3.4% AMERICAN INDIAN AND ALASKA NATIVE ALONE: 18.3% ASIAN ALONE: .9% BLACK OR AFRICAN AMERICAN ALONE: 1.2% NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: 0.2%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 patient's ability to pay. Generally, those individuals with an annual household income at or less than 300% 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 300% 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 multiple communities served by the systemBend, Prineville, Madras, Sisters, 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 2019, 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: 19009920
Software Version: 2019v5.0
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 more than 700 residents throughout the communities (Crook, Deschutes and Jefferson Counties), 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. Respondents were contacted from a list of registered voters, which included cell phones. In gathering responses, a variety of quality control measures were employed, including questionnaire pre-testing and validation. Community Input: Community input was gathered via a collaboration between the St. Charles Health System Community Benefit department and Central Oregon Health Council. The CHNA was developed with data, input, and information from a wide variety of health and community-based organizations, stakeholders and community members. The input was gathered from the Central Oregon Health Councils Community Advisory Council, a number of health-related advisory boards and groups, and via numerous community focus groups throughout the region. Individuals (such as traditional health workers/peer support specialists/community health workers) and organizations were asked to share their expertise through a health equity and social determinants of health lens.

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 more than 700 residents throughout the communities (Crook, Deschutes and Jefferson Counties), 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. Respondents were contacted from a list of registered voters, which included cell phones. In gathering responses, a variety of quality control measures were employed, including questionnaire pre-testing and validation. Community stakeholder interviews: Community input was gathered via a collaboration between the St. Charles Health System Community Benefit department and Central Oregon Health Council. The CHNA was developed with data, input, and information from a wide variety of health and community-based organizations, stakeholders and community members. The input was gathered from the Central Oregon Health Councils Community Advisory Council, a number of health-related advisory boards and groups, and via numerous community focus groups throughout the region. Individuals (such as traditional health workers/peer support specialists/community health workers) and organizations were asked to share their expertise through a health equity and social determinants of health lens.

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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	The CHNA was conducted using many forms of data collection and analysis including the following primary research: Surveys: DHM Research conducted telephone interviews of more than 700 residents throughout the communities (Crook, Deschutes and Jefferson Counties), 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. Respondents were contacted from a list of registered voters, which included cell phones. In gathering responses, a variety of quality control measures were employed, including questionnaire pre-testing and validation. Community Input: Community input was gathered via a collaboration between the St. Charles Health System Community Benefit department and Central Oregon Health Council. The CHNA was developed with data, input, and information from a wide variety of health and community-based organizations, stakeholders and community members. The input was gathered from the Central Oregon Health Councils Community Advisory Council, a number of health-related advisory boards and groups, and via numerous community focus groups throughout the region. Individuals (such as traditional health workers/peer support specialists/community health workers) and organizations were asked to share their expertise through a health equity and social determinants of health lens.

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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 more than 700 residents throughout the communities (Crook, Deschutes and Jefferson Counties), 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. Respondents were contacted from a list of registered voters, which included cell phones. In gathering responses, a variety of quality control measures were employed, including questionnaire pre-testing and validation. .Community Input: Community input was gathered via a collaboration between the St. Charles Health System Community Benefit department and Central Oregon Health Council. The CHNA was developed with data, input, and information from a wide variety of health and community-based organizations, stakeholders and community members. The input was gathered from the Central Oregon Health Councils Community Advisory Council, a number of health-related advisory boards and groups, and via numerous community focus groups throughout the region. Individuals (such as traditional health workers/peer support specialists/community health workers) and organizations were asked to share their expertise through a health equity and social determinants of health lens.

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

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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 that were identified for the St. Charles Bend facility were p rioritized as such:1.Stable Housing & Supportsa.Housingb.Housing Supports for High Utilize rsc.Homelessness2.Address Poverty & Enhance Self Sufficiency a.Living Wage Jobsb.Homelessn essc.Povertyd.Cost of healthy foods/food insecuritye.High school graduation3.Upstream Prev ention: Promotion of Individual Well-Being a.Early Childhood Education & Developmentb.Chil dcarec.Immunizationsd.Adverse Childhood Experiences (ACEs) (across the lifespan)4.Substanc e & Alcohol Misuse Prevention & Treatment a.Alcoholb.Tobaccoc.Other Drugsd.Marijuana5.Beha vioral Health: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicid ed.Emotional Health6.Promote Enhanced Physical Health Across Communities a.Cardiovascular disease (CVD)b.Diabetesc.Obesitya.Preventable DiseasesAfter careful consideration, St. Cha rles Bend selected alcohol misuse prevention as its priority for the 2020-2022 regional he alth implementation strategy. The American Academy of Family Physicians defines alcohol mi suse as a spectrum of behavior, including risky (excessive) alcohol use, alcohol abuse or alcohol dependence. Risky and excessive alcohol use means drinking more that the amount th at results in an increased risk of poor health outcomes. They also mention that in the Uni ted States, 58% of men and 46% of women are estimated to have consumed alcohol in the past 30 days. According to the 2018 Oregon Health Authority (OHA) State of Health Assessment t here has been a 38% increase in the overall rate of alcohol-related deaths in Oregon since 2001 and in the 2017 Pain in the Nation: The Drug, Alcohol, and Suicide Crises and the Ne ed for a National Resiliency Strategy report it shows that 23% of suicides and 40% of suic ide attempts involved alcohol. Oregon also ranks third highest in the country for deaths r elated to alcohol. Alcohol is a risk factor for injuries, violence, unintended pregnancy a nd motor vehicle crashes. In Oregon 33% of driving-related deaths involved alcohol, this w as according to the OHA report. In Deschutes County 32% of motor vehicle crash deaths invo lved alcohol and 21% of adults reported they had drank alcohol excessively in the past 30 days. In the 2013 Prevention Status report from the Center for Disease Control and Prevent ion (CDC) the cost of excessive alcohol use is $2.8 billion, or $1.75 per drink in Oregon. Also in Oregon, in the same report, excessive drinking resulted in 1,302 deaths and 33,93 3 years of potential life lost each year. In Central Oregon, 37% of people ages 18-34 repo rted binge drinking at least once in the last 30 days. In the OHA report the word alcohol appears 25 times and in nine of those times it is in relation to the negative impacts it h as on the other issues facing our communities. St. Charles Bend representatives feel that alcohol misuse prevention is a health need that is severe in Oregon and Deschutes County a nd is something that together

