efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

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
▶ Information about Form 990 and its instructions is at *www IRS gov/form990*

OMB No 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 10-01-2017 , and ending 09-30-2018

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

C Name of organization
ASANTE

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
2650 SISKIYOU BLVD

City or town, state or province, country, and ZIP or foreign postal code
MEDFORD, OR 97504

D Employer identification number
93-0223960

E Telephone number
(541) 789-4103

G Gross receipts $ 1,371,128,917

F Name and address of principal officer
GREG WOJTAL
2650 SISKIYOU BLVD
MEDFORD, OR 97504

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: ▶ WWW ASANTE ORG

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

L Year of formation 1938

M State of legal domicile OR

Part I Summary

1 Briefly describe the organization's mission or most significant activities
ASANTE EXISTS TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COMPASSIONATE MANNER, VALUED BY THE COMMUNITIES WE SERVE

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 2017 (Part V, line 2a)	**5**	5,556
6	Total number of volunteers (estimate if necessary)	**6**	12
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	1,253,490
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	-1,314,941

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	995,872	767,175
9	Program service revenue (Part VIII, line 2g)	643,441,996	761,757,160
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	44,077,981	34,832,613
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	15,349,705	18,688,322
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	703,865,554	816,045,270
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	234,323	503,550
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	367,742,801	409,070,526
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	263,218,612	314,165,348
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	631,195,736	723,739,424
19	Revenue less expenses Subtract line 18 from line 12	72,669,818	92,305,846

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,171,131,040	1,265,166,110
21	Total liabilities (Part X, line 26)	392,303,425	372,205,532
22	Net assets or fund balances Subtract line 21 from line 20	778,827,615	892,960,578

Part II Signature Block

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

Sign Here

****** 2019-08-12
Signature of officer Date

GREG WOJTAL CAFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
JOYLYN M ANKENEY CPA	JOYLYN M ANKENEY CPA	2019-08-12		P00366587

Firm's name ▶ ALDRICH CPAS AND ADVISORS LLP | Firm's EIN ▶ 93-0623286
Firm's address ▶ 5665 SW MEADOWS RD SUITE 200, LAKE OSWEGO, OR 97035 | Phone no (503) 620-4489

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

ASANTE EXISTS TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COMPASSIONATE MANNER, VALUED BY THE COMMUNITIES WE SERVE

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 423,540,079 including grants of $ 0) (Revenue $ 539,016,436)
See Additional Data

4b (Code) (Expenses $ 140,593,025 including grants of $ 0) (Revenue $ 178,925,101)
See Additional Data

4c (Code) (Expenses $ 50,257,038 including grants of $ 503,550) (Revenue $ 63,959,401)
See Additional Data

4d Other program services (Describe in Schedule O)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses ▶** 614,390,142

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	**20a**	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	**20b**	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**	Yes	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**	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**		
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**	298		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**		Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	5,556		
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**			No
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**		Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**		Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .	**4a**			No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**			No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**			No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	**7f**			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**			
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .	**9a**			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	**9b**			
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O	**13a**			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	**14b**			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	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			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6	Did the organization have members or stockholders?	6			No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	8a		Yes	
b	Each committee with authority to act on behalf of the governing body?	8b		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			No

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

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	Yes	
13	Did the organization have a written whistleblower policy?	13	Yes	
14	Did the organization have a written document retention and destruction policy?	14	Yes	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	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		No
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		

Section C. Disclosure

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

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

☐ 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 ▶GREG WOJTAL 2650 SISKIYOU BLVD MEDFORD, OR 97504 (541) 789-4549

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								8,491,337	428,337	2,277,694

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 ▶ 457

			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**	Yes	
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
HEMATOLOGY ONCOLOGY ASSOCIATES 2828 E BARNETT RD MEDFORD, OR 97504	ONCOLOGY SERVICES	41,425,410
SOUTHERN OREGON CARDIOLOGY LLC 520 MEDICAL CENTER DRIVE SUITE 200 MEDFORD, OR 97504	CARDIAC SERVICES	18,249,008
ANESTHESIA ASSOCIATES OF MEDFORD 842 E MAIN ST MEDFORD, OR 97504	PHYSICIAN SERVICES	12,811,563
SOUTHERN OREGON HOSPITALISTS 2640 E BARNETT RD MEDFORD, OR 97504	PHYSICIAN SERVICES	4,803,678
FOCUSONE SOLUTIONS LLC 13609 CALIFORNIA ST STE 420 OMAHA, NE 68154	MANAGEMENT SERVICES	4,243,045

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 ▶ 5

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			
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f 767,175			
	g Noncash contributions included in lines 1a-1f $ _____				
	h Total. Add lines 1a-1f . . . . . ▶	767,175			

Program Service Revenue	Business Code				
2a HOSPITAL SERVICES	622110	761,757,160	760,448,542	1,308,618	
b					
c					
d					
e					
f All other program service revenue					
g Total. Add lines 2a–2f . . . . ▶		761,757,160			

Other Revenue					
3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		13,170,527			13,170,527
4 Income from investment of tax-exempt bond proceeds ▶					
5 Royalties . . . . . ▶					
	(i) Real	(ii) Personal			
6a Gross rents	2,116,966				
b Less rental expenses	3,393,251				
c Rental income or (loss)	-1,276,285				
d Net rental income or (loss) . . . . . ▶		-1,276,285			-1,276,285
	(i) Securities	(ii) Other			
7a Gross amount from sales of assets other than inventory	566,130,727	1,456,668			
b Less cost or other basis and sales expenses	545,901,302	24,007			
c Gain or (loss)	20,229,425	1,432,661			
d Net gain or (loss) . . . . . ▶		21,662,086	1,432,661		20,229,425
8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . a					
b Less direct expenses . . . b					
c Net income or (loss) from fundraising events . . ▶					
9a Gross income from gaming activities See Part IV, line 19 . . . a					
b Less direct expenses . . . b					
c Net income or (loss) from gaming activities . . ▶					
10a Gross sales of inventory, less returns and allowances . . a	5,709,959				
b Less cost of goods sold . . b	5,765,087				
c Net income or (loss) from sales of inventory . . ▶		-55,128		-55,128	
Miscellaneous Revenue	Business Code				
11a OTHER OPERATING INCOME	900099	15,133,376	15,133,376		
b NUTRITION SERVICES	621990	4,329,194	4,329,194		
c JV INCOME	621990	557,165	557,165		
d All other revenue					
e Total. Add lines 11a–11d . . . . . ▶		20,019,735			
12 Total revenue. See Instructions . . . . . ▶		816,045,270	781,900,938	1,253,490	32,123,667

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	503,550	503,550		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	9,520,550	4,760,275	4,760,275	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	301,425,683	260,220,202	41,205,481	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	11,544,418	9,435,603	2,108,815	
9 Other employee benefits	63,453,127	57,694,656	5,758,471	
10 Payroll taxes	23,126,748	19,830,167	3,296,581	
11 Fees for services (non-employees)				
a Management				
b Legal	1,884,423	52,888	1,831,535	
c Accounting	287,343		287,343	
d Lobbying	105,308		105,308	
e Professional fundraising services See Part IV, line 17				
f Investment management fees	1,620,608		1,620,608	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	12,416,372	5,145,805	7,270,567	
12 Advertising and promotion	697,519		697,519	
13 Office expenses	16,707,020	8,353,510	8,353,510	
14 Information technology				
15 Royalties . .				
16 Occupancy	19,993,451	15,917,558	4,075,893	
17 Travel	1,421,704	959,367	462,337	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .				
19 Conferences, conventions, and meetings				
20 Interest	10,262,213	9,235,992	1,026,221	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization . .	47,829,872	35,341,930	12,487,942	
23 Insurance . . .	3,428,715	3,428,715		
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 PATIENT SUPPLIES	122,558,006	122,558,006		
b PURCHASED SERVICES	49,603,131	37,516,946	12,086,185	
c BAD DEBTS	14,688,719	14,688,719		
d OTHER OPERATING EXPENSE	7,086,703	5,816,038	1,270,665	
e All other expenses	3,574,241	2,930,215	644,026	
25 **Total functional expenses.** Add lines 1 through 24e	723,739,424	614,390,142	109,349,282	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ 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	5,177,740	1	43,901,666
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	112,361,883	4	108,204,993
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net	15,542,783	7	20,567,003
	8	Inventories for sale or use	7,977,416	8	8,822,405
	9	Prepaid expenses and deferred charges	8,946,754	9	15,664,379
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 732,527,602			
	b	Less accumulated depreciation — 10b: 407,485,798	348,597,170	10c	325,041,804
	11	Investments—publicly traded securities	593,313,782	11	615,118,669
	12	Investments—other securities See Part IV, line 11		12	
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets See Part IV, line 11	79,213,512	15	127,845,191
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	1,171,131,040	16	1,265,166,110
Liabilities	17	Accounts payable and accrued expenses	10,586,828	17	13,459,587
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	31,850,000	20	31,275,000
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	209,672,838	23	204,459,244
	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	140,193,759	25	123,011,701
	26	**Total liabilities.** Add lines 17 through 25	392,303,425	26	372,205,532
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	778,827,615	27	892,960,578
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	778,827,615	33	892,960,578
	34	Total liabilities and net assets/fund balances	1,171,131,040	34	1,265,166,110

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	816,045,270
2	Total expenses (must equal Part IX, column (A), line 25)	2	723,739,424
3	Revenue less expenses Subtract line 2 from line 1	3	92,305,846
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	778,827,615
5	Net unrealized gains (losses) on investments	5	8,967,090
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	12,860,027
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	892,960,578

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:

Software Version:

EIN: 93-0223960

Name: ASANTE

Form 990, Part III, Line 4a:

ASANTE'S MAIN PROGRAM SERVICE ACCOMPLISHMENT IS THE OPERATION OF ASANTE ROGUE REGIONAL MEDICAL CENTER (ARRMC), A 378 LICENSED BED HOSPITAL LOCATED IN MEDFORD, OREGON ARRMC HAS BEEN NAMED ONE OF THE TOP 100 HOSPITALS IN THE NATION SIX YEARS IN A ROW (2012-2018) THEY EARNED A GRADE "A" HOSPITAL SAFETY SCORE FROM LEAPFROG FOR THE THIRD CONSECUTIVE YEAR THE HOSPITAL ALSO EARNED THE CRITICAL CARE EXCELLENCE AND JOINT REPLACEMENT EXCELLENCE AWARDS FROM HEALTHGRADES HEALTHGRADES ALSO NAMED ARRMC AS ONE OF THE 100 BEST IN AMERICA FOR ORTHOPEDIC SURGERY, SPINE SURGERY AND ONE OF THE 50 BEST FOR VASCULAR SURGERY THE AMERICAN HEART ASSOCIATION AWARDED ARRMC WITH THE GOLD PLUS FOR STEMI RECEIVING CENTER AND US NEWS & WORLD REPORT NAMED ARRMC AS THE #6 HOSPITAL IN OREGON KEY HOSPITAL INPATIENT SERVICES INCLUDE CANCER SERVICES, CARDIOVASCULAR SURGERY, AND INPATIENT CARDIAC CATHERIZATION LABORATORY, GENERAL MEDICINE, GENERAL SURGERY, GYNECOLOGY, NEONATOLOGY, NEUROSCIENCES, OBSTETRICS, ORTHOPEDICS, PEDIATRICS, AND UROLOGY SERVICES OTHER INPATIENT SERVICES INCLUDE BEHAVIORAL HEALTH, REHABILITATION, AND CRITICAL CARE SERVICES, INCLUDING THE REGION'S ONLY LEVEL 3 NEONATAL INTENSIVE CARE UNIT KEY OUTPATIENT SERVICES INCLUDE EMERGENCY SERVICES, AMBULATORY SURGERY, OUTPATIENT LABORATORY TESTING AND DIAGNOSIS, OUTPATIENT CARDIAC CATHERIZATION LAB, IMAGING, SLEEP SERVICES, HOSPICE, AND VARIOUS THERAPIES, INCLUDING BEHAVIORAL, OCCUPATIONAL, PHYSICAL, AND SPEECH DURING FISCAL YEAR 2018, RRMC ADMITTED 16,121 PATIENTS FOR A TOTAL OF 85,607 PATIENT DAYS IT ALSO HAD OVER 500,000 TOTAL OUTPATIENT VISITS AND DELIVERED 1,576 BABIES THE EMERGENCY ROOMS TREATED 49,710 PATIENTS AND THE CHEMISTRY LABS PERFORMED OVER 1 7 MILLION TESTS SURGICAL SERVICES PERFORMED 9,740 INPATIENT AND OUTPATIENT SURGERIES AT RRMC OTHER STATISTICS AT RRMC INCLUDE 25,966 HOSPICE VISITS, 77,070 VISITS TO THE VARIOUS REHAB UNITS, AND OVER 130,000 VISITS TO IMAGING

Form 990, Part III, Line 4b:

ASANTE'S SECOND LARGEST PROGRAM SERVICE ACCOMPLISHMENT BY EXPENSE IS THE OPERATION OF ASANTE THREE RIVERS MEDICAL CENTER (ATRMC), A 125 LICENSED BED HOSPITAL LOCATED IN GRANTS PASS, OREGON ATRMC ALSO RECEIVED A GRADE "A" HOSPITAL SAFETY SCORE FROM LEAPFROG FOR THE THIRD CONSECUTIVE YEAR WOMEN'S CHOICE AWARD NAMED THEM ONE OF AMERICA'S BEST HOSPITALS IN OREGON THERE WERE ALSO NAMED AS ONE OF THE 100 BEST IN AMERICA FOR JOINT REPLACEMENT ADDITIONALLY, HEALTHINSIGHT AWARDED ATRMC FOR HOSPITAL QUALITY SOME OF THE KEY INPATIENT SERVICES AVAILABLE AT TRMC INCLUDE CANCER SERVICES, GENERAL MEDICINE, GENERAL SURGERY, GYNECOLOGY, OBSTETRICS, ORTHOPEDICS, AND PEDIATRICS SOME OF THE KEY OUTPATIENT SERVICES INCLUDE EMERGENCY SERVICES, AMBULATORY SURGERY, OUTPATIENT LAB TESTING, CARDIOPULMONARY SERVICES, OUTPATIENT CARDIAC CATHERIZATION LAB, IMAGING AND VARIOUS THERAPIES INCLUDING PHYSICAL, OCCUPATIONAL, AND SPEECH DURING THE FISCAL YEAR, TRMC ADMITTED 7,294 INPATIENTS FOR A TOTAL OF 26,231 PATIENT DAYS THEY ALSO DELIVERED 776 BABIES AND HAD OVER 250,000 OUTPATIENT VISITS THE CHEMISTRY LAB PERFORMED NEARLY 600,000 TESTS AND THE EMERGENCY ROOM SAW 40,007 PATIENTS THERE WERE 5,834 SURGERIES PERFORMED DURING THE YEAR TRMC'S REHAB DEPARTMENT HAD 41,164 VISITS AND THE VARIOUS IMAGING DEPARTMENTS HAD 94,834 VISITS

Form 990, Part III, Line 4c:

