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Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

▶ Do not enter social security numbers on this form as it may be made public
▶ Information about Form 990 and its instructions is at www.IRS.gov/form990

OMB No 1545-0047

**2014**

**Open to Public Inspection**

**A For the 2014 calendar year, or tax year beginning 07-01-2014 , and ending 06-30-2015**

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

**C** Name of organization
CENTRACARE HEALTH SYSTEM

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1406 6TH AVENUE NORTH

City or town, state or province, country, and ZIP or foreign postal code
ST CLOUD, MN 56303

**D Employer identification number**
41-1813221

E Telephone number
(320) 251-2700

**G** Gross receipts $ 182,914,102

**F** Name and address of principal officer
TERENCE R PLADSON MD
1406 6TH AVENUE NORTH
ST CLOUD, MN 56303

**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 CENTRACARE COM

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

**L** Year of formation 1995

**M** State of legal domicile MN

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities
THE CENTRACARE HEALTH SYSTEM WORKS TO IMPROVE THE HEALTH OF EVERY PATIENT, EVERY DAY

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

**Activities & Governance**

| | | | |
|---|---|---|---|
| **3** | Number of voting members of the governing body (Part VI, line 1a) | **3** | 12 |
| **4** | Number of independent voting members of the governing body (Part VI, line 1b) | **4** | 9 |
| **5** | Total number of individuals employed in calendar year 2014 (Part V, line 2a) | **5** | 1,789 |
| **6** | Total number of volunteers (estimate if necessary) | **6** | 349 |
| **7a** | Total unrelated business revenue from Part VIII, column (C), line 12 | **7a** | 467,332 |
| **b** | Net unrelated business taxable income from Form 990-T, line 34 | **7b** | 0 |

**Revenue**

| | | Prior Year | Current Year |
|---|---|---|---|
| **8** | Contributions and grants (Part VIII, line 1h) | 13,811,966 | 177,151 |
| **9** | Program service revenue (Part VIII, line 2g) | 157,331,689 | 176,778,976 |
| **10** | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 692,785 | -1,028,925 |
| **11** | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 733,069 | 665,361 |
| **12** | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 172,569,509 | 176,592,563 |

**Expenses**

| | | | |
|---|---|---|---|
| **13** | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 9,751 | 1,049 |
| **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) | 70,142,368 | 109,306,522 |
| **16a** | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| **b** | Total fundraising expenses (Part IX, column (D), line 25) ▶791,555 | | |
| **17** | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 93,329,433 | 83,219,962 |
| **18** | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 163,481,552 | 192,527,533 |
| **19** | Revenue less expenses Subtract line 18 from line 12 | 9,087,957 | -15,934,970 |

**Net Assets or Fund Balances**

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| **20** | Total assets (Part X, line 16) | 176,582,230 | 185,298,098 |
| **21** | Total liabilities (Part X, line 26) | 90,797,825 | 94,146,535 |
| **22** | Net assets or fund balances Subtract line 21 from line 20 | 85,784,405 | 91,151,563 |

## 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**

****** | 2016-05-03
Signature of officer | Date

GREGORY R KLUGHERZ CFO
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| TODD A JACKSON | TODD A JACKSON | 2016-05-03 | | P00092672 |

Firm's name ▶ RSM US LLP | Firm's EIN ▶ 42-0714325

Firm's address ▶ 801 NICOLLET MALL SUITE 1100
MINNEAPOLIS, MN 55402 | Phone no (612) 332-4300

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

THE MISSION OF CENTRACARE HEALTH SYSTEM (CCHS) IS TO OPERATE AN INTEGRATED MULTI-ORGANIZATIONAL HEALTH CARE SYSTEM DESIGNED TO PROVIDE ACCESS TO QUALITY HEALTH CARE SERVICES AT AN AFFORDABLE PRICE

**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 $ 48,431,247 including grants of $ ) (Revenue $ 78,389,219 )

CENTRACARE HEALTH SYSTEM (CCHS) IS AN INTEGRATED HEALTH SYSTEM, COMPRISED OF FIVE CRITICAL ACCESS HOSPITALS, ONE ACUTE CARE HOSPITAL, A MULTI-SPECIALTY CLINIC, SURGICAL CENTER, RETAIL PHARMACY NETWORK, NURSING HOME AND A FOUNDATION CCHS SERVES ITS PATIENTS IN 4 MAIN AREAS MONTICELLO HOSPITAL IS CONSIDERED A DISREGARDED ENTITY FOR PURPOSES OF 990 REPROTING, THUS IT IS INCLUDED WITH THIS 990 FILING MONTICELLO HOSPITAL IS A 25 BED CRITICAL ACCESS HOPSITAL AND ALSO OPERATES A 10 BED ACUTE REHAB UNIT IN FISCAL YEAR 2015, THEY HAD 4,879 PATIENT DAYS, 26,785 OUTPATIENT VISITS AND 11,862 EMERGENCY ROOM VISITS' WHICH GENERATED $66,511,641 OF PROGRAM REVENUE AND $57,614,435 OF PROGRAM EXPENSES

**4b** (Code ) (Expenses $ 30,616,933 including grants of $ 1,049 ) (Revenue $ 36,815,507 )

CENTRACARE HEALTH - PAYNESVILLE HOSPITAL IS CONSIDERED A DISREGARDED ENTITY FOR PURPOSES OF 990 REPORTING, THUS IT IS INCLUDED WITH THIS 990 FILING CENTRACARE HEALTH - PAYNESVILLE HOSPITAL IS A 25 BED CRITICAL ACCESS HOSPITAL IN FISCAL YEAR 2015, THEY HAD 2,299 PATIENT DAYS, 32,186 OUTPATIENT VISITS AND 3,586 EMERGENCY ROOM VISITS IN FISCAL YEAR 2015, PAYNESVILLE GENERATED $37,453,716 OF PROGRAM REVENUE AND $30,616,933 OF PROGRAM EXPENSE

**4c** (Code ) (Expenses $ 22,784,542 including grants of $ ) (Revenue $ 32,226,028 )

CENTRACARE LABORATORY SERVICES ALL HOSPITALS UNDER ITS UMBRELLA AS WELL AS CENTRACARE CLINIC IT ALSO PERFORMS TESTS FOR VARIOUS FACILITIES IN THE REGION CENTRACARE LABORATORY PERFORMED 1 8 MILLION TESTS IN FISCAL YEAR 2015 IN FISCAL YEAR 2015 CENTRACARE LABORATORY GENERATED $32,226,028 IN PROGRAM REVENUE AND INCURRED $22,784,542 OF EXPENSES