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Form and Line Reference	Explanation
Facility: St Charles Bend - Part V, Section B, Line 11	with our partners, we will make positive changes. Many local organizations are working to address this need and we believe St. Charles can capitalize on the energy that surrounds t he subject. St. Charles Health System is using the Robert Wood Johnson Foundation County H ealth Rankings to measure the success of its 10-year goal of becoming the first, second an d third ranked counties in the state of Oregon. Alcohol misuse impacts a lot of the metric s shown in the rankings but it is specifically called out in the Excessive drinking and Al cohol-impaired driving deaths sections. By increasing our efforts to prevent alcohol misus e, we would not only be improving the health of the communities we serve, educating our po pulations and enhancing our partnerships, we would also be in alignment with the health sy stems strategic plan and its goals. The following are the significant health needs identif ied in the St. Charles Bend CHNA that will not be addressed in this implementation strateg y: 1.Stable Housing and Supportsa.Housingb.Housing Supports for High Utilizersc.Homelessne ss 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homelessnessc.Povert yd.Cost of healthy foods/food insecuritye.High school graduation 3.Upstream Prevention: Pr omotion of Individual Well-Being a.Early Childhood Education and Developmentb.Childcarec.I mmunizationsd.Adverse Childhood Experiences (ACEs) (across the lifespan) 4.Substance Misus e Prevention and Treatment a.Tobaccob.Other Drugsc.Marijuana 5.Behavioral Health: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicided.Emotional Health 6.P romote Enhanced Physical Health Across Communities a.Cardiovascular disease (CVD)b.Diabete sc.Obesityd.Preventable Diseases In order to achieve real improvement, this plan will only focus on severe issues that the organization has the most ability to impact, has communit y partners available to collaborate with and needs that will further St. Charles strategic goal of creating the top three healthiest counties in Oregon per the Robert Wood Johnson Foundations County Health Rankings. By selecting one priority, a more focused effort can b e made by the caregivers at St. Charles Bend, in collaboration with local partners, to imp rove the health of those the health system serves. Although the other needs listed above a re important, they were not selected for this RHIS. With limited resources available, the St. Charles Bend team felt it was important not to take on too much in order to tackle the selected issue from all angles and have laser-focused energy around improving alcohol mis use prevention efforts in our region. It is important to note that even though the other n eeds werent selected as priorities, work in these areas will continue. Each of the needs i s 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 Madras - Part V, Section B, Line 11	The significant health needs selected for the St. Charles Madras facility were prioritized as such:1.Stable Housing & Supports a.Housingb.Housing Supports for High Utilizersc.Homel essness 2.Address Poverty & Enhance Self Sufficiency a.Living Wage Jobsb.Homelessnessc.Pov ertyd.Cost of healthy foods/food insecuritye.High school graduation 3.Substance & Alcohol Misuse Prevention & Treatment a.Alcoholb.Tobaccoc.Other Drugsd.Marijuana 4.Upstream Preven tion: Promotion of Individual Well-Being a.Early Childhood Education & Developmentb.Childc arec.Immunizationsd.ACEs (across the lifespan) 5.Behavioral Health: Increase Access and Co ordination a.Mental Healthb.Behavioral Healthc.Suicided.Emotional Health 6.Promote Enhance d Physical Health Across Communities a.CVDb.Diabetesc.Obesityd.Preventable DiseasesAfter c areful consideration, St. Charles Madras selected alcohol misuse prevention as its priorit y for the 2020-2022 regional health implementation strategy. The American Academy of Famil y Physicians defines alcohol misuse as a spectrum of behavior, including risky (excessive) alcohol use, alcohol abuse or alcohol dependence. Risky and excessive alcohol use means d rinking more that the amount that results in an increased risk of poor health outcomes. Th ey also mention that in the United States, 58% of men and 46% of women are estimated to ha ve consumed alcohol in the past 30 days. According to the 2018 Oregon Health Authority (OH A) State of Health Assessment there has been a 38% increase in the overall rate of alcohol -related deaths in Oregon since 2001. In the 2017 Pain in the Nation: The Drug, Alcohol, a nd Suicide Crises and the Need for a National Resiliency Strategy report it shows that 23% of suicides and 40% of suicide attempts involved alcohol. Oregon also ranks third highest in the country for deaths related to alcohol. Alcohol is a risk factor for injuries, viol ence, unintended pregnancy and motor vehicle crashes. In Oregon 33% of driving-related dea ths involved alcohol, this was according to the OHA report. In Jefferson County 19% of mot or vehicle crash deaths involved alcohol and 17% of adults reported drinking alcohol exces sively in the past 30 days. In the 2013 Prevention Status report from the Center of Diseas e Control and Prevention (CDC) the cost of excessive alcohol use is $2.8 billion, or $1.75 per drink in Oregon. Also in Oregon, in the same report, excessive drinking resulted in 1 ,302 deaths and 33,933 years of potential life lost each year. In Central Oregon, 37% of p eople ages 18-34 reported binge drinking at least once in the last 30 days. In the OHA rep ort the word alcohol appears 25 times and in nine of those times it is in relation to the negative impacts it has on the other issues facing our communities. St. Charles Madras rep resentatives feel that alcohol misuse prevention is a health need that is severe in Oregon and Jefferson County and that together with our partners, we will make positive changes. Many local organizations are w