ASANTE'S THIRD LARGEST PROGRAM SERVICE ACCOMPLISHMENTS BY EXPENSE ARE THE OPERATION OF ASANTE ASHLAND COMMUNITY HOSPITAL, A 49 LICENSED BED HOSPITAL LOCATED IN ASHLAND, OREGON AND THE OPERATION OF THE CORPORATE DIVISION AACH ALSO RECEIVED A GRADE "A" HOSPITAL SAFETY SCORE FROM LEAPFROG FOR THE THIRD CONSECUTIVE YEAR THEY WERE ALSO RECOGNIZED FOR QUALITY BY HEATHINSIGHT AND RECEIVED AN AWARD FROM HEALTHGRADES FOR OUTSTANDING PATIENT EXPERIENCE ASANTE HEALTH SYSTEM WAS NAMED ONE OF THE "15 TOP HEALTH SYSTEMS IN THE NATION" FOR THE SEVENTH YEAR IN A ROW BY TRUVEN HEALTH ANALYTICS KEY INPATIENT SERICES AVAILABLE AT ACH INCLUDE GENERAL MEDICINE, GENERAL SURGERY, GYNECOLOGY AND OBSTETRICS SOME THE KEY OUTPATIENT SERVICES INCLUDE EMERGENCY SERVICES, AMBULATORY SURGERY, OUTPATIENT LAB TESTING, IMAGING AND VARIOUS THERAPIES DURING THE FISCAL YEAR, ACH ADMITTED 1,294 INPATIENTS FOR A TOTAL OF 4,286 PATIENT DAYS THEY DELIVERED 261 BABIES AND HAD OVER OVER 36,000 OUTPATIENT VISITS THE LAB PERFORMED OVER 150,000 TESTS, THE EMERGENCY ROOM SAW ALMOST 10,000 PATIENTS AND, THERE WERE 2,226 SURGERIES PERFORMED DURING THE YEAR ASANTE'S CORPORATE DIVISION HAS MADE GENEROUS CASH DONATIONS TO NUMEROUS NON-PROFIT ORGANIZATIONS THESE DONATIONS HELP SUPPORT LOCAL SCHOOLS AND OTHER YOUTH ACTIVITIES, SUCH AS LITTLE LEAGUE AND DRUG FREE GRAD NIGHTS AT LOCAL HIGH SCHOOLS THE CORPORATE DIVISION HAS ALSO MADE SIGNIFICANT CONTRIBUTIONS TO NATIONALLY RECOGNIZED MEDICAL ASSOCIATIONS, SUCH AS THE AMERICAN RED CROSS AND DIABETES ASSOCIATIONS OTHER CONTRIBUTIONS HAVE BEEN MADE TO HEALTH ORGANIZATIONS THAT ASSIST THE LOCAL SPANISH SPEAKING POPULATION, AND OTHERS HAVE BEEN MADE TO ORGANIZATIONS THAT ASSIST LOCAL SENIORS OFTEN, INDIGENT AND MEDICAID PATIENTS WILL SHOW UP AT THE EMERGENCY ROOM IN NEED OF SPECIALIZED MEDICAL CARE IN ORDER TO ASSURE THAT UNASSIGNED INDIGENT AND MEDICAID PATIENTS HAVE SPECIALIZED CARE AVAILABLE TO THEM, ASANTE CREATED SOUTHERN OREGON TRAUMA AND EMERGENCY SERVICES (SOTES) SOTES CONTRACTS WITH LOCAL INDEPENDENT PHYSICIANS TO PROVIDE SPECIALIZED CARE TO THESE PATIENTS THROUGHOUT THEIR HOSPITAL STAY THE PHYSICIAN BILLS SOTES, WHICH WILL REIMBURSE THE SPECIALIST AT MEDICARE RATES SOTES OPERATES AT BREAKEVEN EXPENSES ARE FULLY FUNDED AND REIMBURSED TO THE DOCTOR BY THE HOSPITALS

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			
STEPHEN D ROE CHAIRPERSON	2 00	X		X				0	0	0
RAY A COX TREASURER	2 00	X		X				0	0	0
RONALD JONES MD TRUSTEE	2 00	X						0	0	0
ROY VINYARD PRESIDENT & CEO	40 00	X		X				1,236,805	0	160,715
ANNE GOLDEN SECRETARY	2 00	X						0	0	0
DOUGLASS SCHMOR VICE CHAIRPERSON	2 00	X						0	0	0
THOMAS M TUREK MD TRUSTEE	2 00	X						0	0	0
PETER ANGSTADT TRUSTEE	2 00	X						0	0	0
LEE MILLIGAN MD TRUSTEE	1 00 40 00	X						0	428,337	109,226
SANDRA SLATTERY TRUSTEE	2 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KEN TRAUTMAN TRUSTEE	2 00	X						0	0	0
STEPHEN GAMBE TRUSTEE	2 00	X						0	0	0
PATRICIA WINTEMUTE TRUSTEE	2 00	X						0	0	0
MARK HETZ CH INFO OFFICER	40 00			X				533,924	0	204,136
GREG WOJTAL CFO	40 00			X				470,862	0	97,769
PAUL MACUGA PEOPLE OFFICER	40 00			X				347,741	0	86,608
DENNIE CONRAD CHIEF STRATEGY OFFICER	40 00			X				434,116	0	121,811
SCOTT KELLY ASANTE CEO	40 00				X			1,005,591	0	335,747
WIN HOWARD TRMC CEO	40 00				X			614,776	0	215,638
JAMES GREBOSKY CHIEF QUAL&SAFE OFFICER	40 00				X			784,377	0	290,572

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			
SHEILA CLOUGH ACH CEO	40 00				X			409,518	0	117,900
KRISTEN ROY COMPLIANCE OFFICER	40 00				X			199,544	0	47,848
JOHN BONK MEDICAL DOCTOR	40 00					X		386,994	0	55,221
MICHAEL MCCASKILL MEDICAL DOCTOR	40 00					X		500,117	0	57,579
JENNIFER HALL MEDICAL DOCTOR	40 00					X		377,218	0	62,805
ERIC LOELIGER MEDICAL DOCTOR	40 00					X		427,182	0	120,101
CHRIS DAVID MEDICAL DOCTOR	40 00					X		365,323	0	62,706
GREG EDWARDS FORMER PEOPLE OFFICER	40 00						X	191,519	0	58,778
PATRICK HOCKING FORMER CFO	40 00						X	205,730	0	72,534

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

f Enter the number of supported organizations _____

g Provide the following information about the supported organization(s)

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2016 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a **33 1/3% support tests—2017.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests—2016.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s)*	1		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

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

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

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**) See instructions	
9 Distributable amount for 2017 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

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

Additional Data

Software ID:

Software Version:

EIN: 93-0223960

Name: ASANTE

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: 93493226015059

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** ***www.irs.gov/form990*****.**

OMB No 1545-0047

2017

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	**Employer identification number**
ASANTE	93-0223960

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

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

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) 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)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		51,308
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		54,000
j	Total Add lines 1c through 1i			105,308
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
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 1	ASANTE MAINTAINS MEMBERSHIPS IN THE AMERICAN HOSPITAL ASSOC (AHA) AND OREGON ASSOC OF HOSPITALS AND HEALTHCARE SYSTEMS (OAHHS) DURING TAX YEAR 2017, ASANTE PAID MEMBERSHIP DUES TO THE AHA AND OAHHS OF $85,482 AND $225,766 RESPECTIVELY 14 12% OF OAHHS DUES AND 22 73% OF AHA DUES WENT FOR LOBBYING PURPOSES THUS, ASANTE MADE INDIRECT LOBBYING EXPENDITURES OF $51,308 THROUGH ITS MEMBERSHIP DUES ALSO, ASANTE PAID JOHN WATT AND ASSOCIATES (JWA) $54,000 FOR SPECIFIC ISSUES LOBBYING DURING THE TAX YEAR JWA IS AN ADVOCATE FOR ASANTE AND SPECIALIZES IN BALLOT PROPOSITIONS AFFECTING THE HEALTHCARE INDUSTRY

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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 8/17/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ 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	21,035,987	19,768,780	19,809,910	19,262,867	18,901,661
b Contributions	96,879	1,025,379	65,967	369,173	320,785
c Net investment earnings, gains, and losses	1,118,497	712,656	149,912	213,139	181,774
d Grants or scholarships	418,484	470,828	257,009	35,278	141,353
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	21,832,879	21,035,987	19,768,780	19,809,910	19,262,867

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

- a Board designated or quasi-endowment ▶ 74 970 %
- b Permanent endowment ▶ 24 210 %
- c Temporarily restricted endowment ▶ 0 820 %

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

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		26,517,116		26,517,116
b Buildings		359,601,801	177,498,810	182,102,991
c Leasehold improvements		7,875,651	4,766,134	3,109,517
d Equipment		329,289,268	225,220,854	104,068,414
e Other		9,243,766		9,243,766
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				325,041,804

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

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

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

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

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

(a) Description	(b) Book value
(1) INVEST IN HEALTHCARE VENTURES	4,178,469
(2) INTERCOMPANY RECEIVABLES	100,836,932
(3) OTHER ASSETS	22,829,790
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	127,845,191

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	
SELF INSURANCE RESERVE	8,157,198
REIMBURSEMENT DUE GOVT AGENCIES & 3RD PARTIES	9,260,573
OTHER CURRENT LIABILITIES	16,608,592
LONG TERM LIABILITIES	36,902,144
PAYROLL/BENEFITS PAYABLE	39,390,060
CURRENT PORTION LT DEBT	12,693,134
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	123,011,701

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	920,030,235
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	120,294,292		
e	Add lines **2a** through **2d**			2e	120,294,292
3	Subtract line **2e** from line **1**			3	799,735,943
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	1,620,608		
b	Other (Describe in Part XIII)	4b	14,688,719		
c	Add lines **4a** and **4b**			4c	16,309,327
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	816,045,270

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	866,767,484
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	157,716,779		
e	Add lines **2a** through **2d**			2e	157,716,779
3	Subtract line **2e** from line **1**			3	709,050,705
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	14,688,719		
c	Add lines **4a** and **4b**			4c	14,688,719
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	723,739,424

Part XIII **Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 93-0223960
Name: ASANTE

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	THE ASANTE FOUNDATION, A 501(C)(3) ORGANIZATION, IS DIRECTLY RELATED TO AND CONTROLLED BY ASANTE IT IS IDENTIFIED ON SCHEDULE R, PART II AS A RELATED TAX-EXEMPT ORGANIZATION THE ASANTE FOUNDATION MAINTAINS THE ASSETS OF 14 DIFFERENT ENDOWMENTS WITH A NET WORTH OF OVER $21 8 MILLION THE CORPUS OF THE ENDOWMENTS IS TO REMAIN INTACT AND INVESTED IN MARKETABL E SECURITIES AND OTHER FINANCIAL INSTRUMENTS AT THE END OF EACH FISCAL YEAR, ANY INVESTME NT INCOME GENERATED FROM THE ENDOWMENTS IS RELEASED TO ASANTE THE INCOME RECEIVED IS USED TO SUBSIDIZE NUMEROUS PROGRAMS, INCLUDING THE RRMC HOSPICE, PHYSICIAN AND NURSING EDUCATI ON, CHILDREN'S HEALTH, ONCOLOGY PROGRAMS, AND SUPPORT OF THE FRANCIS CHENEY AND THREE RIVE RS FAMILY HOUSES

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	IT IS THE OPINION OF BOTH THE MANAGEMENT OF ASANTE AND KPMG THAT NO UNCERTAIN TAX POSITION S WERE TAKEN DURING THE FISCAL YEAR THIS OPINION IS STATED IN THE FOOTNOTES OF THE AUDITE D CONSOLIDATED FINANCIAL STATEMENTS

Supplemental Information

Return Reference	Explanation
PART XI, LINE 2D - OTHER ADJUSTMENTS	ASANTE FOUNDATION INVESTMENT INCOME 1,297,670 OPERATING INCOME FROM AFFILIATES INCLUDED I N CONSOLIDATED FINANCIAL STMT 70,925,878 PROVIDER TAX NETTED WITH REVENUE FOR TAX RETURN 41,964,646 AFFILIATE INVESTMENT REVENUE INCLUDED IN CONSOLIDATED FINANCIAL STMT 341,011 COST OF GOODS SOLD NETTED WITH REVENUE 5,765,087

Supplemental Information

Return Reference	Explanation
PART XI, LINE 4B - OTHER ADJUSTMENTS	BAD DEBT EXPENSE NETTED WITH REVENUE ON FINANCIAL STMT 14,688,719 FOUNDATION NONOPERATING LOSS INCLUDED IN CONSOLIDATED FINANCIAL STMT

Supplemental Information

Return Reference	Explanation
PART XII, LINE 2D - OTHER ADJUSTMENTS	UNREALIZED LOSS ON INVESTMENTS 10,632,922 AFFILIATE OPERATING EXPENSES INCLUDED IN CONSOL IDATED FINANCIAL STMT 99,354,124 PROVIDER TAX NETTED WITH REVENUE FOR TAX RETURN 41,964,6 46 COST OF GOODS SOLD NETTED WITH REVENUE 5,765,087

Supplemental Information

Return Reference	Explanation
PART XII, LINE 4B - OTHER ADJUSTMENTS	BAD DEBT EXPENSE 14,688,719

Supplemental Information

Return Reference	Explanation
SCHEDULE D PART XI, XII AND XIII	THE FINANCIAL STATEMENTS AND SCHEDULES OF ASANTE ARE AUDITED BY THE ACCOUNTING FIRM OF KPM G THEY ARE COMPILED ON A CONSOLIDATED BASIS THE CONSOLIDATED FINANCIAL STATEMENTS AND SC HEDULES CONTAIN FINANCIAL INFORMATION ABOUT ENTITIES WITHIN ASANTE THAT ARE NOT INCLUDED O N THE ASANTE FORM 990 FINANCIAL INFORMATION ABOUT THE ASANTE FOUNDATION, ASANTE PHYSICIAN S PARTNERS, SOUTHERN OREGON INSURANCE COMPANY, AND ASANTE ASHLAND COMMUNITY HOSPITAL ARE I NCLUDED IN THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS BUT, SINCE EACH OF THOSE ENTITIES RETAIN THEIR OWN TAX IDENTIFICATION NUMBER, THEY FILE THEIR OWN SEPARATE FORM 990 THUS, THEIR FINANCIAL INFORMATION IS EXCLUDED FROM THE ASANTE FORM 990 AND ARE INCLUDED AS RECON CILING ITEMS ON SCHEDULE D ON THE ASANTE FORM 990, SCHEDULE D, PARTS XI, XII, AND XIII, W E HAVE RECONCILED THE TOTAL REVENUES, TOTAL EXPENSES, AND NET ASSETS TO THE CONSOLIDATED S TATEMENT OF OPERATIONS ON THE AUDITED FINANCIAL STATEMENTS IN MANY CASES, THE FINANCIAL I NFORMATION OF THESE OTHER ENTITIES IS CONTAINED WITHIN THE REVENUE, EXPENSES, AND NET ASSE TS ITEMS IN THE FINANCIAL STATEMENT AND MAY NOT BE READILY DISTINGUISHED ON THE FINANCIAL STATEMENT LINE ITEMS

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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 _____ %			
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		
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)		109,787	10,966,255	2,381,285	8,584,970	1 190 %
b Medicaid (from Worksheet 3, column a)		131,788	182,288,653	132,778,317	49,510,336	6 840 %
c Costs of other means-tested government programs (from Worksheet 3, column b)		15,589	22,852,812	19,033,871	3,818,941	0 530 %
d **Total** Financial Assistance and Means-Tested Government Programs		257,164	216,107,720	154,193,473	61,914,247	8 560 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		14,027	4,406,734	361,108	4,045,626	0 560 %
f Health professions education (from Worksheet 5)			3,028,557	35,500	2,993,057	0 410 %
g Subsidized health services (from Worksheet 6)			28,471,793	23,588,903	4,882,890	0 670 %
h Research (from Worksheet 7)			0			
i Cash and in-kind contributions for community benefit (from Worksheet 8)			915,604	94,858	820,746	0 110 %
j **Total.** Other Benefits		14,027	36,822,688	24,080,369	12,742,319	1 750 %
k **Total.** Add lines 7d and 7j		271,191	252,930,408	178,273,842	74,656,566	10 310 %

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			12,461		12,461	0 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			12,461		12,461	0 %

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

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	14,688,719		
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	2,570,526		
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	204,370,028		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	246,559,814		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-42,189,786		
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 1 SISKIYOU IMAGING	RADIOLOGY & IMAGING SVC	66 660 %		33 330 %
2 2 CVI MANAGEMENT CO LLC	MANAGEMENT SERVICES	25 000 %		75 000 %
3 3 CVI REAL PROPERTY	PROPERTY MANAGEMENT	25 000 %		75 000 %
4 4 SOUTHERN OREGON LINEN SVCS	LINEN PROCESSING	39 900 %		
5 5 HEALTH FUTURE LLC	SUPPLIES PURCHASING	16 700 %		
6 6 SURGERY CENTER OF SO OREGON	OUTPATIENT SURGERIES	20 000 %		80 000 %
7 7 LHC	HOME HEALTH	25 000 %		
8 8 ACCENTCARE	HOME HEALTH	25 000 %		
9 9 PROPEL HEALTH	POPULATION HEALTH	33 330 %		
10 10 WOMEN'S CENTER	WOMEN'S IMAGING	50 000 %		
11 11 2859 STATE ST LLC	REAL ESTATE	50 000 %		
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?
3

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 ROGUE REGIONAL MEDICAL CENTER

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	Yes	
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 ASANTE ORG/APP/FILES/PUBLIC/2053/2016-COMMUNITY-HEALTH-NEEDS-ASS			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) HTTP //WWW ASANTE ORG/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

ROGUE REGIONAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
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 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
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 ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
b	☑ The FAP application form was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
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