See Additional Data

**4d** Other program services (Describe in Schedule O )

(Expenses $ 44,134,378 including grants of $ ) (Revenue $ 29,541,925 )

**4e** **Total program service expenses** ▶ 145,967,100

## 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 | | No |
| 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 | Yes | |
| 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 | | No |
| 12a | Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII* | 12a | | No |
| b | Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional* | 12b | Yes | |
| 13 | Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E* | 13 | | No |
| 14a | Did the organization maintain an office, employees, or agents outside of the United States? | 14a | | No |
| b | Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV* | 14b | | No |
| 15 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV* | 15 | | No |
| 16 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV* | 16 | | No |
| 17 | Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions) | 17 | | No |
| 18 | Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II* | 18 | | No |
| 19 | Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III* | 19 | | No |
| 20a | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | 20a | Yes | |
| b | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b | Yes | |

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

| | | | | |
|---|---|---|---|---|
| **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** | | No |
| **22** | Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III* | **22** | | No |
| **23** | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J* | **23** | Yes | |
| **24a** | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a* | **24a** | Yes | |
| **b** | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | **24b** | | No |
| **c** | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | **24c** | | No |
| **d** | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | **24d** | | No |
| **25a** | **Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I* | **25a** | | No |
| **b** | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I* | **25b** | | No |
| **26** | Did the organization report any amount on Part X, line 5, 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** | | No |
| **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** | Yes | |
| **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 | 209 | | |
| 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 | 1,789 | | |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) | 2b | | Yes | |
| 3a | Did the organization have unrelated business gross income of $1,000 or more during the year? . . . | 3a | | 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** | 12 | | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | | | |
| **b** | Enter the number of voting members included in line 1a, above, who are independent . . . . . | **1b** | 9 | | |
| **2** | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? . . . . . | **2** | | | No |
| **3** | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? . | **3** | | | No |
| **4** | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . . | **4** | | | No |
| **5** | Did the organization become aware during the year of a significant diversion of the organization's assets? . | **5** | | | No |
| **6** | Did the organization have members or stockholders? . . . . . | **6** | | | No |
| **7a** | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . . . . | **7a** | | | No |
| **b** | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . . | **7b** | | | No |
| **8** | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | | |
| **a** | The governing body? . . . . . | **8a** | | Yes | |
| **b** | Each committee with authority to act on behalf of the governing body? . . . . . | **8b** | | Yes | |
| **9** | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O* . . . . . | **9** | | | No |

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

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

**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 ▶ GREGORY R KLUGHERZ

1406 SIXTH AVENUE NORTH
ST CLOUD, MN 56303 (320) 251-2700

## 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 | | | |

**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 | | | |
| **1b Sub-Total** . . . . . ▶ | | | | | | | | | | |
| **c Total from continuation sheets to Part VII, Section A** . . . . ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** . . . . . ▶ | | | | | | | | 4,545,066 | 1,692,101 | 1,042,571 |

**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 ▶ 67

| | | | 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 |
|---|---|---|
| CENTRAL MINNESOTA EMERGENCY PHYSICIANS<br>1406 6TH AVE NORTH<br>ST CLOUD, MN 56303 | EMERGENCY COVERAGE | 4,093,135 |
| CENTRACARE CLINIC<br>1200 6TH AVE NORTH<br>ST CLOUD, MN 56303 | PHYSICIAN SERVICES | 3,799,709 |
| MAYO MEDICAL LABORATORIES<br>PO BOX 4100<br>ROCHESTER, MN 559034100 | LABORATORY SERVICES | 3,482,355 |
| METRO ANESTHESIA CONSULTANT<br>9855 AETNA AVE NE<br>MONTICELLO, MN 55362 | ANESTHESIA SERVICES | 2,075,824 |
| CENTRAL MINNESOTA DIAGNOSTIC INC<br>150 10TH STREET NW<br>MILACA, MN 56353 | RADIOLOGY SERVICES | 1,558,968 |

**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 ▶ 26

## 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 | 58,080 | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 119,071 | | | |
| | g | Noncash contributions included in lines 1a-1f $ | | | | | |
| | h | **Total.** Add lines 1a-1f . . . . . ▶ | | 177,151 | | | |
| Program Service Revenue | | | Business Code | | | | |
| | 2a | PATIENT & SERVICE REVENUE | 900099 | 136,525,362 | 136,058,030 | 467,332 | |
| | b | CORPORATE REVENUE | 900099 | 23,465,795 | 23,465,795 | | |
| | c | SHARED/LEGAL SYSTEM REVENUE | 900099 | 6,226,404 | 6,226,404 | | |
| | d | HEALTH INSURANCE PREMIUM CREDIT | 900099 | 6,059,178 | 6,059,178 | | |
| | e | OTHER REVENUE | 900099 | 3,415,919 | 3,415,919 | | |
| | f | All other program service revenue | | 1,086,318 | 1,086,318 | | |
| | g | **Total.** Add lines 2a–2f . . . . . ▶ | | 176,778,976 | | | |
| | 3 | Investment income (including dividends, interest, and other similar amounts) . . . . . ▶ | | -472,878 | | | -472,878 |
| | 4 | Income from investment of tax-exempt bond proceeds . . ▶ | | | | | |
| | 5 | Royalties . . . . . ▶ | | | | | |
| | | | (i) Real / (ii) Personal | | | | |
| | 6a | Gross rents | 5,715,657 | | | | |
| | b | Less rental expenses | 5,699,109 | | | | |
| | c | Rental income or (loss) | 16,548 | | | | |
| | d | Net rental income or (loss) . . . . . ▶ | | 16,548 | | | 16,548 |
| | | | (i) Securities / (ii) Other | | | | |
| | 7a | Gross amount from sales of assets other than inventory | 21,995 | | | | |
| | b | Less cost or other basis and sales expenses | 578,042 | | | | |
| | c | Gain or (loss) | -556,047 | | | | |
| | d | Net gain or (loss) . . . . . ▶ | | -556,047 | | | -556,047 |
| Other Revenue | 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 | 32,169 | | | | |
| | b | Less cost of goods sold . . b | 44,388 | | | | |
| | c | Net income or (loss) from sales of inventory . . ▶ | | -12,219 | | | -12,219 |
| | | Miscellaneous Revenue | Business Code | | | | |
| | 11a | REVENUE FROM JOINT VENTURES | 900099 | 660,907 | 660,907 | | |
| | b | ALL OTHER REVENUE | 900099 | 125 | 125 | | |
| | c | | | | | | |
| | d | All other revenue . . . . | | | | | |
| | e | **Total.** Add lines 11a–11d . . . . . ▶ | | 661,032 | | | |
| | 12 | **Total revenue.** See Instructions . . . . . ▶ | | 176,592,563 | 176,972,676 | 467,332 | -1,024,596 |

## Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | | | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 1,049 | 1,049 | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 3,609,114 | | 3,609,114 | |
| 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 | 89,324,230 | 75,195,891 | 14,099,272 | 29,067 |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 3,948,262 | 3,748,893 | 173,010 | 26,359 |
| 9 Other employee benefits | 8,621,955 | 8,023,582 | 598,373 | |
| 10 Payroll taxes | 3,802,961 | 3,407,367 | 314,439 | 81,155 |
| 11 Fees for services (non-employees) | | | | |
| a Management | | | | |
| b Legal | 666,148 | 13,343 | 652,805 | |
| c Accounting | 129,751 | 5,107 | 124,644 | |
| d Lobbying | 19,762 | 11,051 | 8,601 | 110 |
| e Professional fundraising services See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 22,193,539 | 19,924,850 | 1,933,551 | 335,138 |
| 12 Advertising and promotion | 546,822 | 157,514 | 286,710 | 102,598 |
| 13 Office expenses | 2,676,405 | 1,804,143 | 822,066 | 50,196 |
| 14 Information technology | 16,852,354 | | 16,852,354 | |
| 15 Royalties | | | | |
| 16 Occupancy | 417,584 | 14,150 | 403,434 | |
| 17 Travel | 108,055 | 69,580 | 25,913 | 12,562 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 465,152 | 361,912 | 80,794 | 22,446 |
| 20 Interest | 2,044,398 | 246,430 | 1,797,968 | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 5,266,121 | 3,587,155 | 1,677,030 | 1,936 |
| 23 Insurance | 1,428,437 | 272,578 | 1,155,515 | 344 |
| 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 DRUGS/MEDICAL SUPPLIES | 17,141,948 | 17,141,948 | | |
| b BAD DEBT | 2,924,276 | 2,924,276 | | |
| c MEDICAID SURCHARGE/MN C | 2,443,273 | 2,443,273 | | |
| d | | | | |
| e All other expenses | 7,895,937 | 6,613,008 | 1,153,285 | 129,644 |
| 25 **Total functional expenses.** Add lines 1 through 24e | 192,527,533 | 145,967,100 | 45,768,878 | 791,555 |
| 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 X . . . . . ☐

| | | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | | 15,715,128 | 1 | 17,126,130 |
| | 2 | Savings and temporary cash investments | | 496,690 | 2 | 0 |
| | 3 | Pledges and grants receivable, net | | 0 | 3 | 20,382,978 |
| | 4 | Accounts receivable, net | | 36,583,201 | 4 | 1,031,106 |
| | 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 | | 1,437,263 | 7 | 0 |
| | 8 | Inventories for sale or use | | 2,676,939 | 8 | 2,960,793 |
| | 9 | Prepaid expenses and deferred charges | | 1,386,050 | 9 | 1,414,651 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 187,948,009 | | | |
| | b | Less accumulated depreciation | 10b 103,509,375 | 86,044,616 | 10c | 84,438,634 |
| | 11 | Investments—publicly traded securities | | | 11 | |
| | 12 | Investments—other securities See Part IV, line 11 | | 31,747,194 | 12 | 26,122,345 |
| | 13 | Investments—program-related See Part IV, line 11 | | | 13 | |
| | 14 | Intangible assets | | | 14 | |
| | 15 | Other assets See Part IV, line 11 | | 495,149 | 15 | 31,821,461 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | | 176,582,230 | 16 | 185,298,098 |
| Liabilities | 17 | Accounts payable and accrued expenses | | 33,618,221 | 17 | 38,990,118 |
| | 18 | Grants payable | | | 18 | |
| | 19 | Deferred revenue | | 138,928 | 19 | 0 |
| | 20 | Tax-exempt bond liabilities | | 42,425,678 | 20 | 44,638,396 |
| | 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 | | 8,903,231 | 23 | 6,497,227 |
| | 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 | | 5,711,767 | 25 | 4,020,794 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | | 90,797,825 | 26 | 94,146,535 |
| 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 | | 85,784,405 | 27 | 91,151,563 |
| | 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 | | 85,784,405 | 33 | 91,151,563 |
| | 34 | Total liabilities and net assets/fund balances | | 176,582,230 | 34 | 185,298,098 |

## 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 | 176,592,563 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 192,527,533 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | -15,934,970 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 85,784,405 |
| 5 | Net unrealized gains (losses) on investments | 5 | 699,225 |
| 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 | 20,602,903 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 91,151,563 |

## 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:** 41-1813221
**Name:** CENTRACARE HEALTH SYSTEM

**Form 990, Part III - Line 4c: Program Service Accomplishments (See the Instructions)**

(Code ) (Expenses $ 44,134,378 including grants of $ ) (Revenue $ 29,541,925 )

THE OTHER MAIN ACTIVITY OF CENTRACARE HEALTH SYSTEM IS THE INFORMATION TECHNOLOGY SERVICES PROVIDED TO ALL ENTITIES WITHIN THE CENTRACARE UMBRELLA ACTIVITIES INCLUDE FIELDING HELP DESK CALLS, INSTALLING SOFTWARE AND HARDWARE, MAINTAINING THE SERVERS, AND OTHER RELATED INFORMATION SYSTEM TASKS THE REVENUE GENERATED FROM THIS ACTIVITY IN FISCAL YEAR 2015 WAS $23,465,795 AND GENERATED EXPENSES OF $38,043,127 CENTRACARE SURGICAL CENTER (CCSC) PROVIDES SURGICAL SERVICES TO THE COMMUNITY IT SERVES IN FISCAL YEAR 2015 THERE WERE 3,519 SURGERIES PERFORMED CCSC GENERATED $6,063,139 OF REVENUE AND $6,091,215 OF EXPENSE FOR AN OPERATING LOSS OF $28,112