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Form and Line Reference	Explanation
Facility: St Charles Madras - Part V, Section B, Line 11	orking to address this need and we believe St. Charles can capitalize on the energy that s urrounds the subject. St. Charles Health System is using the Robert Wood Johnson Foundatio n County Health Rankings to measure the success of its 10-year goal of becoming the first, second and third ranked counties in the state of Oregon. Alcohol misuse impacts a lot of the metrics shown in the rankings but it is specifically called out in the Excessive drink ing and Alcohol-impaired driving deaths sections. By increasing our efforts to prevent alc ohol misuse, we would not only be improving the health of the communities we serve, educat ing 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 nee ds identified in the St. Charles Madras CHNA that will not be addressed in this implementa tion strategy: 1.Stable Housing and Supports a.Housingb.Housing Supports for High Utilizer sc.Homelessness 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homeles snessc.Povertyd.Cost of healthy foods/food insecuritye.High school graduation 3.Substance Misuse Prevention and Treatment a.Tobaccob.Other Drugsc.Marijuana 4.Upstream Prevention: P romotion of Individual Well-Being a.Early Childhood Education and Developmentb.Childcarec. Immunizationsd.Adverse Childhood Experiences (ACEs) (across the lifespan) 5.Behavioral Hea lth: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicided.Emotion al Health 6.Promote Enhanced Physical Health Across Communities a.Cardiovascular disease (CVD) b.Diabetesc.Obesityd.Preventable Diseases In order to achieve real improvement, it was determined that this plan would only focus on severe issues that the organization felt it had the most ability to impact, had community partners available to collaborate with and needs that would further its strategic goal of creating the top three healthiest 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 Madras, in c ollaboration with local partners, to improve the health of those the health system serves. Although the other needs listed above are important, they were not selected for this RHIS . With limited resources available, the St. Charles Madras team felt it was important not to take on too much in order to tackle the selected issue from all angles and have laser-f ocused energy around improving alcohol misuse prevention efforts in our region. It is impo rtant to note that even though the other needs werent selected as priorities, work in thes e areas will continue. Each of the needs is an area of focus both internally within St. Ch arles departments and by external partners.

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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.Stable Housing and Supports a.Housingb.Housing Supports for High Utilizersc .Homelessness 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homelessn essc.Povertyd.Cost of healthy foods/food insecuritye.High school graduation 3.Behavioral H ealth: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicided.Emoti onal Health 4.Promote Enhanced Physical Health Across Communities a.Cardiovascular disease (CVD)b.Diabetesc.Obesityd.Preventable Diseases 5.Substance and Alcohol Misuse Prevention and Treatment a.Alcoholb.Tobaccoc.Other Drugsd.Marijuana 6.Upstream Prevention: Promotion of Individual Well-Being a.Early Childhood Education and Developmentb.Childcarec.Immunizat ionsd.Adverse Childhood Experiences (ACEs) (across the lifespan)After careful consideratio n, St. Charles Prineville selected alcohol misuse prevention as its priority for the 2020-2022 regional health implementation strategy. The American Academy of Family Physicians de fines alcohol misuse as a spectrum of behavior, including risky (excessive) alcohol use, a lcohol abuse or alcohol dependence. Risky and excessive alcohol use means drinking more th at the amount that results in an increased risk of poor health outcomes. They also mention that in the United States, 58% of men and 46% of women are estimated to have consumed alc ohol in the past 30 days.[1] According to the 2018 Oregon Health Authority (OHA) State of Health Assessment there has been a 38% increase in the overall rate of alcohol-related dea ths in Oregon since 2001. In the 2017 Pain in the Nation: The Drug, Alcohol, and Suicide C rises and the Need for a National Resiliency Strategy report it shows that 23% of suicides and 40% of suicide attempts involved alcohol. Oregon also ranks third highest in the coun try for deaths related to alcohol.[2] Alcohol is a risk factor for injuries, violence, uni ntended pregnancy and motor vehicle crashes. In Oregon 33% of driving-related deaths invol ved alcohol, this was according to the OHA report.[3] In Crook County 58% of motor vehicle crash deaths involved alcohol and 17% of adults reported drinking excessively in the past 30 days.[4] In the 2013 Prevention Status report from the Center of Disease Control and P revention (CDC) the cost of excessive alcohol use is $2.8 billion, or $1.75 per drink in O regon. Also in Oregon, in the same report, excessive drinking resulted in 1,302 deaths and 33,933 years of potential life lost each year. In Central Oregon, 37% of people ages 18-3 4 reported binge drinking at least once in the last 30 days.[5] In the OHA report the word alcohol appears 25 times and in nine of those times it is in relation to the negative imp acts it has on the other issues facing our communities.St. Charles Prineville representati ves feel that alcohol misuse prevention is a health need that is severe in Oregon and Croo k County and that together wit