ROGUE REGIONAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ROGUE REGIONAL MEDICAL CENTER

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 THREE RIVERS MEDICAL CENTER

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	Yes	
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 ASANTE ORG/APP/FILES/PUBLIC/2053/2016-COMMUNITY-HEALTH-NEEDS-ASS			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url) HTTP //WWW ASANTE ORG/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

THREE RIVERS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
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 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
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 ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
b	☑ The FAP application form was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
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

THREE RIVERS MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

THREE RIVERS MEDICAL CENTER

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 ASHLAND COMMUNITY HOSPITAL

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**	Yes	
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 ASANTE ORG/APP/FILES/PUBLIC/2053/2016-COMMUNITY-HEALTH-NEEDS-ASS			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**	Yes	
a If "Yes" (list url) HTTP //WWW ASANTE ORG/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

ASHLAND COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
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 200 000000000000 % and FPG family income limit for eligibility for discounted care of 400 000000000000 %			
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 ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
b	☑ The FAP application form was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
c	☑ A plain language summary of the FAP was widely available on a website (list url) HTTP //WWW ASANTE ORG/PATIENTS-VISITORS/BILLING-AND-FINANCIAL-ASSISTANCE/			
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

ASHLAND COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

ASHLAND COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care			
a ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b ☑ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d ☐ The hospital facility used a prospective Medicare or Medicaid method			
23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		No
If "Yes," explain in Section C			
24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		No
If "Yes," explain in Section C			

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **1**

	Name and address	Type of Facility (describe)
1	1 - ROGUE VALLEY RX 2900 E BARNETT ROAD MEDFORD, OR 97504	OUTPATIENT PHARMACY
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	COST TO CHARGE RATIO IS USED TO CALCULATE BENEFIT EXPENSES
PART I, LINE 7G	SUBSIDIZED SERVICES INCLUDE BEHAVIORAL HEALTH AND EMERGENCY SERVICES WHICH INCLUDES SOUTHERN OREGON TRAUMA AND EMERGENCY SERVICES (SOTES)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	IN FISCAL 2018, ASANTE'S CONTRIBUTION TO COMMUNITY HEALTH IMPROVEMENTS ADVOCACY INCLUDES $9,436 SPLIT BETWEEN MONETARY DONATIONS AND STAFF SUPPORT FOR EMERGENCY PREPAREDNESS AND DISASTER READINESS DRILLS AND EDUCATION TO THE COMMUNITY
PART III, LINE 2	COST TO CHARGE RATIO

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	PERCENTAGE OF THE POPULATION THAT WOULD QUALIFY FOR CHARITY CARE ACCORDING TO POVERTY RATE FROM CENSUS BUREAU, 17 5% POVERTY RATE IN 2016, THAT PERCENTAGE OF BAD DEBT IS ASSUMED TO BE PART OF MISSED CHARITY CARE
PART III, LINE 4	BAD DEBT EXPENSE IS REPORTED BASED ON GROSS PATIENT CHARGES THAT HAVE BEEN WRITTEN OFF DUE TO NON-PAYMENT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	CERTAIN GOVERNMENT SPONSORED HEALTH INSURANCE COMPANIES, SUCH AS MEDICARE AND MEDICAID, PAY A SIGNIFICANTLY REDUCED AMOUNT FOR MEDICAL SERVICES RENDERED TO THEIR INSUREES OREGON LAW IN ORS 442 200(2) CONSIDERS THE DIFFERENCE BETWEEN THE EXPENSES AND REIMBURSEMENT WITH RESPECT TO MEDICARE AND MEDICAID PATIENTS TO BE COMMUNITY BENEFIT CALCULATION TOTAL MEDICARE PAYMENTS PER COST REPORT LESS TOTAL MEDICARE COSTS PER COST REPORT = UNRECOVERED MEDICARE COST PER COST REPORT
PART III, LINE 9B	IF THERE IS AN INDICATION THAT A PATIENT MAY BE UNABLE TO PAY THEIR BILL, A FINANCIAL QUESTIONNAIRE IS GIVEN OR SENT TO THE PATIENT ON RECEIPT OF THE COMPLETED QUESTIONNAIRE, THE BUSINESS OFFICE WILL DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE AND NOTIFY THE PATIENT WITHIN 20 DAYS ELIGIBILITY IS DETERMINED BASED UPON THE QUESTIONNAIRE AND ON FINANCIAL DOCUMENTS, SUCH AS TAX RETURNS, SSI STATEMENTS, PAYCHECK STUBS, AND FSA/HSA INFORMATION THE PATIENT'S OTHER FINANCIAL OBLIGATIONS, NUMBER OF DEPENDENTS, ASSETS AND OTHER FINANCIAL CIRCUMSTANCES ARE CONSIDERED OFTEN, A PATIENT WILL NOT PROVIDE A FINANCIAL QUESTIONNAIRE, SO THE BUSINESS OFFICE WILL USE SOFT CREDIT CHECKS AND ZIP CODES+4 TO HELP DETERMINE ELIGIBILITY THE PERCENTAGE OF FINANCIAL ASSISTANCE PROVIDED IS BASED UPON A SLIDING SCALE TABLE THAT UTILIZES THE PATIENT FAMILY'S INCOME AS A PERCENTAGE OF THE FEDERAL POVERTY GUIDELINES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION B	UNREIMBURSED COSTS FROM THE MEDICARE PROGRAM (USING THE MEDICARE COST REPORT)
PART VI, LINE 2	ASANTE'S FIVE PRIMARY SOURCES OF INPUT INCLUDE THE COMMUNITY LEADERS FORUM, THE ENVIRONMENTAL ASSESSMENT, THE COMMUNITY ASSESSMENT SURVEY, FORMAL CONVERSATIONS WITH OUR COLLABORATORS, AND IDENTIFIED STRATEGIC PLAN GAPS FROM THE PREVIOUS YEAR

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	THE FINANCIAL ACCESS SPECIALISTS, CREDIT ANALYSTS, AND REGISTRATION PERSONNEL WORK WITH THE PATIENT EITHER AT THE TIME OF SCHEDULING, ARRIVAL AT THE HOSPITAL, OR DURING THE BILLING PROCESS IF THE PATIENT DISCLOSES THEY WILL HAVE DIFFICULTY PAYING, WE ASSIST THEM APPLYING FOR THE OREGON HEALTH PLAN, FINANCIAL ASSISTANCE, OR A PAYMENT PLAN BASED UPON INCOME AND EXPENSES, A PATIENT MAY BE ELIGIBLE FOR CHARITY CARE WRITE-OFF OF BETWEEN 10% AND 100% OF THEIR BILL
PART VI, LINE 4	THE MOST NOTABLE FACT ABOUT THE DEMOGRAPHICS OF OUR SERVICE AREA IS THAT WE HAVE A RATHER ELDERLY POPULATION, BOTH IN OUR PRIMARY SERVICE AREA OF JACKSON AND JOSEPHINE COUNTIES, BUT ALSO OUR SECONDARY SERVICE AREA OF NORTHERN CALIFORNIA AND SOUTHERN OREGON IN FISCAL 2018, PATIENTS 65+ ACCOUNTED FOR 54 3% AND 55 1% OF ADMISSIONS AT RRMC AND TRMC RESPECTIVELY FOR THE NEXT 20 YEARS, THE 65+ AGE GROUP IS FORECAST TO BE THE FASTEST GROWING SEGMENT OF THE POPULATION IN ADDITION, THE OVERALL POPULATION GROWTH OF OUR PRIMARY SERVICE AREA IS ALSO FORECAST TO AVERAGE 1% PER YEAR FOR THE NEXT 30 YEARS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	ALONG WITH PROVIDING QUALITY HEALTHCARE, ASANTE FURTHERS ITS EXEMPT PURPOSE AND FULFILLS ITS MISSION TO THE COMMUNITY BY PROVIDING OR SUBSIDIZING NUMEROUS CLASSES, SUPPORT GROUPS, HEALTH FAIRS, AND SELF-HELP PROGRAMS THESE PROGRAMS ARE AT NO OR LOW COST TO THE PUBLIC THE ASANTE COMMUNITY HEALTH EDUCATION PROGRAM IS AN ONGOING, NO COST PROGRAM, OPEN TO ALL COMMUNITY MEMBERS IN FY 2018, OVER 30 COMMUNITY HEALTH EDUCATION CLASSES WERE OFFERED AT RRMC AND TRMC ON AVERAGE, ATTENDANCE WELL EXCEEDED 75 PEOPLE AT EACH EVENT ASANTE ALSO PROMOTES AND EXTENDS PATIENT CARE BY PROVIDING SPACE AND MATERIALS TO APPROXIMATELY 30 SUPPORT GROUPS ASANTE HOSPICE, RVMC AND TRMC CANCER SERVICES, AND RVMC/TRMC WOMEN AND CHILDREN'S SERVICES PROVIDE STAFF, RESOURCES AND ORGANIZATIONAL SUPPORT FOR VARIOUS WELL-ATTENDED SUPPORT GROUPS AND DEDICATIONAL EVENTS, SUCH AS "CANCER SURVIVOR'S DAY" MANY OTHER SUPPORT GROUPS ARE COMMUNITY-LED, BUT LOGISTICALLY SUPPORTED BY ASANTE HEALTH SYSTEM AND AFFILIATED CLINICAL STAFF MEMBERS THE SMULLIN HEALTH EDUCATION CENTER HOUSES COMMUNITY AND HEALTHCARE RELATED EVENTS ALONG WITH THE ASANTE COMMUNITY HEALTH EDUCATION PROGRAM AND SUPPORT GROUPS, SMULLIN HOSTED OVER 250 EVENTS OPERATIONALLY, ASANTE HEALTH SYSTEM SUPPORTS THESE EVENTS BY PROVIDING SALARIES, BENEFITS, SUPPLIES AND CLASSROOM SPACE ADDITIONALLY, ASANTE IS THE SOLE SUPPORT OF THE FRANCIS CHENEY FAMILY PLACE AND THE THREE RIVERS FAMILY HOUSE MUCH LIKE THE RONALD MCDONALD HOUSE, THESE HOUSES PROVIDE LOW-COST TEMPORARY LODGING FOR FAMILIES OF PATIENTS AT RVMC OR TRMC DONATIONS ARE ACCEPTED, BUT NO ONE IS DENIED LODGING FOR AN INABILITY TO CONTRIBUTE ASANTE HEALTH SYSTEM HAS SEVERAL CLINICAL DEPARTMENTS THAT PROVIDE NON-BILLED SERVICES TO COMMUNITY MEMBERS THESE DEPARTMENTS INCLUDE THE STERILE PROCESSING DEPARTMENT, IMAGING DEPARTMENT, RRMC/TRMC PHARMACIES (BOTH HOSPITAL AND RETAIL), SOCIAL SERVICES, RESOURCE MANAGEMENT, SENIOR TRANSPORTATION, AND THE SUPPORTIVE CARE TEAM RRMC ALSO PROVIDES FREE LAB WORK TO THE PATIENTS OF THE COMMUNITY HEALTH CENTERS THE ASANTE HEALTH SYSTEM STRIVES TO MEET THEIR ON-GOING MISSION ASANTE EXISTS TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COMPASSIONATE MANNER, VALUED BY THE COMMUNITIES WE SERVE
PART VI, LINE 6	ASANTE IS A COMMUNITY OWNED AND GOVERNED NOT-FOR-PROFIT HEALTH SYSTEM PROVIDING COMPREHENSIVE HEALTHCARE SERVICES TO MORE THAN 550,000 RESIDENTS IN NINE COUNTIES THROUGHOUT SOUTHERN OREGON AND NORTHERN CALIFORNIA THE SYSTEM WAS FORMED IN 1995 TO INCLUDE ROGUE REGIONAL MEDICAL CENTER (RRMC) IN MEDFORD, AND THREE RIVERS MEDICAL CENTER (TRMC) IN GRANTS PASS IN 2003, ASANTE FORMED ASANTE COMMUNITY SERVICES, WHICH PROVIDES LIFELINE AND RUNS THE OUTPATIENT PHARMACY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	OR

Additional Data

Software ID:
Software Version:
EIN: 93-0223960
Name: ASANTE

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? **3** 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	ROGUE REGIONAL MEDICAL CENTER 2825 E BARNETT ROAD MEDFORD, OR 97504 WWW ASANTE ORG 14-0451	X	X					X			
2	THREE RIVERS MEDICAL CENTER 500 SW RAMSEY AVE GRANTS PASS, OR 97527 WWW ASANTE ORG 14-1439	X	X					X			
3	ASHLAND COMMUNITY HOSPITAL 280 MAPLE ST ASHLAND, OR 97520 WWW ASANTE ORG 14-1445	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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 5 AS PART OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S REQUIREMENT TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT EVERY THREE YEARS, ASANTE, ROGUE REGIONAL MEDICAL CENTER, ASHLAND COMMUNITY HOSPITAL, AND THREE RIVERS MEDICAL CENTER PARTNERED WITH PROFESSIONAL RESEARCH CONSULTANTS, INC TO COMPLETE 600 COMMUNITY SURVEYS IN FISCAL YEAR 2017 THAT YEAR, WE ALSO HELD A FOCUS GROUP COMPRISED OF 7 KEY COMMUNITY LEADERS FROM JACKSON AND JOSEPHINE COUNTIES THE FOCUS GROUP DISCUSSED THE INDIVIDUAL LEADERS' EXPERIENCES AND PERCEPTIONS OF THE TOP HEALTH CONCERNS IN OUR COMMUNITY

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 5 AS PART OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S REQUIREMENT TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT EVERY THREE YEARS, ASANTE, ROGUE REGIONAL MEDICAL CENTER, ASHLAND COMMUNITY HOSPITAL, AND THREE RIVERS MEDICAL CENTER PARTNERED WITH PRC TO COMPLETE 600 COMMUNITY SURVEYS IN FISCAL YEAR 2017 THAT YEAR, WE ALSO HELD A FOCUS GROUP COMPRISED OF 7 KEY COMMUNITY LEADERS FROM JACKSON AND JOSEPHINE COUNTIES THE FOCUS GROUP DISCUSSED THE INDIVIDUAL LEADERS' EXPERIENCES AND PERCEPTIONS OF THE TOP HEALTH CONCERNS IN OUR COMMUNITY

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 5 AS PART OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S REQUIREMENT TO CONDUCT A COMMUNITY HEALTH NEEDS ASSESSMENT EVERY THREE YEARS, ASANTE, ROGUE REGIONAL MEDICAL CENTER, ASHLAND COMMUNITY HOSPITAL, AND THREE RIVERS MEDICAL CENTER PARTNERED WITH PRC TO COMPLETE 600 COMMUNITY SURVEYS IN FISCAL YEAR 2017 THAT YEAR, WE ALSO HELD A FOCUS GROUP COMPRISED OF 7 KEY COMMUNITY LEADERS FROM JACKSON AND JOSEPHINE COUNTIES THE FOCUS GROUP DISCUSSED THE INDIVIDUAL LEADERS' EXPERIENCES AND PERCEPTIONS OF THE TOP HEALTH CONCERNS IN OUR COMMUNITY

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 6A ASANTE ASHLAND COMMUNITY HOSPITAL IN ASHLAND, OREGONTHREE RIVERS MEDICAL CENTER IN GRANTS PASS, OREGON

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 6A ASANTE ASHLAND COMMUNITY HOSPITAL IN ASHLAND, OREGONROGUE REGIONAL MEDICAL CENTER IN MEDFORD, OREGON

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 6A ROGUE REGIONAL MEDICAL CENTER IN MEDFORD, OREGONTHREE RIVERS MEDICAL CENTER IN GRANTS PASS, OREGON

