



# Capitol Project Reporting Form (CPR-1)

## Reporting Entity Identification and Contact

### Facility

**Name:** St. Charles Health System  
**Federal Tax ID#:** 93-0602940  
**Address:** 2500 NE Neff Road  
**City:** Bend **State:** OR **Zip Code:** 97701

### Individual completing form

**Name:** Nachele Varcoe  
**Title:** Staff Accountant  
**Email:** navarcoe@stcharleshealthcare.org  
**Phone:** 541-706-4763  
**Fax #:** 541-706-6347

*If address is different than facility listed above, please provide:*

**Address:**  
**City:** **State:** **Zip Code:**

## Capital Project Qualitative Information

**1. Provide a brief description of the project.**

Remodel of St. Charles Bend Hospital 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> floors

**2. Proposed start date:** 10/1/2014

**3. Expected completion date:** 9/30/2017

**4. What is the expected project cost?** 30,000,000.00

**5. Describe the expected benefits to the community that your facility serves. Include both direct financial benefits such as charity care as well as qualitative benefits such as access to care and quality improvements. Attach additional pages if needed.**

The St. Charles Bend Hospital 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> floors have not had a major update since they were built in 1975. The remodel will improve the standard of care and the patient experience as well as improve the infrastructure of the hospital. St. Charles is providing health related services and education at a free or discounted rate to the patients who meet the criteria of its charity care policy. Collection/payment policies are the same for all patients. St. Charles criteria for the determination for charity care include the patients or other responsible party's annual household income, number of people in the home and claimed on taxes, assets, credit history, existing medical debt obligations and other indicators of the patients ability to pay. Generally those individuals with a household income at less than 100% of the federal poverty guidelines qualify for charity care. In addition St. Charles provides discounts on a sliding scale to those individuals with an annual household income of between 200% and 400% of the federal poverty guidelines. St. Charles does not pursue collection of amounts determined to qualify as charity care.

**6. In what ways may this project negatively impact the community that your facility serves? Include direct cost such as bonds as well as indirect impacts such as service interruptions. Attach additional pages if needed.**

**The only negative impact of this remodel is the necessity to take a small number of patient rooms out of service for each phase of construction. Typically it will be 10 to 12 patient rooms at a time.**

**7. How has your facility evaluated the need for this project within the community that you serve?**

The St. Charles Bend Hospital 3rd, 4th and 5th floors have not had a major update since they were built in 1975. The remodel will improve the standard of care and the patient experience as well as improve the infrastructure of the hospital.

**8. Are the medical services created by this project already available in the community that your facility serves?**

Yes, they are currently available in the same hospital that is being remodeled.

**Public Notice and Comment**

**1. Provide a link to the webpage where public notice of the capital project was posted. If your facility does not maintain a webpage provide the name of the newspaper where the public notice was made and date of publication. Attach additional pages if needed.**

<http://www.bendbulletin.com/home/2098362-151/st-charles-plans-22-million-bend-renovation>

**2. Describe your facility's method of collecting and reviewing public comments on the capital project. Attach additional pages if needed.**

We will post a copy of this CPR-1 form on our website with an email address for comments to be provided. Comments received will be reviewed and summarized and reported to the COO and CFO of St. Charles Health System.

**Signature and Date**

<b>*Signature:</b>	Nachele Varcoe
<b>Date:</b>	8/3/2015

*\*Entry of name connotes signature*

Please **email** the completed form to: [OHPR.DataSubs@state.or.us](mailto:OHPR.DataSubs@state.or.us)

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