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Form and Line Reference	Explanation
Facility: St Charles Prineville - Part V, Section B, Line 11	h our partners, we will make positive changes. Many local organizations are working to add ress 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 Johnson Foundation County Heal th Rankings to measure the success of its 10-year goal of becoming the first, second and t hird ranked healthiest counties in the state of Oregon. Alcohol misuse impacts a lot of th e metrics shown in the rankings but it is specifically called out in the Excessive drinkin g and Alcohol-impaired driving deaths sections. By increasing our efforts to prevent alcoh ol misuse, we would not only be improving the health of the communities we serve, educatin g our populations and enhancing our partnerships, we would also be in alignment with the h ealth systems strategic plan and its goals. The following are the significant health needs identified in the St. Charles Prineville CHNA that will not be addressed in this implemen tation strategy: 1.Stable Housing and Supports a.Housingb.Housing Supports for High Utiliz ersc.Homelessness 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homel essnessc.Povertyd.Cost of healthy foods/food insecuritye.High school graduation 3.Behavior al Health: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicided.E motional Health 4.Promote Enhanced Physical Health Across Communities a.Cardiovascular dis ease (CVD)b.Diabetesc.Obesityd.Preventable Diseases 5.Substance Misuse Prevention and Trea tment a.Tobaccob.Other Drugsc.Marijuana 6.Upstream Prevention: Promotion of Individual Wel l-Being a.Early Childhood Education and Developmentb.Childcarec.Immunizationsd.Adverse Chi ldhood Experiences (ACEs) (across the lifespan) In order to achieve real improvement, it w as determined that this plan would only focus on severe issues that the organization felt it had the most ability to impact, had community partners available to collaborate with an d needs that would further its strategic goal of becoming the top three healthiest countie s in Oregon per the Robert Wood Johnson Foundations County Health Rankings. By selecting o ne 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 health system s erves. Although the other needs listed above are important, they were not selected for thi s RHIS. With limited resources available, the St. Charles Prineville team felt it was impo rtant not to take on too much in order to tackle the selected issue from all angles and ha ve laser-focused energy around improving alcohol misuse prevention efforts in our region. It is important to note that even though the other needs werent selected as priorities, wo rk in these areas will continue. Each of the needs is an area of focus both internally wit hin St. Charles departments and by external partners.

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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.Stable Housing and Supports a.Housingb.Housing Supports for High Utilizersc.Ho melessness 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homelessness c.Povertyd.Cost of healthy foods/food insecuritye.High school graduation 3.Substance and A lcohol Misuse Prevention and Treatment a.Alcoholb.Tobaccoc.Other Drugsd.Marijuana 4.Upstre am Prevention: Promotion of Individual Well-Being a.Early Childhood Education and Developm entb.Childcarec.Immunizationsd.Adverse Childhood Experiences (ACEs) (across the lifespan) 5.Behavioral Health: Increase Access and Coordination a.Mental Healthb.Behavioral Healthc. Suicided.Emotional Health 6.Promote Enhanced Physical Health Across Communities a.Cardiova scular disease (CVD)b.Diabetesc.Obesityd.Preventable DiseasesAfter careful consideration, St. Charles Redmond selected alcohol misuse prevention as its priority for the 2020-2022 r egional health implementation strategy. The American Academy of Family Physicians defines alcohol misuse as a spectrum of behavior, including risky (excessive) alcohol use, alcohol abuse or alcohol dependence. Risky and excessive alcohol use means drinking more that the amount that results in an increased risk of poor health outcomes. They also mention that in the United States, 58% of men and 46% of women are estimated to have consumed alcohol i n the past 30 days. According to the 2018 Oregon Health Authority (OHA) State of Health As sessment there has been a 38% increase in the overall rate of alcohol-related deaths in Or egon since 2001. In the 2017 Pain in the Nation: The Drug, Alcohol, and Suicide Crises and the Need for a National Resiliency Strategy report it shows that 23% of suicides and 40% of suicide attempts involved alcohol. Oregon also ranks third highest in the country for d eaths related to alcohol. Alcohol is a risk factor for injuries, violence, unintended preg nancy and motor vehicle crashes. In Oregon 33% of driving-related deaths involved alcohol, this was according to the OHA report. In Deschutes County 32% of motor vehicle crash deat hs involved alcohol and 21% of adults had drank excessively in the past 30 days. In the 20 13 Prevention Status report from the Center of Disease Control and Prevention (CDC) the co st of excessive alcohol use is $2.8 billion, or $1.75 per drink in Oregon. Also in Oregon, in the same report, excessive drinking resulted in 1,302 deaths and 33,933 years of poten tial life lost each year. In Central Oregon, 37% of people ages 18-34 reported binge drink ing at least once in the last 30 days. In the OHA report the word alcohol appears 25 times and in nine of those times it is in relation to the negative impacts it has on the other issues facing our communities. St. Charles Redmond representatives feel that alcohol misus e prevention is a health need that is severe in Oregon and Deschutes County and is somethi ng that together with our part