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 6B THE CHNA WAS CONDUCTED WITH THE FOLLOWING ORGANIZATIONS WHICH ARE NOT HOSPITAL FACILITIES ACCESSALLCAREALLIED SOLUTIONSASHLAND EMERGENCY FOOD BANKASHLAND FIRE & RESCUEASHLAND GRACE POINT CHURCHASHLAND HIGH SCHOOLASHLAND SCHOOL DISTRICTBOYS & GIRLS CLUBS OF THE ROGUE VALLEYCASA OF JACKSON AND JOSEPHINE COUNTIESCENTRAL POINT SCHOOL DISTRICT 6CHILDREN'S ADVOCACY CENTER OF JACKSON COUNTYCITY COUNCILCITY OF ASHLANDCITY OF EAGLE POINTCITY OF JACKSONVILLECITY OF MEDFORDCITY OF TALENTCOMMUNITY VOLUNTEER NETWORKCOMPASS HOUSE EASTWOOD BAPTIST CHURCH FOOD & FRIENDS MEALS ON WHEELSGORDON ELWOOD FOUNDATION GRANTS PASS CITY COUNCIL GRANTS PASS DAILY COURIER GRANTS PASS DEPARTMENT OF PUBLIC SAFETY GRANTS PASS FAMILY YMCA GRANTS PASS FIRE RESCUE GRANTS PASS SCHOOL DISTRICT GRANTS PASS SCHOOL DISTRICT 7 HABITAT FOR HUMANITY HEARTS WITH A MISSION HIGHLAND ELEMENTARY SCHOOL HOUSING AUTHORITY OF JACKSON COUNTY JACKSON CARE CONNECT JACKSON COUNTY BOARD OF COMMISSIONERS JACKSON COUNTY HEALTH AND HUMAN SERVICES JACKSON COUNTY LIBRARY JACKSON COUNTY MENTAL HEALTH JACKSON COUNTY PUBLIC HEALTH JEFFERSON REGIONAL HEALTH ALLIANCE JEROME PRAIRIE BIBLE CHURCH JOSEPHINE COUNTY JOSEPHINE COUNTY BOARD OF COMMISSIONERS JOSEPHINE COUNTY FOUNDATION JOSEPHINE COUNTY PUBLIC HEALTH JOSEPHINE COUNTY SCHOOL SYSTEM JOSEPHINE HOUSING COUNCIL JWA PUBLIC AFFAIRS KAIROS KTVL TV LA CLINICALAW ENFORCEMENTLINCOLN ELEMENTARY SCHOOL MAIL TRIBUNE MASLOW PROJECT MEDFORD FIRE-RESCUE MEDFORD PARKS AND RECREATION MEDFORD POLICE DEPARTMENT MEDFORD SCHOOL DISTRICT MERCY FLIGHTS MOUNT ASHLAND ASSOCIATION NAMI NORTH MEDFORD HIGH SCHOOL ONTRACK, INC OPTIONS FOR SOUTHERN OREGON OREGON COMMUNITY FOUNDATION OREGON HEALTH AUTHORITY OREGON SHAKESPEARE FESTIVAL OSU EXTENSION SERVICES OUR LADY OF THE MOUNTAIN CATHOLIC CHURCH PRIMECARE, INC ROGUE COMMUNITY COLLEGE ROGUE COMMUNITY HEALTH ROGUE VALLEY COUNCIL OF GOVERNMENTS ROGUE VALLEY FAMILY YMCA ROGUE VALLEY METROPOLITAN PLANNING ORGANIZATION SISKIYOU COMMUNITY HEALTH CENTER SOREDI (SOUTHERN OREGON REGIONAL ECONOMIC DEVELOPMENT, INC) SOUTHERN OREGON GOODWILL INDUSTRIES ST MARY'S SCHOOLCOMMUNICATION STRATEGIES THE ARC OF JACKSON COUNTY THE CHAMBER OF MEDFORD/JACKSON COUNTY THE SALVATION ARMY, MEDFORD UNITED COMMUNITY ACTION NETWORK UCANUNITED WAY OF JACKSON COUNTY WORKSOURCE ROGUE VALLEY

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 6B THE CHNA WAS CONDUCTED WITH THE FOLLOWING ORGANIZATIONS WHICH ARE NOT HOSPITAL FACILITIES ACCESSALLCAREALLIED SOLUTIONSASHLAND EMERGENCY FOOD BANKASHLAND FIRE & RESCUEASHLAND GRACE POINT CHURCHASHLAND HIGH SCHOOLASHLAND SCHOOL DISTRICTBOYS & GIRLS CLUBS OF THE ROGUE VALLEYCASA OF JACKSON AND JOSEPHINE COUNTIESCENTRAL POINT SCHOOL DISTRICT 6CHILDREN'S ADVOCACY CENTER OF JACKSON COUNTYCITY COUNCILCITY OF ASHLANDCITY OF EAGLE POINTCITY OF JACKSONVILLECITY OF MEDFORDCITY OF TALENTCOMMUNITY VOLUNTEER NETWORKCOMPASS HOUSE EASTWOOD BAPTIST CHURCH FOOD & FRIENDS MEALS ON WHEELSGORDON ELWOOD FOUNDATION GRANTS PASS CITY COUNCIL GRANTS PASS DAILY COURIER GRANTS PASS DEPARTMENT OF PUBLIC SAFETY GRANTS PASS FAMILY YMCA GRANTS PASS FIRE RESCUE GRANTS PASS SCHOOL DISTRICT GRANTS PASS SCHOOL DISTRICT 7 HABITAT FOR HUMANITY HEARTS WITH A MISSION HIGHLAND ELEMENTARY SCHOOL HOUSING AUTHORITY OF JACKSON COUNTY JACKSON CARE CONNECT JACKSON COUNTY BOARD OF COMMISSIONERS JACKSON COUNTY HEALTH AND HUMAN SERVICES JACKSON COUNTY LIBRARY JACKSON COUNTY MENTAL HEALTH JACKSON COUNTY PUBLIC HEALTH JEFFERSON REGIONAL HEALTH ALLIANCE JEROME PRAIRIE BIBLE CHURCH JOSEPHINE COUNTY JOSEPHINE COUNTY BOARD OF COMMISSIONERS JOSEPHINE COUNTY FOUNDATION JOSEPHINE COUNTY PUBLIC HEALTH JOSEPHINE COUNTY SCHOOL SYSTEM JOSEPHINE HOUSING COUNCIL JWA PUBLIC AFFAIRS KAIROS KTVL TV LA CLINICALAW ENFORCEMENTLINCOLN ELEMENTARY SCHOOL MAIL TRIBUNE MASLOW PROJECT MEDFORD FIRE-RESCUE MEDFORD PARKS AND RECREATION MEDFORD POLICE DEPARTMENT MEDFORD SCHOOL DISTRICT MERCY FLIGHTS MOUNT ASHLAND ASSOCIATION NAMI NORTH MEDFORD HIGH SCHOOL ONTRACK, INC OPTIONS FOR SOUTHERN OREGON OREGON COMMUNITY FOUNDATION OREGON HEALTH AUTHORITY OREGON SHAKESPEARE FESTIVAL OSU EXTENSION SERVICES OUR LADY OF THE MOUNTAIN CATHOLIC CHURCH PRIMECARE, INC ROGUE COMMUNITY COLLEGE ROGUE COMMUNITY HEALTH ROGUE VALLEY COUNCIL OF GOVERNMENTS ROGUE VALLEY FAMILY YMCA ROGUE VALLEY METROPOLITAN PLANNING ORGANIZATION SISKIYOU COMMUNITY HEALTH CENTER SOREDI (SOUTHERN OREGON REGIONAL ECONOMIC DEVELOPMENT, INC) SOUTHERN OREGON GOODWILL INDUSTRIES ST MARY'S SCHOOLCOMMUNICATION STRATEGIES THE ARC OF JACKSON COUNTY THE CHAMBER OF MEDFORD/JACKSON COUNTY THE SALVATION ARMY, MEDFORD UNITED COMMUNITY ACTION NETWORK UCANUNITED WAY OF JACKSON COUNTY WORKSOURCE ROGUE VALLEY

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 6B THE CHNA WAS CONDUCTED WITH THE FOLLOWING ORGANIZATIONS WHICH ARE NOT HOSPITAL FACILITIES ACCESSALLCAREALLIED SOLUTIONSASHLAND EMERGENCY FOOD BANKASHLAND FIRE & RESCUEASHLAND GRACE POINT CHURCHASHLAND HIGH SCHOOLASHLAND SCHOOL DISTRICTBOYS & GIRLS CLUBS OF THE ROGUE VALLEYCASA OF JACKSON AND JOSEPHINE COUNTIESCENTRAL POINT SCHOOL DISTRICT 6CHILDREN'S ADVOCACY CENTER OF JACKSON COUNTYCITY COUNCILCITY OF ASHLANDCITY OF EAGLE POINTCITY OF JACKSONVILLECITY OF MEDFORDCITY OF TALENTCOMMUNITY VOLUNTEER NETWORKCOMPASS HOUSE EASTWOOD BAPTIST CHURCH FOOD & FRIENDS MEALS ON WHEELSGORDON ELWOOD FOUNDATION GRANTS PASS CITY COUNCIL GRANTS PASS DAILY COURIER GRANTS PASS DEPARTMENT OF PUBLIC SAFETY GRANTS PASS FAMILY YMCA GRANTS PASS FIRE RESCUE GRANTS PASS SCHOOL DISTRICT GRANTS PASS SCHOOL DISTRICT 7 HABITAT FOR HUMANITY HEARTS WITH A MISSION HIGHLAND ELEMENTARY SCHOOL HOUSING AUTHORITY OF JACKSON COUNTY JACKSON CARE CONNECT JACKSON COUNTY BOARD OF COMMISSIONERS JACKSON COUNTY HEALTH AND HUMAN SERVICES JACKSON COUNTY LIBRARY JACKSON COUNTY MENTAL HEALTH JACKSON COUNTY PUBLIC HEALTH JEFFERSON REGIONAL HEALTH ALLIANCE JEROME PRAIRIE BIBLE CHURCH JOSEPHINE COUNTY JOSEPHINE COUNTY BOARD OF COMMISSIONERS JOSEPHINE COUNTY FOUNDATION JOSEPHINE COUNTY PUBLIC HEALTH JOSEPHINE COUNTY SCHOOL SYSTEM JOSEPHINE HOUSING COUNCIL JWA PUBLIC AFFAIRS KAIROS KTVL TV LA CLINICALAW ENFORCEMENTLINCOLN ELEMENTARY SCHOOL MAIL TRIBUNE MASLOW PROJECT MEDFORD FIRE-RESCUE MEDFORD PARKS AND RECREATION MEDFORD POLICE DEPARTMENT MEDFORD SCHOOL DISTRICT MERCY FLIGHTS MOUNT ASHLAND ASSOCIATION NAMI NORTH MEDFORD HIGH SCHOOL ONTRACK, INC OPTIONS FOR SOUTHERN OREGON OREGON COMMUNITY FOUNDATION OREGON HEALTH AUTHORITY OREGON SHAKESPEARE FESTIVAL OSU EXTENSION SERVICES OUR LADY OF THE MOUNTAIN CATHOLIC CHURCH PRIMECARE, INC ROGUE COMMUNITY COLLEGE ROGUE COMMUNITY HEALTH ROGUE VALLEY COUNCIL OF GOVERNMENTS ROGUE VALLEY FAMILY YMCA ROGUE VALLEY METROPOLITAN PLANNING ORGANIZATION SISKIYOU COMMUNITY HEALTH CENTER SOREDI (SOUTHERN OREGON REGIONAL ECONOMIC DEVELOPMENT, INC) SOUTHERN OREGON GOODWILL INDUSTRIES ST MARY'S SCHOOLCOMMUNICATION STRATEGIES THE ARC OF JACKSON COUNTY THE CHAMBER OF MEDFORD/JACKSON COUNTY THE SALVATION ARMY, MEDFORD UNITED COMMUNITY ACTION NETWORK UCANUNITED WAY OF JACKSON COUNTY WORKSOURCE ROGUE VALLEY

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 11 IDENTIFIED HEALTH NEEDS THE TOP TWELVE HEALTH NEEDS IDENTIFIED BY BOTH SURVEY AND FOCUS GROUP PARTICIPANTS ARE 1 ACCESS TO HEALTH CARE SERVICES 2 MENT AL HEALTH & SUBSTANCE ABUSE 3 HEART DISEASE AND STROKE 4 INFANT HEALTH AND FAMILY PLANNI NG 5 DIABETES 6 NUTRITION 7 RESPIRATORY DISEASES 8 CANCER 9 DISABILITY AND HEALTH 10 INJURY AND VIOLENCE PREVENTION 11 TOBACCO USE 12 DEMENTIAS, INCLUDING ALZHEIMER'S DISEA SEIMPLEMENTATION STRATEGYEACH OF THE INITIATIVES AND ACTIONS BELOW AS THEY RELATE TO THE T OP 12 COMMUNITY HEALTH NEEDS (ONLY 8 ARE LISTED DUE TO SPACE CONSTRAINTS) CATEGORIES AS ID ENTIFIED IN THE CHNA WILL BE FULFILLED OR IMPLEMENTED BY ASANTE ASANTE ASHLAND COMMUNITY HOSPITAL (AACH) ASANTE ROGUE REGIONAL MEDICAL CENTER (ARRMC) ASANTE THREE RIVERS MEDICAL C ENTER (ATRMC) ASANTE PHYSICIAN PARTNERS (APP) 1 ACCESS TO HEALTH CARE SERVICES CURRENT I NCREASED THE NUMBER OF APP PROVIDERS HIRED CERTIFIED APPLICATION COUNSELORS TO HELP INCREA SE ACCESS TO CARE FOR OHP PATIENTS OPENED THE TRANSITIONAL CARE CLINIC AT ATRMC ADDED AN U RGENT CARE LOCATION IN MEDFORD SPONSORED ROGUE COMMUNITY COLLEGE HEALTH PROFESSIONALS CURR ICULUM PROGRAMS FOR STUDENTS PROVIDED FUNDING FOR THE SCHOOL NURSE PROGRAM IN THE ASHLAND AND PHOENIX-TALENT SCHOOL DISTRICTS ADDED DISCHARGE PLANNERS AND CASE MANAGERS AT ARRMC TO REDUCE READMISSION RATES IMPLEMENTED A NURSE TRIAGE PROGRAM AT THE CONTACT CENTER FOR SEL ECT APP CLINICS ADDED 24/7 ACCESS TO TELE-INTENSIVISTS FOR ICU PATIENTS AT ATRMC AND AACH SPONSORED THE HOLMES PARK HOUSE HOSPICE CARE FACILITY SPONSORED THE ST VINCENT DE PAUL DE NTAL VAN SPONSORED THE ROGUE VALLEY SOROPTIMIST WINE WALK FOR WOMEN'S HEALTH TO BENEFIT PR EVENTION, DETECTION, TREATMENT AND SUPPORT SERVICES FOR UNINSURED AND UNDER-INSURED WOMEN AND CHILDREN FUTURE EXPAND THE USE OF TELEMEDICINE CAPABILITIES FOR APP PROVIDERS RECRUIT AND HIRE ADDITIONAL APP PROVIDERS OPEN AN URGENT CARE CLINIC IN WHITE CITY AND EXPLORE UR GENT CARE OPPORTUNITIES IN CENTRAL POINT OPEN ADDITIONAL RETAIL HEALTH CARE CLINICS WITHIN ASANTE'S SERVICE AREA EXPAND THE NURSE TRIAGE PROGRAM FOR ALL APP PRIMARY CARE CLINICS 2 MENTAL HEALTH & SUBSTANCE ABUSE CURRENT ADDED FOUR BEHAVIORAL HEALTH "SWING" ROOMS IN TH E ARRMC EMERGENCY DEPARTMENT REMODELED AND ADDED ONE ROOM TO THE PSYCHIATRIC CRISIS UNIT I N THE ARRMC EMERGENCY DEPARTMENT TO ACCOMMODATE PATIENTS OF ALL AGES ADOPTED THE TRAUMA-IN FORMED CARE MODEL CREATED THE COMFORT ROOM IN THE BEHAVIORAL HEALTH UNIT AT ARRMC PAINTED THE PSYCHIATRIC CARE ROOMS AT ATRMC TO A MORE SOOTHING COLOR INCREASED THE NUMBER OF APP B EHAVIORAL HEALTH STAFF MEMBERS ADDED LICENSED CLINICAL SOCIAL WORKERS TO APP FAMILY PRACTI CE CLINICS AS PART OF THE MEDICAL HOME MODEL OF CARE PROVIDED FINANCIAL SUPPORT TO COMPASS HOUSE FOR TRANSITIONAL CARE FROM HOSPITAL TO HOME SPONSORED THE NATIONAL ALLIANCE ON MENT AL ILLNESS MARCH 4 HOPE, REESTABLISHING ASANTE'S RELATIONSHIP WITH NAMI OF SOUTHERN OREGON PARTNERED WITH NAMI OF SOUTHE