## 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 | | | |
| (1) TERENCE R PLADSON MD<br>PRESIDENT/CEO | 30 00<br>10 00 | X | | X | | | | 1,248,123 | 0 | 260,124 |
| (1) GENE WINDFELDT<br>DIRECTOR, CHAIR | 2 00 | X | | X | | | | 4,500 | 0 | 0 |
| (2) ROBERT WHITE<br>DIRECTOR, VICE CHAIR | 2 00 | X | | X | | | | 1,500 | 0 | 0 |
| (3) THOMAS W LEITHER MD<br>DIRECTOR & SURGEON | 2 00<br>38 00 | X | | | | | | 0 | 414,621 | 41,519 |
| (4) CHRISTOPHER COBORN<br>DIRECTOR | 2 00<br>2 00 | X | | | | | | 1,500 | 0 | 0 |
| (5) DAVID AGERTER MD<br>DIRECTOR | 2 00<br>2 00 | X | | | | | | 1,000 | 0 | 0 |
| (6) DENISE ROSIN<br>DIRECTOR | 2 00<br>2 00 | X | | | | | | 1,500 | 0 | 0 |
| (7) STEVE LARAWAY<br>DIRECTOR | 2 00 | X | | | | | | 1,000 | 0 | 0 |
| (8) MIKE BENUSA<br>DIRECTOR | 2 00 | X | | | | | | 2,000 | 0 | 0 |
| (9) MOHAMED YASSIN MD<br>DIRECTOR | 2 00 | X | | | | | | 2,000 | 0 | 0 |
| (10) MARY JO WILLIAMSON<br>DIRECTOR | 2 00 | X | | | | | | 1,000 | 0 | 0 |
| (11) ROBERT STOCKER MD<br>DIRECTOR & OB/GYN | 2 00<br>38 00 | X | | | | | | 0 | 635,078 | 19,500 |
| (12) JOSEPH UPHUS<br>DIRECTOR | 2 00 | X | | | | | | 2,000 | 0 | 0 |
| (13) GREGORY R KLUGHERZ<br>TREASURER/CFO | 16 00<br>24 00 | | | X | | | | 0 | 642,402 | 136,804 |
| (14) PAUL R HARRIS<br>CORPORATE SECRETARY | 25 00<br>15 00 | | | X | | | | 431,612 | 0 | 93,140 |
| (15) GERRY G GILBERTSON<br>ADMINISTRATOR-MELROSE | 0 50<br>39 50 | | | | X | | | 257,415 | 0 | 49,857 |
| (16) DANIEL J SWENSON<br>ADMINISTRATOR-LONG PRAIRIE | 0 50<br>39 50 | | | | X | | | 243,186 | 0 | 55,657 |
| (17) DELANO A CHRISTANSON<br>ADMINISTRATOR - SAUK CENTR | 0 50<br>39 50 | | | | X | | | 212,170 | 0 | 62,752 |
| (18) MARY E WELLS<br>ADMINISTRATOR - MONTICELLO | 40 00 | | | | X | | | 272,079 | 0 | 53,961 |
| (19) JOSEPH D HELLIE<br>VICE PRESIDENT | 38 00<br>2 00 | | | | X | | | 221,579 | 0 | 52,790 |
| (20) DENNIS C MILEY<br>ADMINISTRATOR-PAYNESVILLE | 40 00 | | | | X | | | 232,381 | 0 | 60,237 |
| (21) JOSEPH M BLONSKI MD<br>PHYSICIAN | 40 00<br>0 00 | | | | | X | | 299,316 | 0 | 41,468 |
| (22) MARK J LARKIN<br>VICE PRESIDENT OF DEVELOPMENT | 40 00<br>0 00 | | | | | X | | 286,565 | 0 | 68,438 |
| (23) MARY V PHIPPS<br>DIRECTOR | 40 00<br>0 00 | | | | | X | | 229,749 | 0 | 42,490 |
| (24) ALLEN HORN MD<br>PHYSICIAN RELATIONS | 40 00 | | | | | X | | 329,291 | 0 | 3,834 |

## 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 | | | |
| (26) MARSHALL SMITH<br>.....<br>FORMER OFFICER (CEO-MONTICELLO) | 0 00<br>.....<br>0 00 | | | | | | X | 263,600 | 0 | 0 |

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# SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

## Public Charity Status and Public Support

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

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

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

**Name of the organization**
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

**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 11, 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 )

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 organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )

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

11 ☑ 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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g

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 . . . . . 7

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- 9 above or IRC section (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) |
|---|---|---|---|---|---|---|
| See Additional Data Table | | | | | | |
| | | | | | | |
| **Total** 7 | | | | | 53,652,561 | |

**Part II** **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

## Section A. Public Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ") | | | | | | |
| 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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (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 2014 (line 6, column (f) divided by line 11, column (f)) | **14** |
| 15 | Public support percentage for 2013 Schedule A, Part II, line 14 | **15** |

**16a** **33 1/3% support test—2014.** 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—2013.** 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—2014.** 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—2013.** 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 9 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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (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 2014 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 | Public support percentage from 2013 Schedule A, Part III, line 15 | 16 | |

## Section D. Computation of Investment Income Percentage

| | | | |
|---|---|---|---|
| 17 | Investment income percentage for **2014** (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 | Investment income percentage from **2013** Schedule A, Part III, line 17 | 18 | |

19a **33 1/3% support tests—2014.** 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—2013.** 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 11 of Part I If you checked 11a of Part I, complete Sections A and B If you checked 11b of Part I, complete Sections A and C If you checked 11c of Part I, complete Sections A, D, and E If you checked 11d 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 | Yes | |
| 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 | | No |
| 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 | | No |
| 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 11a or 11b in Part I, answer (b) and (c) below.* | 4a | | No |
| 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 | | No |
| 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 (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) 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 | | No |
| 7 | Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990) .* | 7 | | No |
| 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 II of Schedule L (Form 990).* | 8 | | No |
| 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 | | No |
| b | Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.*** | 9b | | No |
| c | Did a disqualified person (as defined in line 9(a)) 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 | | No |
| 10a | Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer b below.* | 10a | | No |
| 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 | | |
| 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 | | No |
| b | A family member of a person described in (a) above? | 11b | | No |
| 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 | | No |