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	ners, we will make positive changes. Many local organizations are working to address this need and we believe St. Charles can capitalize on the energy that surrounds the subject. S t. Charles Health System is using the Robert Wood Johnson Foundation County Health Ranking s to measure the success of its 10-year goal of becoming the first, second and third ranke d healthiest counties in the state of Oregon. Alcohol misuse impacts a lot of the metrics shown in the rankings but it is specifically called out in the Excessive drinking and Alco hol-impaired driving deaths sections. By increasing our efforts to prevent alcohol misuse, we would not only be improving the health of the communities we serve, educating our popu lations and enhancing our partnerships, we would also be in alignment with the health syst ems strategic plan and its goals. The following are the significant health needs identifie d in the St. Charles Redmond CHNA that will not be addressed in this implementation strate gy: 1.Stable Housing and Supports a.Housingb.Housing Supports for High Utilizersc.Homeless ness 2.Address Poverty and Enhance Self Sufficiency a.Living Wage Jobsb.Homelessnessc.Pove rtyd.Cost of healthy foods/food insecuritye.High school graduation 3.Substance Misuse Prev ention and Treatment a.Tobaccob.Other Drugsc.Marijuana 4.Upstream Prevention: Promotion of Individual Well-Being a.Early Childhood Education and Developmentb.Childcarec.Immunizatio nsd.Adverse Childhood Experiences (ACEs) (across the lifespan) 5.Behavioral Health: Increa se Access and Coordination a.Mental Healthb.Behavioral Healthc.Suicided.Emotional Health 6 .Promote Enhanced Physical Health Across Communities a.Cardiovascular disease (CVD)b.Diabe tesc.Obesityd.Preventable Diseases In order to achieve real improvement, it was determined that this plan would only focus on severe issues that the organization felt it had the mo st ability to impact, had community partners available to collaborate with and needs that would further its strategic goal of creating the top three healthiest counties in Oregon p er 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 Redmond, in collaborati on with local partners, to improve the health of those the health system serves. Although the other needs listed above are important, they were not selected for this RHIS. With lim ited resources available, the St. Charles Redmond team felt it was important not to take o n too much in order to tackle the selected issue from all angles and have laser-focused en ergy around improving alcohol misuse prevention efforts in our region. It is important to note that even though the other needs werent selected as priorities, work in these areas w ill continue. Each of the needs is an area of focus both internally within St. Charles dep artments 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	Cascade SurgiCenter 2200 NE Neff Rd 100 Bend, OR 97701	Surgery Center
3	St Charles Family Care Redmond 211 NW Larch Ave Redmond, OR 97756	Primary Care Clinic
4	Sage View Psychiatric Center 1885 NE Purcell Blvd Bend, OR 97701	Mental Health Services
5	Central Oregon Magnetic Resonance Imaging 1460 NE Medical Center Dr Bend, OR 97701	MRI Center
6	St Charles Sleep Center Bend 2042 Williamson Ct Bend, OR 97701	Sleep Lab
7	St Charles Family Care Prineville 384 SE Combs Flat Road Prineville, OR 97754	Rural Health Clinic
8	St Charles Pulmonary Clinic Bend 2500 NE Neff Rd Bend, OR 97701	Lung Clinic
9	St Charles Center for Womens Health Redmond 340 NW 5th Street Ste 101 Redmond, OR 97756	OB/GYN Clinic
10	St Charles Immediate Care East 2600 NE Neff Rd Bend, OR 97701	Immediate Care Clinic
11	Behavioral Health Bend 2542 Courtney Dr Bend, OR 97701	Behavioral Health Clinic
12	St Charles Sleep Center Redmond 655 NW Jackpine Ave Redmond, OR 97756	Sleep Lab
13	St Charles Family Care Sisters 630 Arrowleaf Trail Sisters, OR 97759	Primary Care Clinic
14	St Charles Family Care Bend East 2965 NE Conners Ave Ste 127 Bend, OR 97701	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)
16	St Charles Pulmonary Clinic Redmond 655 NW Jackpine Ave Redmond, OR 97756	Lung Clinic
1	St Charles Heart & Lung Specialists 2500 NE Neff Rd Bend, OR 97701	Cardiothoracic Surgery
2	St Charles Paliative Care 2500 NE Neff Rd Bend, OR 97701	Paliative Care Clinic
3	St Charles Hospice 2275 Northeast Doctors Dr Suite 6 Bend, OR 97754	Hospice Care
4	St Charles Preoperative Medicine 2500 NE Neff Rd Bend, OR 97701	Comprehensive Care for Surgery Patients
5	St Charles Infectious Disease 2965 NE Conners Ave Suite 127 Bend, OR 97701	Infectious Disease Clinic
6	St Charles Family Care Madras 480 NE A St Madras, OR 97741	Primary Care Clinic
7	Redmond Surgical Specialists 1245 NW 4th Street Redmond, OR 97756	Surgical Specialists
8	Behavioral Health Redmond 916 SW 17th St Suite 202 Redmond, OR 97756	Behavioral Health Clinic
9	St Charles Anticoagulation Clinic Bend 2275 NE Doctors Drive Bend, OR 97701	Anticoag Clinic
10	Sisters Diagnostic Radiology 630 N Arrowleaf Trail Sisters, OR 97759	Radiology
11	St Charles Sisters Lab Services 630 N Arrowleaf Trail Sisters, OR 97759	Outpatient Lab
12	Sisters School Based Health Clinic 1680 W McKimmey Butte Rd Sisters, OR 97759	School Based Clinic
13	St Charles Wound Care & Ostomy Clinic 2275 Northeast Doctors Dr Suite 6 Bend, OR 97701	Wound & Ostomy Care
14	St Charles Neonatology 2500 NE Neff Rd Bend, OR 97701	Neonatal Intensive Care Unit