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
ROGUE REGIONAL MEDICAL CENTER	RN OREGON TO CREATE A QUARTERLY COMMUNITY MENTAL HEALTH LECTURE SERIES PROVIDED FINANCIAL COMMITMENT TO SUPPORT THE CRISIS RESOLUTION CENTER IN MEDFORD PROVIDED ONGOING FINANCIAL S UPPORT FOR THE GRANTS PASS SOBERING CENTER PROVIDED FINANCIAL SUPPORT FOR ADDICTIONS RECOV ERY CENTER'S MEDICALLY-MONITORED DETOXIFICATION CENTER PARTNERED WITH ASHLAND POLICE DEPAR TMENT, ON TRACK AND AACH TO CREATE A DRUG-SURRENDER PROGRAM FOR PEOPLE WITH CHEMICAL DEPEN DENCY FUTURE RENOVATE THE BEHAVIORAL HEALTH UNIT AND INCREASE THE NUMBER OF BEDS FROM 18 TO 24 OFFER TELEMEDICINE CONSULTS AND EVALUATIONS FOR MENTAL HEALTH PATIENTS 3 HEART DISE ASE AND STROKE CURRENT PRIMARY FINANCIAL SPONSOR OF THE PULSEPOINT HEART ATTACK NOTIFICAT ION APP IN JACKSON AND JOSEPHINE COUNTIES ESTABLISHED A CO-MANAGEMENT AGREEMENT WITH SOUTH ERN OREGON CARDIOLOGY REDUCED CLINICAL VARIATION AND STANDARDIZED SUPPLY COSTS IN THE CATH LAB AT ARRMC PARTNERED WITH OHSU FOR TELESTROKE AT ATRMC RECEIVED ACUTE STROKE READY CERT IFICATION AT ATRMC BY OUR ACCREDITING AGENCY, DNV GL (DET NORSKE VERITAS GERMANISCHER LLOY D) PROMOTED NATIONAL HEART MONTH ACTIVITIES AND EDUCATION SUPPORTED MENDED HEARTS PEER-TO- PEER SUPPORT GROUP REINSTATED SEVERAL CATH LABS AT ARRMC TO ACCOMMODATE INCREASED PATIENT VOLUMES ADDED A TRANSCATHETER AORTIC VALVE REPLACEMENT PROGRAM AT ARRMC AS LEADING EDGE HE ART CARE FOR PATIENTS EXPANDED THE SCOPE OF CARDIAC REHABILITATION SERVICES AT ARRMC SPONS ORED THE AMERICAN COLLEGE OF CARDIOLOGY OREGON CARDIOVASCULAR SYMPOSIUM AND NURSING HEART FAILURE CONFERENCE CONSISTENTLY MET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFELINE RECEIVING CENTER GOLD PLUS RECOGNITION CONSISTENTLY M ET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFEL INE GOLD PLUS STEMI RECOGNITION FUTURE SUPPORT THE RECRUITMENT OF ADDITIONAL NEUROSURGEON S TO SOUTHERN OREGON ATTAIN LEVEL II TRAUMA CENTER STATUS AT ARRMC 4 INFANT HEALTH AND FA MILY PLANNING CURRENT HIRED MATERNAL FETAL MEDICINE PROVIDERS CREATED A MIDWIFERY PROGRAM AT APP AND AACH MAINTAINED THE ONLY REGIONAL NEONATAL INTENSIVE CARE UNIT (NICU) PURCHASE D AN ISOLETTE TRANSPORTER FOR FRAGILE INFANTS HIRED SIX PEDIATRIC HOSPITALISTS DEVELOPED A FORMAL PEDIATRIC HOSPITALIST PROGRAM HIRED A PEDIATRIC ONCOLOGIST RENOVATED THE PEDIATRIC UNIT AT ARRMC PARTNERED WITH OHSU TO PROVIDE TELEMEDICINE FOR PEDIATRIC INPATIENTS IMPLEM ENTED OHSU ROTATING CLINICS FOR PEDIATRIC PATIENTS IMPLEMENTED QUIET TIME IN THE NICU AND SPECIAL CARE NURSERY TO PROMOTE HEALING RENOVATED AND EXPANDED THE FAMILY BIRTH CENTER AT AACH ADDED THREE PEDIATRIC CARE ROOMS AT ATRMC FUTURE DEVELOP AN OBSTETRICAL LABORIST SER VICE AT ARRMC 5 DIABETES CURRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTP ATIENT HEALTH FOR DIABETES NUTRITION EDUCATION ESTABLISHED A DIABETES CARE CENTER AND NUTR ITION SERVICES IN MEDFORD AND GRANTS PASS ADDED INPATIENT CONSULTS FOR PEOPLE WITH DIABETE S ESTABLISHED BLOOD GLUCOSE MO

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
ROGUE REGIONAL MEDICAL CENTER	NITORING CLINICS HIRED AN APP ENDOCRINOLOGIST 6 NUTRITION, PHYSICAL ACTIVITY AND WEIGHT C URRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTPATIENT HEALTH FOR COOKING C LASSES AND DIABETES NUTRITION EDUCATION PARTNERED WITH SOUTHERN OREGON BARIATRIC CENTER AN D OREGON SURGICAL SPECIALISTS HIRED INPATIENT AND OUTPATIENT NUTRITION COUNSELORS HELD ANN UAL EMPLOYEE FITNESS AND WEIGHT MANAGEMENT CHALLENGES SPONSORED THE ANNUAL PEAR BLOSSOM RU N AND WALK SPONSORED SEVERAL COMMUNITY SPORTING EVENTS TO SUPPORT LOCAL SCHOOL AND YOUTH P ROGRAMS SPONSORED THE HEALTHY FOOD FESTIVAL IN GRANTS PASS SPONSORED THE ACCESS FOOD SHARE PROGRAM SPONSORED THE FRIENDS OF JOSEPHINE COUNTY FOOD BANK DONATED FOOD TO HEARTS WITH A MISSION FOR HOMELESS YOUTH SPONSORED BLUE ZONES PROJECT IN GRANTS PASS FOR HEALTHIER, MOR E ACTIVE LIVING SPONSORED THE ASHLAND HIGH SCHOOL SPORTS PROGRAM AND ATHLETIC TRAINERS TO ENSURE PLAYER SAFETY SPONSORED THE ASHLAND CHAMBER OF COMMERCE COMMUNITY-WIDE HEALTH AND W ELLBEING INITIATIVE FUTURE ADD COMPREHENSIVE PRIMARY CARE PLUS (CPC+) AS PART OF THE MEDI CAL HOME MODEL OF CARE 7 RESPIRATORY DISEASES CURRENT REMODELED AND EXPANDED CARDIOPULMO NARY SERVICES AT ARRMC HIRED SEVEN PULMONOLOGISTS AND TWO PULMONARY NURSE PRACTITIONERS TO APP EXPANDED CARDIOPULMONARY TESTING SERVICES TO AACH IMPLEMENTED A PROCESS TO SCHEDULE D ISCHARGED PATIENTS WITH PNEUMONIA AND RESPIRATORY ISSUES TO AN APP PULMONOLOGIST IMPLEMENT ED A ROTATING APP PULMONOLOGIST IN GRANTS PASS IMPLEMENTED TELEMEDICINE PULMONARY INTENSIV ISTS CONSULTS AT ALL THREE HOSPITALS ADDED A SLEEP LAB PROGRAM AT ATRMC FUTURE OFFER LUNG CANCER SCREENING CLINICS RECRUIT ADDITIONAL PULMONOLOGISTS TO APP 8 CANCER CURRENT ESTA BLISHED A GYNECOLOGIC CANCER SUPPORT GROUP HIRED A PEDIATRIC ONCOLOGIST PARTNERED WITH OHS U TO BRING A CANCER SPECIALIST/SURGEON TO ARRMC EACH MONTH PROMOTED NATIONAL BREAST CANCER AWARENESS MONTH ACTIVITIES AND EDUCATION HIRED AN ONCOLOGY NURSE NAVIGATOR FOR ALL CANCER -TYPES EXPANDED THE BREAST CANCER NURSE NAVIGATOR PROGRAM TO JOSEPHINE COUNTY ADDED 3-D MA MMOGRAPHY TO ALL THREE IMAGING CENTERS ADDED BREAST MRI CAPABILITY AT ARRMC REMODELED THE SPEARS CANCER CENTER AND UPGRADED WITH A NEW LINEAR ACCELERATOR FUTURE RECRUIT AN EAR, NO SE AND THROAT PHYSICIAN TO DO NECK AND THROAT CANCER SURGERIES PROVIDE DIRECT INFUSION INT ERVENTION FOR CHEMO PATIENTS OFFER LUNG CANCER SCREENING CLINICS BUILD AN ONCOLOGY MEDICAL OFFICE TO PROVIDE COMPREHENSIVE CANCER SERVICES

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 11 IDENTIFIED HEALTH NEEDS THE TOP TWELVE HEALTH NEEDS IDENTIFIED BY BOTH SURVEY AND FOCUS GROUP PARTICIPANTS ARE 1 ACCESS TO HEALTH CARE SERVICES 2 MENT AL HEALTH & SUBSTANCE ABUSE 3 HEART DISEASE AND STROKE 4 INFANT HEALTH AND FAMILY PLANNI NG 5 DIABETES 6 NUTRITION 7 RESPIRATORY DISEASES 8 CANCER 9 DISABILITY AND HEALTH 10 INJURY AND VIOLENCE PREVENTION 11 TOBACCO USE 12 DEMENTIAS, INCLUDING ALZHEIMER'S DISEA SEIMPLEMENTATION STRATEGYEACH OF THE INITIATIVES AND ACTIONS BELOW AS THEY RELATE TO THE T OP 12 COMMUNITY HEALTH NEEDS (ONLY 8 ARE LISTED DUE TO SPACE CONSTRAINTS) CATEGORIES AS ID ENTIFIED IN THE CHNA WILL BE FULFILLED OR IMPLEMENTED BY ASANTE ASANTE ASHLAND COMMUNITY HOSPITAL (AACH) ASANTE ROGUE REGIONAL MEDICAL CENTER (ARRMC) ASANTE THREE RIVERS MEDICAL C ENTER (ATRMC) ASANTE PHYSICIAN PARTNERS (APP) 1 ACCESS TO HEALTH CARE SERVICES CURRENT I NCREASED THE NUMBER OF APP PROVIDERS HIRED CERTIFIED APPLICATION COUNSELORS TO HELP INCREA SE ACCESS TO CARE FOR OHP PATIENTS OPENED THE TRANSITIONAL CARE CLINIC AT ATRMC ADDED AN U RGENT CARE LOCATION IN MEDFORD SPONSORED ROGUE COMMUNITY COLLEGE HEALTH PROFESSIONALS CURR ICULUM PROGRAMS FOR STUDENTS PROVIDED FUNDING FOR THE SCHOOL NURSE PROGRAM IN THE ASHLAND AND PHOENIX-TALENT SCHOOL DISTRICTS ADDED DISCHARGE PLANNERS AND CASE MANAGERS AT ARRMC TO REDUCE READMISSION RATES IMPLEMENTED A NURSE TRIAGE PROGRAM AT THE CONTACT CENTER FOR SEL ECT APP CLINICS ADDED 24/7 ACCESS TO TELE-INTENSIVISTS FOR ICU PATIENTS AT ATRMC AND AACH SPONSORED THE HOLMES PARK HOUSE HOSPICE CARE FACILITY SPONSORED THE ST VINCENT DE PAUL DE NTAL VAN SPONSORED THE ROGUE VALLEY SOROPTIMIST WINE WALK FOR WOMEN'S HEALTH TO BENEFIT PR EVENTION, DETECTION, TREATMENT AND SUPPORT SERVICES FOR UNINSURED AND UNDER-INSURED WOMEN AND CHILDREN FUTURE EXPAND THE USE OF TELEMEDICINE CAPABILITIES FOR APP PROVIDERS RECRUIT AND HIRE ADDITIONAL APP PROVIDERS OPEN AN URGENT CARE CLINIC IN WHITE CITY AND EXPLORE UR GENT CARE OPPORTUNITIES IN CENTRAL POINT OPEN ADDITIONAL RETAIL HEALTH CARE CLINICS WITHIN ASANTE'S SERVICE AREA EXPAND THE NURSE TRIAGE PROGRAM FOR ALL APP PRIMARY CARE CLINICS 2 MENTAL HEALTH & SUBSTANCE ABUSE CURRENT ADDED FOUR BEHAVIORAL HEALTH "SWING" ROOMS IN TH E ARRMC EMERGENCY DEPARTMENT REMODELED AND ADDED ONE ROOM TO THE PSYCHIATRIC CRISIS UNIT I N THE ARRMC EMERGENCY DEPARTMENT TO ACCOMMODATE PATIENTS OF ALL AGES ADOPTED THE TRAUMA-IN FORMED CARE MODEL CREATED THE COMFORT ROOM IN THE BEHAVIORAL HEALTH UNIT AT ARRMC PAINTED THE PSYCHIATRIC CARE ROOMS AT ATRMC TO A MORE SOOTHING COLOR INCREASED THE NUMBER OF APP B EHAVIORAL HEALTH STAFF MEMBERS ADDED LICENSED CLINICAL SOCIAL WORKERS TO APP FAMILY PRACTI CE CLINICS AS PART OF THE MEDICAL HOME MODEL OF CARE PROVIDED FINANCIAL SUPPORT TO COMPASS HOUSE FOR TRANSITIONAL CARE FROM HOSPITAL TO HOME SPONSORED THE NATIONAL ALLIANCE ON MENT AL ILLNESS MARCH 4 HOPE, REESTABLISHING ASANTE'S RELATIONSHIP WITH NAMI OF SOUTHERN OREGON PARTNERED WITH NAMI OF SOUTHE

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
THREE RIVERS MEDICAL CENTER	RN OREGON TO CREATE A QUARTERLY COMMUNITY MENTAL HEALTH LECTURE SERIES PROVIDED FINANCIAL COMMITMENT TO SUPPORT THE CRISIS RESOLUTION CENTER IN MEDFORD PROVIDED ONGOING FINANCIAL S UPPORT FOR THE GRANTS PASS SOBERING CENTER PROVIDED FINANCIAL SUPPORT FOR ADDICTIONS RECOV ERY CENTER'S MEDICALLY-MONITORED DETOXIFICATION CENTER PARTNERED WITH ASHLAND POLICE DEPAR TMENT, ON TRACK AND AACH TO CREATE A DRUG-SURRENDER PROGRAM FOR PEOPLE WITH CHEMICAL DEPEN DENCY FUTURE RENOVATE THE BEHAVIORAL HEALTH UNIT AND INCREASE THE NUMBER OF BEDS FROM 18 TO 24 OFFER TELEMEDICINE CONSULTS AND EVALUATIONS FOR MENTAL HEALTH PATIENTS 3 HEART DISE ASE AND STROKE CURRENT PRIMARY FINANCIAL SPONSOR OF THE PULSEPOINT HEART ATTACK NOTIFICAT ION APP IN JACKSON AND JOSEPHINE COUNTIES ESTABLISHED A CO-MANAGEMENT AGREEMENT WITH SOUTH ERN OREGON CARDIOLOGY REDUCED CLINICAL VARIATION AND STANDARDIZED SUPPLY COSTS IN THE CATH LAB AT ARRMC PARTNERED WITH OHSU FOR TELESTROKE AT ATRMC RECEIVED ACUTE STROKE READY CERT IFICATION AT ATRMC BY OUR ACCREDITING AGENCY, DNV GL (DET NORSKE VERITAS GERMANISCHER LLOY D) PROMOTED NATIONAL HEART MONTH ACTIVITIES AND EDUCATION SUPPORTED MENDED HEARTS PEER-TO- PEER SUPPORT GROUP REINSTATED SEVERAL CATH LABS AT ARRMC TO ACCOMMODATE INCREASED PATIENT VOLUMES ADDED A TRANSCATHETER AORTIC VALVE REPLACEMENT PROGRAM AT ARRMC AS LEADING EDGE HE ART CARE FOR PATIENTS EXPANDED THE SCOPE OF CARDIAC REHABILITATION SERVICES AT ARRMC SPONS ORED THE AMERICAN COLLEGE OF CARDIOLOGY OREGON CARDIOVASCULAR SYMPOSIUM AND NURSING HEART FAILURE CONFERENCE CONSISTENTLY MET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFELINE RECEIVING CENTER GOLD PLUS RECOGNITION CONSISTENTLY M ET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFEL INE GOLD PLUS STEMI RECOGNITION FUTURE SUPPORT THE RECRUITMENT OF ADDITIONAL NEUROSURGEON S TO SOUTHERN OREGON ATTAIN LEVEL II TRAUMA CENTER STATUS AT ARRMC 4 INFANT HEALTH AND FA MILY PLANNING CURRENT HIRED MATERNAL FETAL MEDICINE PROVIDERS CREATED A MIDWIFERY PROGRAM AT APP AND AACH MAINTAINED THE ONLY REGIONAL NEONATAL INTENSIVE CARE UNIT (NICU) PURCHASE D AN ISOLETTE TRANSPORTER FOR FRAGILE INFANTS HIRED SIX PEDIATRIC HOSPITALISTS DEVELOPED A FORMAL PEDIATRIC HOSPITALIST PROGRAM HIRED A PEDIATRIC ONCOLOGIST RENOVATED THE PEDIATRIC UNIT AT ARRMC PARTNERED WITH OHSU TO PROVIDE TELEMEDICINE FOR PEDIATRIC INPATIENTS IMPLEM ENTED OHSU ROTATING CLINICS FOR PEDIATRIC PATIENTS IMPLEMENTED QUIET TIME IN THE NICU AND SPECIAL CARE NURSERY TO PROMOTE HEALING RENOVATED AND EXPANDED THE FAMILY BIRTH CENTER AT AACH ADDED THREE PEDIATRIC CARE ROOMS AT ATRMC FUTURE DEVELOP AN OBSTETRICAL LABORIST SER VICE AT ARRMC 5 DIABETES CURRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTP ATIENT HEALTH FOR DIABETES NUTRITION EDUCATION ESTABLISHED A DIABETES CARE CENTER AND NUTR ITION SERVICES IN MEDFORD AND GRANTS PASS ADDED INPATIENT CONSULTS FOR PEOPLE WITH DIABETE S ESTABLISHED BLOOD GLUCOSE MO