## Part IV Supporting Organizations (continued)

### 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, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided? | 1 | | No |
| 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 | Yes | |
| 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 | | No |

### 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 | Yes | |
| **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 | Yes | |

## 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 **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) | | | |

| 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 2014 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-2014 | (iii) Distributable Amount for 2014 |
|---|---|---|---|
| 1 Distributable amount for 2014 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2014 | | | |
| a From 2009. . . . . | | | |
| b From 2010. . . . . | | | |
| c From 2011. . . . . | | | |
| d From 2012. . . . . | | | |
| e From 2013. . . . . | | | |
| f **Total** of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2014 distributable amount | | | |
| i Carryover from 2009 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2014 from Section D, line 7 $ _____ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2014 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 **Excess distributions carryover to 2015.** Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a From 2010. . . . . | | | |
| b From 2011. . . . . | | | |
| c From 2012. . . . . | | | |
| d From 2013. . . . . | | | |
| e From 2014. . . . . | | | |

**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**

| Return Reference | Explanation |
|---|---|
| PART IV, SECTION E, LINE 3B | CENTRACARE HEALTH SYSTEM, AS THE PARENT AND SOLE CORPORATE MEMBER OF EACH OF ITS SUPPORTED ORGANIZATIONS, HAS THE AUTHORITY TO APPROVE CERTAIN GOVERNANCE DECISIONS, AS OUTLINED IN EACH ORGANIZATION'S BYLAWS |
| FORM 990, SCHEDULE A, PART IV, SECTION E, LINE 3A | CENTRACARE HEALTH SYSTEM, AS THE PARENT AND SOLE CORPORATE MEMBER OF EACH OF ITS SUPPORTED ORGANIZATIONS, HAS THE AUTHORITY TO APPOINT OR ELECT A MAJORITY OF THE SUPPORTED ORGANIZATION'S BOARD OF DIRECTORS, AS OUTLINED IN EACH ORGANIZATION'S BYLAWS |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 41-1813221
**Name:** CENTRACARE HEALTH SYSTEM

**Form 990, Sch A, Part I, Line 11g - Provide the following information about the supported organization(s).**

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|---|---|---|---|---|---|---|
| | | | Yes | No | | |
| (A) ST CLOUD HOSPITAL | 410695596 | | Yes | | 38,313,970 | 0 |
| (A) CENTRACARE CLINIC | 411806657 | | Yes | | 10,004,563 | 0 |
| (B) CENTRACARE HEALTH SYSTEM - MELROSE | 411865315 | | Yes | | 1,541,305 | 0 |
| (C) CENTRACARE HEALTH SYSTEM - LONG PRAIRIE | 411924645 | | Yes | | 1,441,473 | 0 |
| (D) CENTRAL MINNESOTA EMERGENCY PHYSICIANS | 411708142 | | Yes | | 705,858 | 0 |
| (E) CENTRACARE HEALTH FOUNDATION | 411855173 | | Yes | | 124,764 | 0 |
| (F) CENTRACARE HEALTH SYSTEM - SAUK CENTRE | 452438973 | | Yes | | 1,520,628 | 0 |

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# 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

**2014**

**Open to Public Inspection**

**If the organization answered "Yes" to 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" to 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" to 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 |
|---|---|
| CENTRACARE HEALTH SYSTEM | 41-1813221 |

### 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

2 Political expenditures ▶ $ _____

3 Volunteer hours _____

### 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- |
|---|---|---|---|---|
| | | | | |
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**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) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (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 to 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? | | No | |
| 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 | | 19,386 |
| j | Total Add lines 1c through 1i | | | 19,386 |
| 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 | CCHS PAYS DUES TO SEVERAL ASSOCIATIONS AND GROUPS INCLUDING THE FOLLOWING THE MINNESOTA HOSPITAL ASSOCIATION (MHA), AMERICAN MEDICAL GROUP (AMA), AND THE AMERICAN HOSPITAL ASSOCIATION (AHA), A PORTION OF WHICH RELATES TO LOBBYING ACTIVITIES FOR FY 2015, MHA HAS DETERMINED THAT 3 9% OR $6,662 OF ITS MEMBERSHIP DUES WERE USED FOR LOBBYING PURPOSES THE AMERICAN MEDICAL GROUP HAS DETERMINED THAT 20% OR $2,850 OF ITS MEMBERSHIP DUES WERE USED FOR LOBBYING PURPOSES THE AMERICAN HOSPITAL ASSOCIATION HAD DETERMINED 22 80% OR $9,874 OF ITS MEMBERSHIP DUES ARE RELATED TO LOBBYING THE TOTAL LOBBYING EXPENSES FOR FY15 TOTALED $19,386 |
| | |
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**Part IV Supplemental Information *(continued)***

| Return Reference | Explanation |
|---|---|
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**SCHEDULE D** (Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to 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

**2014**

**Open to Public Inspection**

**Name of the organization**
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

## Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to 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" to 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, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, 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" to 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 in 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 in 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" to 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" to Form 990, Part IV, line 10.

| | | (a) Current year | (b) Prior year | (b) (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|---|
| 1a | Beginning of year balance | | | | | |
| b | Contributions | | | | | |
| c | Net investment earnings, gains, and losses | | | | | |
| d | Grants or scholarships | | | | | |
| e | Other expenditures for facilities and programs | | | | | |
| f | Administrative expenses | | | | | |
| g | End of year balance | | | | | |

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

- a Board designated or quasi-endowment ▶
- b Permanent endowment ▶
- c Temporarily restricted endowment ▶

The percentages in 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) | | |
| (ii) related organizations | 3a(ii) | | |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | | |

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' to 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 | | 8,777,911 | | 8,777,911 |
| b Buildings | | 125,994,762 | 61,930,108 | 64,064,654 |
| c Leasehold improvements | | | | |
| d Equipment | | 52,659,887 | 41,556,410 | 11,103,477 |
| e Other | | 515,449 | 22,857 | 492,592 |
| **Total.** Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶ | | | | 84,438,634 |