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 Trauma & Acute Care 2275 Northeast Doctors Dr Suite 6 Bend, OR 97701	Trauma and & Surgical Services
1	St Charles Rheumatology 2965 NE Connors Ave Bend, OR 97701	Rheumatology Clinic
2	St Charles Lab Clinic Redmond 1553 NW Canal Blvd Redmond, OR 97756	Lab Services
3	St Charles Imaging Redmond 211 NW Larch Ave Redmond, OR 97756	Imaging Services
4	St Charles Immediate Care South 61250 SE Coombs Place Bend, OR 97702	Urgent Care Clinic
5	St Charles Family Care Bend South 61250 SE Coombs Place Bend, OR 97701	Primary Care Clinic
6	St Charles Imaging Bend East 2500 NE Neff Road Bend, OR 97701	Imaging Services
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 Family Care Clinic La Pine 51600 Hunnington Rd La Pine, OR 97739	PRIMARY CARE CLINIC
14	St Charles Imaging Services La Pine 51600 Hunnington Rd La Pine, OR 97739	IMAGING SERVICES

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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

2019

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 . . . . . ▶ 27

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: 19009920
Software Version: 2019v5.0
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
BESTCARE TREATMENT SERVICES PO Box 1710 REDMOND, OR 97756	93-1269087	501(C)(3)	34,500	0			Treatment & prevention of addiction
BETHLEHEM INN 3705 N HWY 97 BEND, OR 97701	93-1323419	501(c)(3)	10,000	0			HOMELESS SHELTER AND SERVICES

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
BOYS & GIRLS CLUB OF BEND 500 NW WALL STREET BEND, OR 97701	93-1127536	501(C)(3)	14,200	0			ENABLE YOUNG PEOPLE TO REACH THEIR
CENTER FOUNDATION 2200 NE Neff Road BEND, OR 97701	93-1296341	501(c)(3)	5,480	0			PROVISION OF NO COST MEDICAL 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
CO COUNCIL ON AGING 373 NE Greenwood Ave BEND, OR 97701	93-0661229	501(C)(3)	25,000	0			Suicide Prevention & Basic Needs
CONFEDERATED TRIBES OF WARM PO BOX 1747 REDMOND, OR 97756	93-0639711	501(c)(3)	10,000	0			Alcohol, tobacco & drug free activi

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	11,887	0			VETERAN & SR. SUICIDE PREVENTION
DESTINATION REHAB PO Box 8316 BEND, OR 97708	81-1349238	501(C)(3)	8,000	0			REHAB FOR NEURO CONDITIONS

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
FAMILY ACCESS NETWORK FOUND 2125 NE DAGGETT LN BEND, OR 97701	20-3534560	501(C)(3)	12,500	0			Access to basic needs for children
GIVING PLATE 61445 S HWY 97 S BEND, OR 97702	80-0553186	501(C)(3)	8,745	0			COMMUNITY FOOD BANK