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
THREE RIVERS MEDICAL CENTER	NITORING CLINICS HIRED AN APP ENDOCRINOLOGIST 6 NUTRITION, PHYSICAL ACTIVITY AND WEIGHT C URRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTPATIENT HEALTH FOR COOKING C LASSES AND DIABETES NUTRITION EDUCATION PARTNERED WITH SOUTHERN OREGON BARIATRIC CENTER AN D OREGON SURGICAL SPECIALISTS HIRED INPATIENT AND OUTPATIENT NUTRITION COUNSELORS HELD ANN UAL EMPLOYEE FITNESS AND WEIGHT MANAGEMENT CHALLENGES SPONSORED THE ANNUAL PEAR BLOSSOM RU N AND WALK SPONSORED SEVERAL COMMUNITY SPORTING EVENTS TO SUPPORT LOCAL SCHOOL AND YOUTH P ROGRAMS SPONSORED THE HEALTHY FOOD FESTIVAL IN GRANTS PASS SPONSORED THE ACCESS FOOD SHARE PROGRAM SPONSORED THE FRIENDS OF JOSEPHINE COUNTY FOOD BANK DONATED FOOD TO HEARTS WITH A MISSION FOR HOMELESS YOUTH SPONSORED BLUE ZONES PROJECT IN GRANTS PASS FOR HEALTHIER, MOR E ACTIVE LIVING SPONSORED THE ASHLAND HIGH SCHOOL SPORTS PROGRAM AND ATHLETIC TRAINERS TO ENSURE PLAYER SAFETY SPONSORED THE ASHLAND CHAMBER OF COMMERCE COMMUNITY-WIDE HEALTH AND W ELLBEING INITIATIVE FUTURE ADD COMPREHENSIVE PRIMARY CARE PLUS (CPC+) AS PART OF THE MEDI CAL HOME MODEL OF CARE 7 RESPIRATORY DISEASES CURRENT REMODELED AND EXPANDED CARDIOPULMO NARY SERVICES AT ARRMC HIRED SEVEN PULMONOLOGISTS AND TWO PULMONARY NURSE PRACTITIONERS TO APP EXPANDED CARDIOPULMONARY TESTING SERVICES TO AACH IMPLEMENTED A PROCESS TO SCHEDULE D ISCHARGED PATIENTS WITH PNEUMONIA AND RESPIRATORY ISSUES TO AN APP PULMONOLOGIST IMPLEMENT ED A ROTATING APP PULMONOLOGIST IN GRANTS PASS IMPLEMENTED TELEMEDICINE PULMONARY INTENSIV ISTS CONSULTS AT ALL THREE HOSPITALS ADDED A SLEEP LAB PROGRAM AT ATRMC FUTURE OFFER LUNG CANCER SCREENING CLINICS RECRUIT ADDITIONAL PULMONOLOGISTS TO APP 8 CANCER CURRENT ESTA BLISHED A GYNECOLOGIC CANCER SUPPORT GROUP HIRED A PEDIATRIC ONCOLOGIST PARTNERED WITH OHS U TO BRING A CANCER SPECIALIST/SURGEON TO ARRMC EACH MONTH PROMOTED NATIONAL BREAST CANCER AWARENESS MONTH ACTIVITIES AND EDUCATION HIRED AN ONCOLOGY NURSE NAVIGATOR FOR ALL CANCER -TYPES EXPANDED THE BREAST CANCER NURSE NAVIGATOR PROGRAM TO JOSEPHINE COUNTY ADDED 3-D MA MMOGRAPHY TO ALL THREE IMAGING CENTERS ADDED BREAST MRI CAPABILITY AT ARRMC REMODELED THE SPEARS CANCER CENTER AND UPGRADED WITH A NEW LINEAR ACCELERATOR FUTURE RECRUIT AN EAR, NO SE AND THROAT PHYSICIAN TO DO NECK AND THROAT CANCER SURGERIES PROVIDE DIRECT INFUSION INT ERVENTION FOR CHEMO PATIENTS OFFER LUNG CANCER SCREENING CLINICS BUILD AN ONCOLOGY MEDICAL OFFICE TO PROVIDE COMPREHENSIVE CANCER SERVICES

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 11 IDENTIFIED HEALTH NEEDS THE TOP TWELVE HEALTH NEEDS IDENTIFIED BY BOTH SURVEY AND FOCUS GROUP PARTICIPANTS ARE 1 ACCESS TO HEALTH CARE SERVICES 2 MENT AL HEALTH & SUBSTANCE ABUSE 3 HEART DISEASE AND STROKE 4 INFANT HEALTH AND FAMILY PLANNI NG 5 DIABETES 6 NUTRITION 7 RESPIRATORY DISEASES 8 CANCER 9 DISABILITY AND HEALTH 10 INJURY AND VIOLENCE PREVENTION 11 TOBACCO USE 12 DEMENTIAS, INCLUDING ALZHEIMER'S DISEA SEIMPLEMENTATION STRATEGYEACH OF THE INITIATIVES AND ACTIONS BELOW AS THEY RELATE TO THE T OP 12 COMMUNITY HEALTH NEEDS (ONLY 8 ARE LISTED DUE TO SPACE CONSTRAINTS) CATEGORIES AS ID ENTIFIED IN THE CHNA WILL BE FULFILLED OR IMPLEMENTED BY ASANTE ASANTE ASHLAND COMMUNITY HOSPITAL (AACH) ASANTE ROGUE REGIONAL MEDICAL CENTER (ARRMC) ASANTE THREE RIVERS MEDICAL C ENTER (ATRMC) ASANTE PHYSICIAN PARTNERS (APP) 1 ACCESS TO HEALTH CARE SERVICES CURRENT I NCREASED THE NUMBER OF APP PROVIDERS HIRED CERTIFIED APPLICATION COUNSELORS TO HELP INCREA SE ACCESS TO CARE FOR OHP PATIENTS OPENED THE TRANSITIONAL CARE CLINIC AT ATRMC ADDED AN U RGENT CARE LOCATION IN MEDFORD SPONSORED ROGUE COMMUNITY COLLEGE HEALTH PROFESSIONALS CURR ICULUM PROGRAMS FOR STUDENTS PROVIDED FUNDING FOR THE SCHOOL NURSE PROGRAM IN THE ASHLAND AND PHOENIX-TALENT SCHOOL DISTRICTS ADDED DISCHARGE PLANNERS AND CASE MANAGERS AT ARRMC TO REDUCE READMISSION RATES IMPLEMENTED A NURSE TRIAGE PROGRAM AT THE CONTACT CENTER FOR SEL ECT APP CLINICS ADDED 24/7 ACCESS TO TELE-INTENSIVISTS FOR ICU PATIENTS AT ATRMC AND AACH SPONSORED THE HOLMES PARK HOUSE HOSPICE CARE FACILITY SPONSORED THE ST VINCENT DE PAUL DE NTAL VAN SPONSORED THE ROGUE VALLEY SOROPTIMIST WINE WALK FOR WOMEN'S HEALTH TO BENEFIT PR EVENTION, DETECTION, TREATMENT AND SUPPORT SERVICES FOR UNINSURED AND UNDER-INSURED WOMEN AND CHILDREN FUTURE EXPAND THE USE OF TELEMEDICINE CAPABILITIES FOR APP PROVIDERS RECRUIT AND HIRE ADDITIONAL APP PROVIDERS OPEN AN URGENT CARE CLINIC IN WHITE CITY AND EXPLORE UR GENT CARE OPPORTUNITIES IN CENTRAL POINT OPEN ADDITIONAL RETAIL HEALTH CARE CLINICS WITHIN ASANTE'S SERVICE AREA EXPAND THE NURSE TRIAGE PROGRAM FOR ALL APP PRIMARY CARE CLINICS 2 MENTAL HEALTH & SUBSTANCE ABUSE CURRENT ADDED FOUR BEHAVIORAL HEALTH "SWING" ROOMS IN TH E ARRMC EMERGENCY DEPARTMENT REMODELED AND ADDED ONE ROOM TO THE PSYCHIATRIC CRISIS UNIT I N THE ARRMC EMERGENCY DEPARTMENT TO ACCOMMODATE PATIENTS OF ALL AGES ADOPTED THE TRAUMA-IN FORMED CARE MODEL CREATED THE COMFORT ROOM IN THE BEHAVIORAL HEALTH UNIT AT ARRMC PAINTED THE PSYCHIATRIC CARE ROOMS AT ATRMC TO A MORE SOOTHING COLOR INCREASED THE NUMBER OF APP B EHAVIORAL HEALTH STAFF MEMBERS ADDED LICENSED CLINICAL SOCIAL WORKERS TO APP FAMILY PRACTI CE CLINICS AS PART OF THE MEDICAL HOME MODEL OF CARE PROVIDED FINANCIAL SUPPORT TO COMPASS HOUSE FOR TRANSITIONAL CARE FROM HOSPITAL TO HOME SPONSORED THE NATIONAL ALLIANCE ON MENT AL ILLNESS MARCH 4 HOPE, REESTABLISHING ASANTE'S RELATIONSHIP WITH NAMI OF SOUTHERN OREGON PARTNERED WITH NAMI OF SOUTHE

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
ASHLAND COMMUNITY HOSPITAL	RN OREGON TO CREATE A QUARTERLY COMMUNITY MENTAL HEALTH LECTURE SERIES PROVIDED FINANCIAL COMMITMENT TO SUPPORT THE CRISIS RESOLUTION CENTER IN MEDFORD PROVIDED ONGOING FINANCIAL S UPPORT FOR THE GRANTS PASS SOBERING CENTER PROVIDED FINANCIAL SUPPORT FOR ADDICTIONS RECOV ERY CENTER'S MEDICALLY-MONITORED DETOXIFICATION CENTER PARTNERED WITH ASHLAND POLICE DEPAR TMENT, ON TRACK AND AACH TO CREATE A DRUG-SURRENDER PROGRAM FOR PEOPLE WITH CHEMICAL DEPEN DENCY FUTURE RENOVATE THE BEHAVIORAL HEALTH UNIT AND INCREASE THE NUMBER OF BEDS FROM 18 TO 24 OFFER TELEMEDICINE CONSULTS AND EVALUATIONS FOR MENTAL HEALTH PATIENTS 3 HEART DISE ASE AND STROKE CURRENT PRIMARY FINANCIAL SPONSOR OF THE PULSEPOINT HEART ATTACK NOTIFICAT ION APP IN JACKSON AND JOSEPHINE COUNTIES ESTABLISHED A CO-MANAGEMENT AGREEMENT WITH SOUTH ERN OREGON CARDIOLOGY REDUCED CLINICAL VARIATION AND STANDARDIZED SUPPLY COSTS IN THE CATH LAB AT ARRMC PARTNERED WITH OHSU FOR TELESTROKE AT ATRMC RECEIVED ACUTE STROKE READY CERT IFICATION AT ATRMC BY OUR ACCREDITING AGENCY, DNV GL (DET NORSKE VERITAS GERMANISCHER LLOY D) PROMOTED NATIONAL HEART MONTH ACTIVITIES AND EDUCATION SUPPORTED MENDED HEARTS PEER-TO- PEER SUPPORT GROUP REINSTATED SEVERAL CATH LABS AT ARRMC TO ACCOMMODATE INCREASED PATIENT VOLUMES ADDED A TRANSCATHETER AORTIC VALVE REPLACEMENT PROGRAM AT ARRMC AS LEADING EDGE HE ART CARE FOR PATIENTS EXPANDED THE SCOPE OF CARDIAC REHABILITATION SERVICES AT ARRMC SPONS ORED THE AMERICAN COLLEGE OF CARDIOLOGY OREGON CARDIOVASCULAR SYMPOSIUM AND NURSING HEART FAILURE CONFERENCE CONSISTENTLY MET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFELINE RECEIVING CENTER GOLD PLUS RECOGNITION CONSISTENTLY M ET QUALITY AND SAFETY CRITERIA TO BE AWARDED THE AMERICAN HEART ASSOCIATION MISSION LIFEL INE GOLD PLUS STEMI RECOGNITION FUTURE SUPPORT THE RECRUITMENT OF ADDITIONAL NEUROSURGEON S TO SOUTHERN OREGON ATTAIN LEVEL II TRAUMA CENTER STATUS AT ARRMC 4 INFANT HEALTH AND FA MILY PLANNING CURRENT HIRED MATERNAL FETAL MEDICINE PROVIDERS CREATED A MIDWIFERY PROGRAM AT APP AND AACH MAINTAINED THE ONLY REGIONAL NEONATAL INTENSIVE CARE UNIT (NICU) PURCHASE D AN ISOLETTE TRANSPORTER FOR FRAGILE INFANTS HIRED SIX PEDIATRIC HOSPITALISTS DEVELOPED A FORMAL PEDIATRIC HOSPITALIST PROGRAM HIRED A PEDIATRIC ONCOLOGIST RENOVATED THE PEDIATRIC UNIT AT ARRMC PARTNERED WITH OHSU TO PROVIDE TELEMEDICINE FOR PEDIATRIC INPATIENTS IMPLEM ENTED OHSU ROTATING CLINICS FOR PEDIATRIC PATIENTS IMPLEMENTED QUIET TIME IN THE NICU AND SPECIAL CARE NURSERY TO PROMOTE HEALING RENOVATED AND EXPANDED THE FAMILY BIRTH CENTER AT AACH ADDED THREE PEDIATRIC CARE ROOMS AT ATRMC FUTURE DEVELOP AN OBSTETRICAL LABORIST SER VICE AT ARRMC 5 DIABETES CURRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTP ATIENT HEALTH FOR DIABETES NUTRITION EDUCATION ESTABLISHED A DIABETES CARE CENTER AND NUTR ITION SERVICES IN MEDFORD AND GRANTS PASS ADDED INPATIENT CONSULTS FOR PEOPLE WITH DIABETE S ESTABLISHED BLOOD GLUCOSE MO