**Part VII** **Investments—Other Securities.** Complete if the organization answered 'Yes' to 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) FUNDS HELD BY TRUSTEE UNDER BOND INDENTURES | 12,874,438 | C |
| (B) FUNDS HELD BY BOARD FOR FUTURE PROPERTY & EQUIP REPLACEMENT/EXPANSION | 13,247,907 | C |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 12 )* ▶ | 26,122,345 | |

**Part VIII** **Investments—Program Related.** Complete if the organization answered 'Yes' to 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 |
|---|---|---|
| | | |
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| | | |
| | | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 13 )* ▶ | | |

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

| (a) Description | (b) Book value |
|---|---|
| (1) DEFERRED DEBT ACQUISITION COST | 226,949 |
| (2) DUE FROM AFFILIATED ORGANIZATIONS | 19,201,899 |
| (3) OTHER ASSETS | 12,392,613 |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total.** *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶ | 31,821,461 |

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

| 1 (a) Description of liability | (b) Book value |
|---|---|
| Federal income taxes | |
| LT SETTLEMENT RESERVES | 218,014 |
| PENSION ACCRUAL | 99,167 |
| CONTINGENT CONSIDERATION | 1,380,878 |
| DUE TO AFFILIATES | 2,322,735 |
| | |
| | |
| | |
| | |
| | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 25 )* ▶ | 4,020,794 |

**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' to Form 990, Part IV, line 12a.

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

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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

**Part XIII Supplemental Information**

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

| Return Reference | Explanation |
|---|---|
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**Part XIII Supplemental Information *(continued)***

| Return Reference | Explanation |
|---|---|
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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

# Hospitals

▶ Complete if the organization answered "Yes" to 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

**2014**

**Open to Public Inspection**

**Name of the organization**
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

## 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<br>☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities<br>☐ 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<br>☐ 100% ☐ 150% ☐ 200% ☑ Other 17500 0000000000 % | 3a | Yes | |
| 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<br>☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ % | 3b | Yes | |
| 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 | Yes | |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care? | 5c | | No |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| | Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H | | | |

**7** Financial Assistance and Certain Other Community Benefits at Cost

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | | | 330,163 | 0 | 330,163 | 0 330 % |
| b Medicaid (from Worksheet 3, column a) | | | 18,934,456 | 14,891,944 | 4,042,512 | 4 070 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 19,264,619 | 14,891,944 | 4,372,675 | 4 400 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 22,224 | 0 | 22,224 | 0 020 % |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | 12,329 | | 12,329 | 0 010 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 21,351 | | 21,351 | 0 020 % |
| j **Total.** Other Benefits | | | 55,904 | | 55,904 | 0 050 % |
| k **Total.** Add lines 7d and 7j | | | 19,320,523 | 14,891,944 | 4,428,579 | 4 450 % |

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

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

**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 2,475,646 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements | | | |

**Section B. Medicare**

| | | | |
|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 28,370,130 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 28,250,787 |
| 7 | Subtract line 6 from line 5 This is the surplus (or shortfall) | 7 | 119,343 |
| 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 MONTICELLO CANCER CENTER | RADIATION & ONCOLOGY SERVICES | 60 000 % | 0 % | 0 % |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

## Part V Facility Information

### Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? **2**

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 | | | | | | | | | | |
| | | | | | | | | | | |
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## 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** CENTRACARE HEALTH - MONTICELLO

**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 | ☑ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☑ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA 2013 | | | |
| 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 | |
| 6a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes | |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C | 6b | | No |
| 7 | Did the hospital facility make its CHNA report widely available to the public? | 7 | Yes | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| a | ☑ Hospital facility's website (list url) WWW.CENTRACARE.COM | | | |
| 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 2013 | | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes | |
| a | If "Yes" (list url) WWW.CENTRACARE.COM | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | 12a | | No |
| b | If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| c | If "Yes" to 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)*

CENTRACARE HEALTH - MONTICELLO

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

| | | | Yes | No |
|---|---|---|---|---|
| **Financial Assistance Policy (FAP)** | | | | |
| | 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 175 000000000000% and FPG family income limit for eligibility for discounted care of 250 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 | Included measures to publicize the policy 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) | | | |
| b | ☑ The FAP application form was widely available on a website (list url) WWW CENTRACARE COM | | | |
| c | ☐ A plain language summary of the FAP was widely available on a website (list url) WWW CENTRACARE COM | | | |
| 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 | ☑ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | | |
| h | ☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☑ Other (describe in Section C) | | | |
| **Billing and Collections** | | | | |
| 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 non-payment? | 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 | ☑ Actions that require a legal or judicial process | | | |
| d | ☑ Other similar actions (describe in Section C) | | | |
| e | ☐ None of these actions or other similar actions were permitted | | | |

## Part V Facility Information *(continued)*

CENTRACARE HEALTH - MONTICELLO

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

| | | | Yes | No |
|---|---|---|---|---|
| **19** | Did the hospital facility or other authorized third 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** | Yes | |
| | 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** | ☑ Actions that require a legal or judicial process | | | |
| **d** | ☑ 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 18 (check all that apply) | | | |
| **a** | ☐ Notified individuals of the financial assistance policy on admission | | | |
| **b** | ☑ Notified individuals of the financial assistance policy prior to discharge | | | |
| **c** | ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| **d** | ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| **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) | | | |
| **Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)** | | | | |
| **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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| **b** | ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| **c** | ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| **d** | ☑ Other (describe in Section C) | | | |
| **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** CENTRACARE HEALTH - PAYNESVILLE

**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 | Yes | |
| **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 | | No |
| | 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** | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| **j** | ☐ Other (describe in Section C) | | | |
| **4** | Indicate the tax year the hospital facility last conducted a CHNA 20 ___ | | | |
| **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 | | |
| **6a** | 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 | | |
| **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 | | |
| **7** | Did the hospital facility make its CHNA report widely available to the public? | 7 | | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply) | | | |
| **a** | ☐ Hospital facility's website (list url) _____ | | | |
| **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 | | |
| **9** | Indicate the tax year the hospital facility last adopted an implementation strategy 20 ___ | | | |
| **10** | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | | |
| **a** | If "Yes" (list url) _____ | | | |
| **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" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | | |
| **c** | If "Yes" to 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)*