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
J BAR J YOUTH SERVICES 62895 Hamby Rd BEND, OR 97701	93-0677650	501(c)(3)	5,870	0			SUICIDE PREVENTION
JEFFERSON CNTY FAITH BASED 278 Southeast 8th Street MADRAS, OR 97741	46-1018517	501(C)(3)	12,000	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
JERICHO ROAD PO Box 1623 REDMOND, OR 97753	56-2653566	501(c)(3)	5,750	0			SUPPORT FOR HOMELESS
KEMPLE MEMORIAL CHILD DENTAL 1029 NW 14TH St Ste 101 BEND, OR 97701	93-1241460	501(C)(3)	7,500	0			DENTAL CARE 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
KIDS CENTER 1375 NW KINGSTON AVE BEND, OR 97701	94-3169200	501(c)(3)	10,000	0			CHILD ABUSE PREVENTION & TREATMENT
LA PINE COMMUNITY KITCHEN 16480 FINLEY BUTTE RD LA PINE, OR 97739	20-2087631	501(C)(3)	6,050	0			Provide food & clothing to resident

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
LEADERSHIP BEND FOUNDATION 777 NW WALL ST BEND, OR 97701	93-1224982	501(C)(3)	10,000	0			Community leadership development pr
LINES FOR LIFE 5100 SW MACADAM AVE STE 400 PORTLAND, OR 97239	93-0725294	501(C)(3)	28,000	0			Substance abuse and suicide prevent

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MOUNTAIN STAR FAMILY RELIEF 2125 NE Daggett Ln BEND, OR 97701	42-1560891	501(C)(3)	10,000	0			Help prevent Child Abuse & Neglect
OR ASSOC OF HOSPITALS 400 KRUSE WAY PLACE LAKE OSWEGO, OR 97035	94-3098610	501(C)(3)	582,802	0			SUSTAINING RURAL HOSPITALS

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
RIMROCK TRAILS ADOLESCENT TRE 1333 NW 9TH STREET BEND, OR 97701	93-1019081	501(C)(3)	7,000	0			DRUG & ALCOHOL TREATMENT FOR ADOLES
SHEPHERDS HOUSE PO Box 5484 BEND, OR 97708	75-3207723	501(C)(3)	15,500	0			Homeless shelter and services

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)	54,269	0			To support fundraising activities
THE SHIELD 60401 TALL PINE AVE BEND, OR 97702	83-1162216	501(C)(3)	8,000	0			MENTAL HEALTH SERVICES

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
TOUR DES CHUTES 70 SW Century Dr STE 100-273 BEND, OR 97702	20-2006038	501(c)(3)	10,000	0			SUPPORTS CANCER CARE
VOLUNTEERS IN MEDICINE 2300 NE Neff Rd BEND, OR 97701	93-1327847	501(C)(3)	239,024	0			FREE MEDICAL 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
YOUTH VILLAGE PO BOX 341154 MEMPHIS, TN 38184	58-1716970	501(C)(3)	64,391	0			HELP TROUBLED CHILDREN

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Schedule J (Form 990)

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

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I 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 on 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 on 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**	Yes	
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**		

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: 19009920
Software Version: 2019v5.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1Absalon Jeffrey MD CHIEF PHYSICIAN EXECUTIVE	(i)	430,073		80,349	62,298	28,006	600,726	4,646
	(ii)							
1Adams Aaron CEO Bend & Redmond	(i)	314,986		498	49,236	26,893	391,613	
	(ii)							
2Berry Rebecca VP Human Resources	(i)	249,973		39,574	43,335	22,072	354,954	
	(ii)							
3Binder Darren SVP Chief Legal & Risk Officer	(i)	193,485	10,000	58,543	20,417	15,804	298,249	
	(ii)							
4Brickhouse Jeremiah SVP/CIO	(i)	281,072		41,237	46,675	26,360	395,344	26,923
	(ii)							
5Golda David VP Hospital Administor Madras	(i)	161,721		145	10,120	26,484	198,470	
	(ii)							
6Guyn Jim MD SVP Population Health	(i)	379,880	400	48,623	16,800	28,824	474,527	
	(ii)							
7Laughlin James MD Physician	(i)	587,645	108,809	680	16,800	27,072	741,006	
	(ii)							
8Marchiando Rod SVP Improvement & Strategy	(i)	265,512		42,630	45,011	28,531	381,684	
	(ii)							
9Martin William MD Physician	(i)	635,266	65,691	19,510	25,050	28,751	774,268	
	(ii)							
10Pennavaria Laura CHIEF MEDICAL OFFICER, SCMG	(i)	220,938		4,663	13,681	18,946	258,228	
	(ii)							
11Pfister Robert SVP Chief Quality and Safety Physic	(i)	341,536		23,889	37,217	26,799	429,441	
	(ii)							
12Powell Michael CHIEF PHARMACY OFFICER	(i)	176,625		19,807	12,400	26,307	235,139	
	(ii)							
13Rafael Allen MD Physician	(i)	600,009	100,062	20,172	16,800	27,096	764,139	
	(ii)							
14Reedy James CNO Redmond	(i)	155,899		39,600			195,499	
	(ii)							
15Robinson Debra CNO Bend	(i)	203,735	500	823	12,593	22,052	239,703	
	(ii)							
16Shields Todd VP Hospital Administor Prineville	(i)	167,469		5,535	10,958	25,943	209,905	
	(ii)							
17Simmons Iman SVP COO	(i)	361,792		71,805	56,337	27,824	517,758	
	(ii)							
18Slater Matthew MD Physician	(i)	840,295		23,127	11,200	21,820	896,442	
	(ii)							
19Sluka Joseph President	(i)	707,093		155,249	121,848	27,170	1,011,360	127,437
	(ii)							