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
ASHLAND COMMUNITY HOSPITAL	NITORING CLINICS HIRED AN APP ENDOCRINOLOGIST 6 NUTRITION, PHYSICAL ACTIVITY AND WEIGHT C URRENT BUILT A DEMONSTRATION KITCHEN AT ASANTE CENTER FOR OUTPATIENT HEALTH FOR COOKING C LASSES AND DIABETES NUTRITION EDUCATION PARTNERED WITH SOUTHERN OREGON BARIATRIC CENTER AN D OREGON SURGICAL SPECIALISTS HIRED INPATIENT AND OUTPATIENT NUTRITION COUNSELORS HELD ANN UAL EMPLOYEE FITNESS AND WEIGHT MANAGEMENT CHALLENGES SPONSORED THE ANNUAL PEAR BLOSSOM RU N AND WALK SPONSORED SEVERAL COMMUNITY SPORTING EVENTS TO SUPPORT LOCAL SCHOOL AND YOUTH P ROGRAMS SPONSORED THE HEALTHY FOOD FESTIVAL IN GRANTS PASS SPONSORED THE ACCESS FOOD SHARE PROGRAM SPONSORED THE FRIENDS OF JOSEPHINE COUNTY FOOD BANK DONATED FOOD TO HEARTS WITH A MISSION FOR HOMELESS YOUTH SPONSORED BLUE ZONES PROJECT IN GRANTS PASS FOR HEALTHIER, MOR E ACTIVE LIVING SPONSORED THE ASHLAND HIGH SCHOOL SPORTS PROGRAM AND ATHLETIC TRAINERS TO ENSURE PLAYER SAFETY SPONSORED THE ASHLAND CHAMBER OF COMMERCE COMMUNITY-WIDE HEALTH AND W ELLBEING INITIATIVE FUTURE ADD COMPREHENSIVE PRIMARY CARE PLUS (CPC+) AS PART OF THE MEDI CAL HOME MODEL OF CARE 7 RESPIRATORY DISEASES CURRENT REMODELED AND EXPANDED CARDIOPULMO NARY SERVICES AT ARRMC HIRED SEVEN PULMONOLOGISTS AND TWO PULMONARY NURSE PRACTITIONERS TO APP EXPANDED CARDIOPULMONARY TESTING SERVICES TO AACH IMPLEMENTED A PROCESS TO SCHEDULE D ISCHARGED PATIENTS WITH PNEUMONIA AND RESPIRATORY ISSUES TO AN APP PULMONOLOGIST IMPLEMENT ED A ROTATING APP PULMONOLOGIST IN GRANTS PASS IMPLEMENTED TELEMEDICINE PULMONARY INTENSIV ISTS CONSULTS AT ALL THREE HOSPITALS ADDED A SLEEP LAB PROGRAM AT ATRMC FUTURE OFFER LUNG CANCER SCREENING CLINICS RECRUIT ADDITIONAL PULMONOLOGISTS TO APP 8 CANCER CURRENT ESTA BLISHED A GYNECOLOGIC CANCER SUPPORT GROUP HIRED A PEDIATRIC ONCOLOGIST PARTNERED WITH OHS U TO BRING A CANCER SPECIALIST/SURGEON TO ARRMC EACH MONTH PROMOTED NATIONAL BREAST CANCER AWARENESS MONTH ACTIVITIES AND EDUCATION HIRED AN ONCOLOGY NURSE NAVIGATOR FOR ALL CANCER -TYPES EXPANDED THE BREAST CANCER NURSE NAVIGATOR PROGRAM TO JOSEPHINE COUNTY ADDED 3-D MA MMOGRAPHY TO ALL THREE IMAGING CENTERS ADDED BREAST MRI CAPABILITY AT ARRMC REMODELED THE SPEARS CANCER CENTER AND UPGRADED WITH A NEW LINEAR ACCELERATOR FUTURE RECRUIT AN EAR, NO SE AND THROAT PHYSICIAN TO DO NECK AND THROAT CANCER SURGERIES PROVIDE DIRECT INFUSION INT ERVENTION FOR CHEMO PATIENTS OFFER LUNG CANCER SCREENING CLINICS BUILD AN ONCOLOGY MEDICAL OFFICE TO PROVIDE COMPREHENSIVE CANCER SERVICES

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 16J PARTIAL INFORMATION, BUT NOT THE ENTIRE POLICY, ABOUT APPLYING FOR FINANCIAL AID IS PRINTED ON THE PATIENT'S BILLING STATEMENT THE ENTIRE FINANCIAL ASSISTANCE POLICY IS POSTED ON THE ASANTE WEBSITE AT WWW ASANTE ORG THE ENTIRE POLICY IS ALSO ON POSTERS IN THE PATIENT REGISTRATION DEPARTMENT IF A PATIENT WISHES TO APPLY FOR FINANCIAL AID, THEY ARE DIRECTED TO CALL THE HOSPITAL FOR A FINANCIAL ASSISTANCE APPLICATION

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 16J PARTIAL INFORMATION, BUT NOT THE ENTIRE POLICY, ABOUT APPLYING FOR FINANCIAL AID IS PRINTED ON THE PATIENT'S BILLING STATEMENT THE ENTIRE FINANCIAL ASSISTANCE POLICY IS POSTED ON THE ASANTE WEBSITE AT WWW ASANTE ORG THE ENTIRE POLICY IS ALSO ON POSTERS IN THE PATIENT REGISTRATION DEPARTMENT IF A PATIENT WISHES TO APPLY FOR FINANCIAL AID, THEY ARE DIRECTED TO CALL THE HOSPITAL FOR A FINANCIAL ASSISTANCE APPLICATION

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 16J PARTIAL INFORMATION, BUT NOT THE ENTIRE POLICY, ABOUT APPLYING FOR FINANCIAL AID IS PRINTED ON THE PATIENT'S BILLING STATEMENT THE ENTIRE FINANCIAL ASSISTANCE POLICY IS POSTED ON THE ASANTE WEBSITE AT WWW ASANTE ORG THE ENTIRE POLICY IS ALSO ON POSTERS IN THE PATIENT REGISTRATION DEPARTMENT IF A PATIENT WISHES TO APPLY FOR FINANCIAL AID, THEY ARE DIRECTED TO CALL THE HOSPITAL FOR A FINANCIAL ASSISTANCE APPLICATION

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 18E ROGUE REGIONAL MEDICAL CENTER'S "POLICY" IS TO ALLOW THIRD PARTIES TO PERFORM LAWSUITS, PLACE LIENS ON RESIDENCES, AND GARNISH WAGES, BUT ONLY AS A FINAL RESORT HOWEVER, THE ASANTE BUSINESS OFFICE IS AUTHORIZED TO PLACE A VOLUNTARY LIEN ON A PATIENTS RESIDENCE ON CERTAIN RARE CIRCUMSTANCES THE PATIENT MUST APPROVE THE VOLUNTARY LIEN FIRST

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 18E THREE RIVERS MEDICAL CENTER'S "POLICY" IS TO ALLOW THIRD PARTIES TO PERFORM LAWSUITS, PLACE LIENS ON RESIDENCES, AND GARNISH WAGES, BUT ONLY AS A FINAL RESORT HOWEVER, THE ASANTE BUSINESS OFFICE IS AUTHORIZED TO PLACE A VOLUNTARY LIEN ON A PATIENTS RESIDENCE ON CERTAIN RARE CIRCUMSTANCES THE PATIENT MUST APPROVE THE VOLUNTARY LIEN FIRST

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 18E ROGUE REGIONAL MEDICAL CENTER'S "POLICY" IS TO ALLOW THIRD PARTIES TO PERFORM LAWSUITS, PLACE LIENS ON RESIDENCES, AND GARNISH WAGES, BUT ONLY AS A FINAL RESORT HOWEVER, THE ASANTE BUSINESS OFFICE IS AUTHORIZED TO PLACE A VOLUNTARY LIEN ON A PATIENTS RESIDENCE ON CERTAIN RARE CIRCUMSTANCES THE PATIENT MUST APPROVE THE VOLUNTARY LIEN FIRST

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
ROGUE REGIONAL MEDICAL CENTER	PART V, SECTION B, LINE 20E NOTIFY INDIVIDUALS OF FAP PRIOR TO DISCHARGE

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
THREE RIVERS MEDICAL CENTER	PART V, SECTION B, LINE 20E NOTIFY INDIVIDUALS OF FAP PRIOR TO DISCHARGE

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
ASHLAND COMMUNITY HOSPITAL	PART V, SECTION B, LINE 20E NOTIFY INDIVIDUALS OF FAP PRIOR TO DISCHARGE

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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 . . . . . ▶

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

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of 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
PART I, LINE 2	ONCE AN APPLICANT HAS BEEN APPROVED FOR GRANT FUNDS, THE GRANT AGREEMENT SPECIFIES THAT ALL GRANT MONIES ARE TO BE SPENT FOR ONLY THE PURPOSE SPELLED OUT IN THE APPLICATION THE COUNTY CONNECTIONS COMMITTEE MUST KNOW WHERE THE DONATED MONEY WILL BE ALLOCATED, AND IF A FUNDRAISING EVENT, HOW THE RAISED MONEY WILL BE ALLOCATED USUALLY, A DETAILED BUDGET OF THE GRANTEE'S CURRENT YEAR IS REQUIRED, AS WELL AS ANY REPORTS OR MINUTES FROM PREVIOUS EVENTS
SCHEDULE I, PART I, LINE 2	WHEN ASANTE RECEIVES A REQUEST FOR GRANT FUNDS FROM AN OUTSIDE ORGANIZATION, THE REQUEST IS REVIEWED BY EITHER THE JACKSON COUNTY OR JOSEPHINE COUNTY COMMUNITY CONNECTIONS COMMITTEE THE APPLICANT MUST FILL OUT AN APPLICATION FORM AND PROVIDE SUPPORTING DOCUMENTS OR EVENT MATERIALS TO BE SELECTED, THE ORGANIZATION MUST MEET THE FOLLOWING CRITERIA 1)THE GRANT MUST SUPPORT STRATEGIC INITIATIVES, 2)IT MUST HAVE A DIRECT IMPACT ON THE HEALTHCARE OF THE COMMUNITY, 3)THE ORGANIZATION MUST BE A NOT-FOR-PROFIT HEALTH, HUMAN SERVICES, OR EDUCATION RELATED ORGANIZATION, 4)THE ORGANIZATION COLLABORATES WITH OTHER NOT-FOR-PROFIT ORGANIZATIONS AND, 5)THE GRANT MUST BE A RELATION BUILDING OPPORTUNITY

Additional Data

Software ID:
Software Version:
EIN: 93-0223960
Name: ASANTE

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
COMPASS HOUSE 332 W 6TH STREET MEDFORD, OR 97501	93-1294230	501(C)(3)	100,000		CASH		SUPPORT THE EXPANSION OF EXISTING COMPASS HOUSE PROGRAMS AND FACILITIES TO SERVE A HIGHER NUMBER OF OUR COUNTY'S CITIZENS LIVING WITH MENTAL ILLNESS WITH TRANSITIONAL HOUSING, EMOTIONAL SUPPORT, FINANCIAL LITERACY AND LIFE SKILLS TRAINING
JACKSON COUNTY SART 2305 ASHLAND ST ASHLAND, OR 97520	81-0650183	501(C)(3)	45,000		CASH		FUNDS ARE DEDICATED TO THE SUPPORT OF THE TRAINING AND PROVISION OF SANE NURSES WITHIN IN JACKSON COUNTY

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
GRANTS PASS SOBERING CENTER 1010 SW FOUNDRY ST GRANTS PASS, OR 97526	46-4365248	501(C)(3)	10,000		CASH		SUPPORT DRUG AND ALCOHOL ABUSE INITIATIVE IN JOSEPHINE COUNTY
HOLLY THEATRE 315 S FRONT ST MEDFORD, OR 97501	46-0930033	501(C)(3)	22,500		CASH		SUPPORT ADA MODIFICATIONS TO ENHANCE ACCESS, PROMOTE COMMUNITY INCLUSION AND IMPROVE THE QUALITY OF LIFE FOR COMMUNITY MEMBERS LIVING WITH DISABILITY

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
MEFORD PARKS AND RECREATION FOUNDATION 701 N COLUMBUS AVE MEDFORD, OR 97501	20-3488320	501(C)(3)	10,000		CASH		FOR THE PURCHASE OF THERAPEUTIC SWINGS, SPECIFICALLY ENGINEERED FOR THE ENJOYMENT OF THOSE WITH PHYSICAL IMPAIRMENTS THAT PREVENT SAFE USE OF TRADITIONAL SWINGS
OREGON WINE EXPERIENCE 2650 SISKIYOU BLVD MEDFORD, OR 97504	93-6087366	501(C)(3)	19,625		CASH		SUPPORT CMN FUNDRAISER

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNITED WAY OF JACKSON COUNTY 60 HAWTHORNE ST MEDFORD, OR 97504	93-0576632	501(C)(3)	10,000		CASH		REMEDIATION OF UNITED WAY'S NEW SPACE TO PROVIDE MEETING SPACES FOR HEALTH EDUCATION SUCH AS CPR AND FIRST AID CLASSES
PEAR BLOSSOM RUN PO BOX 335 MEDFORD, OR 97501	47-5622033	501(C)(3)	15,000		CASH		PROVIDE ACCESS TO YMCA PROGRAMS FOR COMMUNITY MEMBERS WOULD OTHERWISE NOT HAVE ACCESS DUE TO PHYSICAL LIMITATION, FINANCIAL OR GEOGRAPHICAL CONSTRAINTS

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
ACCESS FOOD BANK 3630 AVIATION WAY MEDFORD, OR 97504	93-0665396	501(C)(3)	13,500		CASH		SUPPORT ACCESS NUTRITION PROGRAMS SERVING JACKSON COUNTY'S LOW INCOME FAMILIES AND INDIVIDUALS, SENIORS AND PEOPLE WITH DISABILITIES
MAKE A WISH FOUNDATION 2000 SW 1ST AVE STE 410 PORTLAND, OR 97201	82-0385049	501(C)(3)	7,500		CASH		ADOPT A WISH OF A YOUNG JACKSON COUNTY 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
ROGUE VALLEY GROWERS AND CRAFTERS MARKET PO BOX 4041 MEDFORD, OR 97501	93-0995451	501(C)(3)	5,000		CASH		FACILITATE THE PURCHASE OF LOCALLY GROWN FRESH PRODUCE BY JACKSON COUNTY RESIDENTS RECEIVING SNAP BENEFITS
OREGON BUSINESS COUNCIL CHARITABLE INSTITUTE 1100 SW 6TH AVE STE 1608 PORTLAND, OR 97204	93-1240928	501(C)(3)	100,000		CASH		BLUE ZONE PROJECT - THE FOCUS OF THIS PROJECT IS TO IMPROVE THE QUALITY OF LIFE AND HEALTH OF COMMUNITY MEMBERS THROUGH A NUMBER OF INITIATIVES AND COMMUNITY PROGRAMS ADDRESSING NUTRITION, SOCIAL AND EMOTIONAL WELL-BEING AND CONNECTION, PHYSICAL ACTIVITY AND COMMUNITY

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
JOSEPHINE COUNTY FOOD BANK PO BOX 250 GRANTS PASS, OR 97528	47-1904505	501(C)(3)	15,000		CASH		SUPPORT NUTRITION PROGRAMS SERVING JOSEPHINE COUNTY'S LOW AND NO INCOME FAMILIES AND INDIVIDUALS, SENIORS AND PEOPLE WITH DISABILITIES
ASHLAND CHAMBER OF COMMERCE PO BOX 1360 ASHLAND, OR 97520	93-0115140	501(C)(3)	30,000		CASH		SUPPORT "ASHLAND COMMUNITY WELLBEING INITIATIVE", WHICH FOCUSES ON CREATING COMMUNITY PROGRAMS AND INITIATIVES THAT ENHANCE THE COMMUNITY'S HEALTH AND WELLBEING AND REDUCE THE ECONOMIC BURDEN OF POOR HEALTH ON EMPLOYERS, OUR GOVERNMENT AND INDIVIDUAL CITIZENS

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

Part I Questions Regarding Compensation

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

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 3	THE SALARY RANGE OF THE EXECUTIVE STAFF IS SET BY THE ASANTE COMPENSATION COMMITTEE AND IS APPROVED BY THE ASANTE BOARD OF DIRECTORS ON AN ANNUAL BASIS HOWEVER, ROY VINYARD, THE CEO/EXECUTIVE DIRECTOR OF ASANTE HAS HIS SALARY DETERMINED BY INDEPENDANT COMPENSATION CONSULTANTS, WRITTEN EMPLOYMENT CONTRACTS, AND A COMPENSATION SURVEY AND STUDY HIS FINAL SALARY MUST BE APPROVED BY THE ASANTE BOARD OF DIRECTORS
PART I, LINE 4B	ASANTE HAS AN EXECUTIVE RESTORATION PLAN WHICH INCLUDES ASANTE VP& CHIEF MEDICAL INFORMATION OFFICER LEE MILLIGAN, MD, ARRMC CEO SCOTT KELLY, ATRMC CEO WIN HOWARD, AACH CEO SHEILA CLOUGH, CIO MARK HETZ, CHIEF QUALITY AND SAFETY OFFICER JAMES GREBOSKY, MD, VP OF MEDICAL AFFAIRS ERIC LOELIGER, MD, AND CSO DENNIE CONRAD THIS PLAN STATES FIXED PAYMENTS WILL BE RECEIVED AT PRE-DETERMINED INTERVALS FROM ASANTE IF STILL EMPLOYED BY ASANTE IN THEIR CURRENT ROLL AT THE TIME OF VESTING IF EMPLOYMENT TERMINATES BY ASANTE FOR ANY REASON PRIOR TO VESTING, THEY WILL NOT HAVE CLAIM TO THE FUNDS SELECT EXECUTIVES AGREED TO PARTICIPATE IN CAP-EX IN PLACE OF A TRADITIONAL SERP SEE SCHEDULE L, PART V, FOR A BROADER DESCRIPTION