CENTRACARE HEALTH - PAYNESVILLE

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

| | | | Yes | No |
|---|---|---|---|---|
| **Financial Assistance Policy (FAP)** | | | | |
| | 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 175 000000000000% and FPG family income limit for eligibility for discounted care of 250 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 | Included measures to publicize the policy 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) | | | |
| b | ☑ The FAP application form was widely available on a website (list url) WWW CENTRACARE COM | | | |
| c | ☐ A plain language summary of the FAP was widely available on a website (list url) WWW CENTRACARE COM | | | |
| 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 | ☑ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | | |
| h | ☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☑ Other (describe in Section C) | | | |
| **Billing and Collections** | | | | |
| 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 non-payment? | 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 | ☑ Actions that require a legal or judicial process | | | |
| d | ☑ Other similar actions (describe in Section C) | | | |
| e | ☐ None of these actions or other similar actions were permitted | | | |

## Part V Facility Information *(continued)*

CENTRACARE HEALTH - PAYNESVILLE

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

| | | | Yes | No |
|---|---|---|---|---|
| **19** | Did the hospital facility or other authorized third 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** | Yes | |
| | 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** | ☑ Actions that require a legal or judicial process | | | |
| **d** | ☑ 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 18 (check all that apply) | | | |
| **a** | ☐ Notified individuals of the financial assistance policy on admission | | | |
| **b** | ☑ Notified individuals of the financial assistance policy prior to discharge | | | |
| **c** | ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| **d** | ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| **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** | | No |
| | 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) | | | |
| **Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)** | | | | |
| **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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| **b** | ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| **c** | ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| **d** | ☑ Other (describe in Section C) | | | |
| **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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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 Additional Data Table | |
| | |
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| | |

**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? **8**

| | Name and address | Type of Facility (describe) |
|---|---|---|
| **1** | MONTICELLO CARE CENTER<br>1104 EAST RIVER STREET<br>MONTICELLO,MN 55362 | SKILLED NURSING FACILITY |
| **2** | MONTICELLO CLINIC<br>1001 HART BLVD STE 100<br>MONTICELLO,MN 55362 | CLINIC |
| **3** | KORONIS MANOR CARE CENTER<br>200 WEST FIRST STREET<br>PAYNESVILLE,MN 56362 | SKILLED NURSING FACILITY |
| **4** | CCH PAYNESVILLE- BELGRADE CLINIC<br>505 NELSON AVENUE<br>BELGRADE,MN 56312 | CLINIC |
| **5** | CCH PAYNESVILLE - COLD SPRING CLINIC<br>308 FIFTH AVENUE SOUTH<br>COLD SPRING,MN 56320 | CLINIC |
| **6** | CCH PAYNESVILLE - EDEN VALLEY CLINIC<br>405 MEEKER AVENUE<br>EDEN VALLEY,MN 56362 | CLINIC |
| **7** | CCH PAYNESVILLE - PAYNESVILLE CLINIC<br>200 WEST FIRST STREET<br>PAYNESVILLE,MN 56362 | CLINIC |
| **8** | CCH PAYNESVILLE - RICHMOND CLINIC<br>130 FIRST STREET NE<br>RICHMOND,MN 56368 | CLINIC |
| **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

| Form and Line Reference | Explanation |
|---|---|
| PART I, LINE 6A | CENTRACARE HEALTH SYSTEM PREPARES AN ANNUAL COMMUNITY BENEFIT REPORT THAT INCLUDES ALL RELATED ORGANIZATIONS |

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LINE 7 | THE HOSPITALS' TOTAL EXPENSES (NET OF BAD DEBT) WERE REDUCED BY OTHER OPERATING REVENUE (NET OF HER INCENTIVE REVENUE) AND ALSO BY MEDICAID SURCHARGE AND TAXES, AND THEN DIVIDED BY TOTAL PATIENT REVENUE TO DETERMINE COST TO CHARGE RATIO |

| Form and Line Reference | Explanation |
| --- | --- |
| PART I, LN 7 COL(F) | THE HOSPITALS' BAD DEBT EXPENSE WAS ESTIMATED USING THE COST TO CHARGE RATION DESCRIBED IN PART I, LINE 7 AND MULTIPLYING BY TOTAL BAD DEBTS (WHICH ARE WRITTEN OFF AT GROSS CHARGES UNLESS A SELF PAY DISCOUNT WAS TAKEN ON THE ACCOUNT PRIOR TO BEING WRITTEN OFF) |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 2 | THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 4 | THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON THE HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE, CENTRACARE FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST-DUE PATIENT BALANCES WITH COLLECTION AGENCIES SUBJECT TO THE TERMS OF CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY CENTRACARE |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 8 | THE SHORTFALL OF $185,935 IN TREATING MEDICARE PATIENTS SHOULD BE CONSIDERED A COMMUNITY BENEFIT IN ITS ENTIRETY THE HOSPITALS PROVIDE AN EXCELLENT LEVEL OF CARE TO THE PEOPLE IN THE COMMUNITIES SERVED DESPITE THE SHORTFALL IN REIMBURSEMENT FORM MEDICARE, THE HOSPITALS CONTINUES TO PROVIDE ESSENTIAL HEALTHCARE SERVICES TO THE POPULATION THE AMOUNT ON LINE 7 OF PART III WAS DETERMINED BY UTILIZING THE MEDICARE COST REPORT UTILIZING KEY SECTIONS OF THAT REPORT, PRIMARILY THE D SERIES AND E SERIES |