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				
21 Steinke Pamela SVP Quality/CNE	(i)	291,479		60,133	68,623	22,020	442,255	36,344
	(ii)							
1 Stevens Carla SR Director Periop & Cardiovascular	(i)	188,033		4,381	11,557	3,081	207,052	
	(ii)							
2 Vlessis Angelo MD Physician	(i)	667,903	30	2,322	5,600	28,979	704,834	
	(ii)							
3 Welander Jennifer Senior VP/CFO	(i)	361,098		63,987	36,733	22,067	483,885	41,925
	(ii)							

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

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 instructions and the latest information.

OMB No. 1545-0047

2019

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		3,580,000		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	75,121,022	115,767,222		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds	44,185	2,415		
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	74,785,984	67,328,216		
11	Other spent proceeds		45,969,500		
12	Other unspent proceeds		1,267,008		
13	Year of substantial completion	2017			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X				
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, 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 ISSUED 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 2(C): THE REBATE REPORT WAS PREPARED BY BLX GROUP LLC, AND DATED FEBRUARY 28, 2019.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(f): THE SERIES 2016A BONDS REFUND THE BORROWER'S 2005B BONDS WHICH WERE ISSUED ON DECEMBER 21, 2005.PART III, LINE 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 M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art				
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded				
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies	X	107	27,346	COST OR STATED
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (_____)				
26	Other ▶ (_____)				
27	Other ▶ (_____)				
28	Other ▶ (_____)				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement — 29

		Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?		No
b	If "Yes," describe the arrangement in Part II.		
31	Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?		No
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		No
b	If "Yes," describe in Part II.		
33	If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

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

Return Reference	Explanation

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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

2019

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 two immediate care clinics to provide low-cost urgent care services to the community; the imme diate care clinics provided services for more than 22,500 patient visits in 2019. OTHER PR OGRAM SERVICES 7: Home Health/Hospice OTHER PROGRAM SERVICES 8: Net Gain/(Loss)on sale of inventory OTHER PROGRAM SERVICES 9: Healthcare JV Income/(Loss) OTHER PROGRAM SERVICES 10: IT Support OTHER PROGRAM SERVICES 11: Patient Interest OTHER PROGRAM SERVICES 12: Educati on, Reimbursed Salaries, Outside Repairs and Supply Sales

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Line 4: Description of Significant Changes to Organizational Documents	During 2019, the Board of Directors of St. Charles Health System, Inc. (SCHS) amended and restated SCHS Bylaws to update and clarify the requirements relating to the composition of the Board and to specifically set forth the distinction between the roles of committees h aving board-delegated authority and committees functioning in an advisory capacity. The ot her terms of the amended and restated SCHS Bylaws are generally consistent with the prior version, but were restated in a different format intended to achieve greater internal cons istency and clarity.

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 reviewed by the Audit & Compliance Committee on behalf of the Board of Directors for fina l review before 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 2019.

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 2019.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 https://emma.msrb.org/Home/Index.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Other Changes In Net Assets Or Fund Balances - Other Decreases	DISTRIBUTIONS PAID TO NONCONTROLLING OWNERS = -$9450000

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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

2019

Open to Public Inspection

Name of the organization
St Charles Health System Inc

Employer identification number
93-0602940

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) Cascade Medical Buildings LLC 2200 NE Neff Rd Bend, OR 97701 27-0037327	Real Estate Rental	OR	761,000	50,003,237	St Charles Health System Inc

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

(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	27,005,455	12,412,813		No		Yes		70.000 %
(2) HEART CENTER OF THE CASCADES 2500 NE NEFF RD BEND, OR 97701 38-3724947	MEDICAL BUILDING	OR	NA	related	329,011	1,923,595		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 2000 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		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	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: 19009920
Software Version: 2019v5.0
EIN: 93-0602940
Name: St Charles Health System Inc

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
ST CHARLES FOUNDATION	b	54,269	CASH
ST CHARLES FOUNDATION	c	1,853,624	CASH/BOOK VALUE
ST CHARLES FOUNDATION	o	542,953	BOOK VALUE
ST CHARLES FOUNDATION	r	215,264	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	j	202,121	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	m	38,920,484	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	p	307,352	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	q	4,198,740	BOOK VALUE
CASCADE MEDICAL IMAGING LLC	s	22,050,000	CASH
HEART CENTER OF THE CASCADES	d	3,798,000	BOOK VALUE
HEART CENTER OF THE CASCADES	j	30,120	BOOK VALUE
HEART CENTER OF THE CASCADES	k	1,620,000	BOOK VALUE
HEART CENTER OF THE CASCADES	m	363,945	BOOK VALUE
HEART CENTER OF THE CASCADES	s	232,000	CASH