Additional Data

Software ID:
Software Version:
EIN: 93-0223960
Name: ASANTE

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				
1ROY VINYARD PRESIDENT & CEO	(I)	774,796	220,506	241,503	121,240	39,475	1,397,520	0
	(II)	0	0	0	0	0	0	0
1LEE MILLIGAN MD TRUSTEE	(I)	0	0	0	0	0	0	0
	(II)	342,860	0	85,477	84,069	25,157	537,563	0
2MARK HETZ CH INFO OFFICER	(I)	297,731	83,134	153,059	170,116	34,020	738,060	0
	(II)	0	0	0	0	0	0	0
3GREG WOJTAL CFO	(I)	390,647	25,000	55,215	79,744	18,025	568,631	0
	(II)	0	0	0	0	0	0	0
4PAUL MACUGA PEOPLE OFFICER	(I)	251,338	50,000	46,403	67,655	18,953	434,349	0
	(II)	0	0	0	0	0	0	0
5DENNIE CONRAD CHIEF STRATEGY OFFICER	(I)	314,184	45,695	74,237	101,880	19,931	555,927	0
	(II)	0	0	0	0	0	0	0
6SCOTT KELLY ASANTE CEO	(I)	491,890	150,015	363,686	318,046	17,701	1,341,338	0
	(II)	0	0	0	0	0	0	0
7WIN HOWARD TRMC CEO	(I)	341,618	64,448	208,710	186,185	29,453	830,414	0
	(II)	0	0	0	0	0	0	0
8JAMES GREBOSKY CHIEF QUAL&SAFE OFFICER	(I)	392,217	117,702	274,458	267,964	22,608	1,074,949	0
	(II)	0	0	0	0	0	0	0
9SHEILA CLOUGH ACH CEO	(I)	271,187	79,644	58,687	92,440	25,460	527,418	0
	(II)	0	0	0	0	0	0	0
10KRISTEN ROY COMPLIANCE OFFICER	(I)	160,544	15,000	24,000	36,916	10,932	247,392	0
	(II)	0	0	0	0	0	0	0
11JOHN BONK MEDICAL DOCTOR	(I)	373,142	13,852	0	34,200	21,021	442,215	0
	(II)	0	0	0	0	0	0	0
12MICHAEL MCCASKILL MEDICAL DOCTOR	(I)	479,760	20,357	0	40,800	16,779	557,696	0
	(II)	0	0	0	0	0	0	0
13JENNIFER HALL MEDICAL DOCTOR	(I)	358,442	18,776	0	34,200	28,605	440,023	0
	(II)	0	0	0	0	0	0	0
14ERIC LOELIGER MEDICAL DOCTOR	(I)	305,211	39,746	82,225	90,700	29,401	547,283	0
	(II)	0	0	0	0	0	0	0
15CHRIS DAVID MEDICAL DOCTOR	(I)	356,525	8,798	0	34,200	28,506	428,029	0
	(II)	0	0	0	0	0	0	0
16GREG EDWARDS FORMER PEOPLE OFFICER	(I)	72,872	65,601	53,046	53,923	4,855	250,297	0
	(II)	0	0	0	0	0	0	0
17PATRICK HOCKING FORMER CFO	(I)	90,166	103,778	11,786	64,341	8,193	278,264	0
	(II)	0	0	0	0	0	0	0

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

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 IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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	HOSP AUTH OF MEDFORD OR	52-1378932	584283FL4	02-17-2010	239,059,650	FINANCE HOSPITAL EXPANSION		X		X		X
B	STATE OF OREGON	93-6001787	NONEAVAIL	12-29-2011	30,000,000	FINANCE ELEC MED REC SOFTWARE		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	50,560,000	28,857,603		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	239,059,650	30,000,000		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	3,511,327	192,035		
8	Credit enhancement from proceeds	2,680,107			
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	31,041,115	29,807,965		
11	Other spent proceeds	201,827,101			
12	Other unspent proceeds				
13	Year of substantial completion	2011	2013		

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

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X			X				
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X							
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 ▶		0 250 %		0 100 %				
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		0 250 %		0 100 %				
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?		X		X				
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								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

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
DATE REBATE COMPUTATION PERFORMED	ISSUER NAME HOSP AUTH OF MEDFORD OR DATE THE REBATE COMPUTATION WAS PERFORMED 02/16/2017 ISSUER NAME STATE OF OREGON DATE THE REBATE COMPUTATION WAS PERFORMED 02/16/2017

Return Reference	Explanation
PART IV LINE 2C	ARBITRAGE REBATE CALCULATION PERFORMED BY BLX ON FEB , 2018 NO REBATE LIABILITY DUE

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

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

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

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1) ROY VINYARD	ASANTE CEO	SEE PART V		X	3,000,000	4,859,303		No	Yes		Yes	
Total				▶ $		4,859,303						

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

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

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

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No

Part V **Supplemental Information**

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

Return Reference	Explanation
SCHEDULE L PART II	THE EO PROVIDES SUPPLEMENTAL RETIREMENT BENEFITS THROUGH AN ALTERNATIVE FUNDING ARRANGEMENT THE IRS CALLS "COLLATERAL ASSIGNMENT SPLIT DOLLAR" (CASD) ALTHOUGH THE IRS REQUIRES REPORTING IN THE LOAN SECTION OFSCHEDULE L, CASD IS NOT AN ACTUAL LOAN--NO FUNDS ARE TRANSFERRED TO THE EXECUTIVE RATHER, THE "LOAN" TREATMENT APPLIES BECAUSE AFTER THE EXECUTIVE HAS RECEIVED RETIREMENT BENEFITS, THE EO RECOVERS ALL OF ITS OUTLAYS PLUS INTEREST THE RECOVERY RIGHT IS A KEY ADVANTAGE OF CASD FOR THE EO RATHER THAN PAYING RETIREMENT BENEFITS TO THE EXECUTIVE THAT WOULD NEVER BE RECOVERED, UNDER CASD THE EO RECOVERS NOT ONLY ITS OUTLAYS, BUT ALSO CONSIDERATIONFOR THE TIME VALUE OF MONEY CASD WORKS AS FOLLOWS THE EO DEPOSITS FUNDS INTO A CASH VALUE LIFE INSURANCE POLICY ON THE EXECUTIVE'S LIFE DURING LIFE, TO THE EXTENT THE EXECUTIVE FULFILLS SERVICE AND VESTING REQUIREMENTS, THE EXECUTIVE CAN BORROWAGAINST VALUES IN THE POLICY TO SUPPLEMENT RETIREMENT INCOME POLICY PERFORMANCE IS CLOSELY MONITORED IF POLICY PERFORMANCE LAGS, THE EXECUTIVE'S BORROWING RIGHTS ARE REDUCED TO PROTECT THE EO'S RECOVERYRIGHTS AT THE EXECUTIVE'S DEATH, THE POLICY DEATH PROCEEDS ARE FIRST USED TO REPAY THE EO ITS DEPOSITS PLUS COMPOUNDED INTEREST (AT THE IRS LONG-TERM APPLICABLE FEDERAL RATE) THE EXECUTIVE'S BENEFICIARY THEN RECEIVESANY PROJECTED RETIREMENT BORROWING THE EXECUTIVE DID NOT ACCESS DURING LIFE ANY REMAINING DEATH PROCEEDS ARE AVAILABLE TO BE PAID TO THE EXECUTIVE'S BENEFICIARY

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

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

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	POLICY SUMMARY THE FEDERAL FORMS 990 AND 990-T ARE FEDERALLY MANDATED LEGAL DOCUMENTS THAT ARE HIGHLY REGULATED WITHIN ASANTE, THEY ARE TO BE PREPARED BY PERSONNEL IN THE ACCOUNTING DEPARTMENT ADDITIONAL ASSISTANCE WILL BE PROVIDED BY PERSONNEL IN THE MARKETING, COMPLIANCE, AND EXECUTIVE DEPARTMENTS BEFORE FINAL SUBMISSION OF THE DOCUMENTS, THEY ARE TO HAVE ASANTE BOARD REVIEW POLICY DETAILS 1 WHEN FINAL AUDITED FINANCIAL INFORMATION IS AVAILABLE, ACCOUNTING PERSONNEL WILL COMPILE THE NEEDED INFORMATION TO PREPARE THE APPROPRIATE RETURNS FOR THE PRIOR FISCAL YEAR 2 AS NEEDED, ACCOUNTING WILL FILE ALL APPROPRIATE EXTENSIONS ON A TIMELY BASIS HOWEVER, THE FINAL SUBMISSION CAN NEVER BE EXTENDED PAST AUGUST 15TH OF THE YEAR FOLLOWING THE FISCAL YEAR BEING FILED 3 IN ADDITION TO NORMAL PREPARATION, ACCOUNTING PERSONNEL WILL COORDINATE WITH PERSONNEL IN MARKETING, COMPLIANCE, AND POSSIBLY THE EXECUTIVE DEPARTMENTS IN PREPARING THE VARIOUS SCHEDULES NEEDED TO COMPLETE THE RETURN ALL WORK PAPERS ARE TO BE RETAINED IN A PERMANENT FILE 4 WHEN ALL NECESSARY INFORMATION HAS BEEN COMPILED, IT IS TO BE LOADED INTO APPROPRIATE TAX SOFTWARE 5 WHEN COMPLETED, A DRAFT RETURN WILL BE REVIEWED BY THE CHIEF ADMINISTRATIVE AND FINANCE OFFICER AFTER THE REVIEW, ACCOUNTING WILL CLEAR ALL REVIEW NOTES AND COMMENTS 6 ONCE REVIEWED BY THE CAFO, AN ADDITIONAL REVIEW WILL BE PERFORMED BY AN OUTSIDE CPA FIRM ACCOUNTING WILL AGAIN CLEAR ANY ADDITIONAL REVIEW NOTES AND COMMENTS SUBMITTED BY THE OUTSIDE CPA 7 THE CHIEF EXECUTIVE OFFICER AND MEMBERS OF THE BOARD OF DIRECTORS WILL LOOK OVER THE FINAL SET OF RETURNS AND MAKE FURTHER COMMENTS AND CORRECTIONS, AS IS APPROPRIATE 8 ONCE ALL REVIEWS AND CORRECTIONS ARE MADE, THE CAFO WILL SIGN ALL APPROPRIATE RETURNS FOR FILING 9 ALL RETURNS WILL THEN BE FILED EITHER ELECTRONICALLY OR PAPER COPY WITH THE APPROPRIATE GOVERNMENT AGENCY A COPY OF EACH RETURN IS TO BE KEPT IN THE ACCOUNTING DEPARTMENT AND A COPY OF THE 990 AND 990-T WILL BE KEPT AT CORPORATE HEADQUARTERS FOR PUBLIC DISPLAY AND COPYING, AS REQUESTED

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	EACH YEAR, ASANTE MAILS TO ALL ASANTE MANAGEMENT, KEY EMPLOYEES, AND BOARD MEMBERS A CONFL ICT OF INTEREST QUESTIONAIRE TO COMPLY WITH ASANTE'S CONFLICT OF INTEREST POLICY# 400-LD-0 34 AND 036 THE PURPOSE OF THE POLICY IS TO PROTECT ASANTE'S INTERESTS WHEN IT IS CONTEMPL ATING ENTERING INTO A TRANSACTION OR ARRANGEMENT THAT MIGHT BENEFIT THE PRIVATE INTERESTS OF A BOARD MEMBER OR OFFICER OF THE CORPORATION IN ADDITION, ALL ASANTE EMPLOYEES HAVE AN OBLIGATION TO DISCLOSE CONFLICTS OF INTEREST OR POTENTIAL CONFLICTS TO THEIR SUPERVISOR THE CORPORATE COMPLIANCE OFFICER IS RESPONSIBLE FOR ADMINISTERING, MONITORING, AND INVESTI GATING ANY POSSIBLE CONFLICTS AND MAKE AN ANNUAL REPORT TO THE BOARD OF DIRECTORS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS ANNUALLY REVIEWS THE COMPENSATION OF THE CEO AND OTHER KEY EMPLOYEES THE REVIEW COMPARES THE COMPENSATION OF THE CEO AND OTHER KEY EMPLOYEES WITH COMPENSATION DATA FOR JOB INCUMBENTS IN COMPARABLE POSITIONS AT OTHER HEALTHCARE ORGANIZATIONS OF SIMILAR SIZE AND SCOPE THE DATA IS PROVIDED AND PRESENTED TO THE COMPENSATION COMMITTEE BY AN OUTSIDE CONSULTANT THE COMPENSATION COMMITTEE SETS THE A CTUAL ANNUAL CASH COMPENSATION FOR THE CEO AND SALARY RANGES FOR THE OTHER KEY EMPLOYEES THE COMMITTEE ALSO SETS TOTAL COMPENSATION OPPORTUNITY FOR THE CEO AND EACH OF THE KEY EMP LOYEES, CONSISTENT WITH THE EXECUTIVE COMPENSATION PHILOSOPHY MINUTES OF THE COMMITTEE DE LIBERATIONS AND DECISIONS ARE RECORDED AND MAINTAINED THE MOST RECENT EXECUTIVE COMPENSAT ION REVIEW WAS COMPLETED IN 2016

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	CURRENTLY, ASANTE DOES NOT MAKE AVAILABLE TO THE GENERAL PUBLIC COPIES OF ITS GOVERNING DO CUMENTS, CONFLICT OF INTEREST POLICY, OR ITS FINANCIAL STATEMENTS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	PRIOR YEAR EQUITY TRANSFER ADJUSTMENT 11,619,345 DONATED CAPITAL 1,240,682

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493226015059

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
ASANTE

Employer identification number
93-0223960

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) ASANTE ASHLAND COMMUNITY HOSPITAL 280 MAPLE ST ASHLAND, OR 97520 81-5427847	MEDICAL BILLING	OR	7,640,103	34,816,348	ASANTE
(2) ASANTE THREE RIVERS MEDICAL CENTER LLC 500 SW RAMSEY GRANTS PASS, OR 97527 57-1181758	MEDICAL BILLING	OR	9,886,125	73,194,454	ASANTE
(3) ASANTE COMMUNITY SERVICES LLC 2650 SISKIYOU BLVD MEDFORD, OR 97504 57-1181752	MEDICAL BILLING	OR	0	0	ASANTE
(4) HEALTH ALLIANCE OF SOUTHERN OREGON 2620 E BARNETT MEDFORD, OR 97504 37-1768822	MANAGE/IMPROVE POPULATION HEALTH	OR	-64,289	-64,289	ASANTE
(5) SOUTHERN OREGON TRAUMA AND EMERGENCY SERVICES 2650 SISKIYOU BLVD MEDFORD, OR 97504 54-2085981	MEDICAL BILLING	OR	-341,675	-661,090	ASANTE

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)ASANTE FOUNDATION 2650 SISKIYOU BLVD MEDFORD, OR 97504 93-6087366	FUNDRAISING	OR	501(C)(3)	LINE 12B, II	ASANTE	Yes	
(2)SOUTHERN OREGON INSURANCE COMPANY 745 FORT STREET SUITE 800 HONOLULU, HI 96813 20-1578637	CAPTIVE INSURANCE	HI	501(C)(3)	LINE 12B, II	ASANTE	Yes	
(3)ASANTE PHYSICIAN PARTNERS 2650 SISKIYOU BLVD MEDFORD, OR 97504 38-3849354	PHYSICIAN GROUP	OR	501(C)(3)	LINE 3	ASANTE	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

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

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		No
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j		No
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		No
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		No
q Reimbursement paid by related organization(s) for expenses	1q		No
r Other transfer of cash or property to related organization(s)	1r		No
s Other transfer of cash or property from related organization(s)	1s		No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)ASANTE FOUNDATION	C	767,175	CASH
(2)ASANTE FOUNDATION	O	750,950	CASH
(3)APP	O	66,136,570	CASH

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)