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 9B | THE COLLECTION POLICIES AT THE HOSPITALS REQUIRE COLLECTION STAFF TO OFFER CHARITY TO PATIENTS WHO INDICATE THAT PAYMENT MAY BE AN ISSUE IF A PATIENT DOES QUALIFY FOR FULL CHARITY, ALL OTHER COLLECTION EFFORTS MUST CEASE, IF A PATIENT QUALIFIES FOR PARTIAL CHARITY, COLLECTION EFFORTS WILL CONTINUE ON THE BALANCE OF THE ACCOUNT THESE PROVISIONS APPLY TO BOTH HOSPITAL EMPLOYED COLLECTION STAFF AND COLLECTION AGENCY STAFF NO PATIENTS, WHETHER THEY QUALIFY FOR CHARITY OR NOT, ARE REPORTED TO CREDIT RATING AGENCIES |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 2 | THE ORGANIZATIONS' STRATEGIC PLANNING ASSESSES THE NEEDS OF THE COMMUNITY AND PATIENTS THROUGH PATIENT SATISFACTION SURVEYS, COMMENT CARDS, COMMUNITY ASSESSMENTS AND A DIVERSE OPERATING COMMITTEE THAT REPRESENTS THE COMMUNITY AND BRINGS TO THE TABLE ISSUES, CONCERNS AND RECOMMENDATIONS FOR HEALTH CARE SERVICES |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 3 | INPATIENTS WHO ARE SELF PAY ARE IDENTIFIED, AND A REPRESENTATIVE OF MONTICELLO'S OR PAYNESVILLE'S BILLING DEPARTMENT EXPLAINS THE CHARITY CARE POLICY TO PATIENTS THEY ALSO EXPLAIN THE SELF PAY DISCOUNT AND SCREENS THE PATIENT FOR ELIGIBILITY FOR ANY STATE OR FEDERAL PROGRAMS THEY ALSO ASSIST THE PATIENT WITH ANY PAPERWORK REQUIRED TO APPLY FOR SUCH PROGRAMS OUTPATIENTS WHO ARE SELF PAY RECEIVE AN AUTOMATIC SELF PAY DISCOUNT IF THE PATIENT DOES NOT REMIT PAYMENT, COLLECTION STAFF ATTEMPT TO REACH THE PATIENT BY PHONE PATIENTS ARE TOLD ABOUT THE CHARITY PROGRAM FOR BOTH INPATIENTS AND OUTPATIENTS, ALL STATEMENTS CONTAIN A LETTER REGARDING THE AVAILABILITY OF CHARITY CARE ALSO ALL PRECOLLECTION LETTERS HAVE THIS SAME LANGUAGE INDICATING THE AVAILABILITY AND PROCESS OF OBTAINING CHARITY CARE |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 4 | CENTRACARE HEALTH - MONTICELLO IS LOCATED IN CENTRAL MINNESOTA IN WRIGHT COUNTY THE 2010 CENSUS SHOWS A POPULATION OF 11,553 WHICH WAS A 46 84% INCREASE OVER THE 2000 FIGURE OF 7,867 THIS AREA OF THE STATE IS SHOWING A SIGNIFICANT INCREASE IN POPULATION AND IS EXPECTED TO CONTINUE INTO THE FUTURE THE AGE DEMOGRAPHICS OF THE REGION ARE AS FOLLOWS 0-5 13 34% 6-11 10 95%, 12 TO 17 10 01%, 18 TO 24 9 17%, 25-34 18 61%, 35-44 13 77%, 45-54 10 01%, 55-64 6 73%, 65-74 3 38%, 75-84 2 50%, 85+ 1 54% THE 2010 CENSUS DATA ETHNICITY BREAKDOWN FOR MONTICELLO, MN WAS AS FOLLOWS CAUCASIAN 92 47%, HISPANIC 3 54%, ASIAN 1 06%, AFRICAN AMERICAN 1 03%, OTHER 3 6% CENTRACARE HEALTH - PAYNESVILLE IS LOCATED IN CENTRAL MINNESOTA IN STEARNS COUNTY THE 2010 CENSUS SHOWS A POPULATION OF 2,115 WHICH WAS A 6 70% DECREASE OVER THE 2000 FIGURE OF 2,267 THIS AREA OF THE STATE IS SHOWING A SLIGHT DECREASE IN POPULATION AND IS EXPECTED TO CONTINUE INTO THE FUTURE THE AGE DEMOGRAPHICS OF THE REGION ARE AS FOLLOWS 0-5 8 04% 6-11 7 14%, 12 TO 17 8 89%, 18 TO 24 7 85%, 25-34 10 07%, 35-44 11 49%, 45-54 13 19%, 55-64 12 53%, 65-74 8 18%, 75-84 3 91%, 85+ 4 87% THE 2010 CENSUS DATA ETHNICITY BREAKDOWN FOR PAYNESVILLE, MN WAS AS FOLLOWS CAUCASIAN 97 21%, HISPANIC 2 32%, ASIAN 38%, AND AFRICAN AMERICAN 09% |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 | THE ORGANIZATION PROMOTES THE HEALTH OF THE COMMUNITY IN SEVERAL IMPORTANT WAYS ONE OF THESE WAYS IS THROUGH THE COMMUNITY COLLABORATION COMMITTEE (CCC), A STANDING COMMITTEE OF THE CENTRACARE HEALTH FOUNDATION THE CCC HAS A MEMBERSHIP OF OVER 30 PERSONS REPRESENTING HEALTHCARE AND COMMUNITY NEEDS ACROSS CENTRAL MINNESOTA THE CCC MEETS MONTHLY TO DISCUSS WAYS TO ADDRESS TYPICAL HEALTH ISSUES THROUGH AWARENESS BUILDING, EDUCATION AND/OR AN INTERVENTION PROJECT THERE ARE SEVERAL COMMUNITY HEALTH OUTREACH INITIATIVES THAT THE FOUNDATION IS INVOLVED WITH THESE INITIATIVES INCLUDE 1) BLEND CHILDHOOD OBESITY COALITION OF CENTRAL MINNESOTA (GOAL IS TO REDUCE THE INCIDENCE OF CHILDHOOD OBESITY BY 2016), 2) SMOKE FREE COMMUNITIES (CONTINUED EFFORTS TO CREATE CLEAN INDOOR AND OUTDOOR AIR FOR ALL), 3) TOBACCO CESSATION SERVICES CLINICS (COLLABORATION WITH CLINIC, 4) CENTRACARE CLINIC TEAM BASED CARE PILOT, 5) ST CLOUD HOSPITAL - TRANSITION OF CARE PILOT (CREATE MORE SEAMLESS INTEGRATION FROM CARE SETTING TO CARE SETTING, AND 6) CLINIC - DIVERSITY AND CULTURAL COMPETENCY TRAINING |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 6 | THE ORGANIZATION IS PART OF CENTRACARE HEALTH SYSTEM (CCHS) WHICH PROVIDES A BROAD RANGE OF HEALTH CARE SERVICES TO THE PATIENTS OF CENTRAL MINNESOTA CCHS IS DEDICATED TO IMPROVING THE HEALTH OF PEOPLE LIVING AND WORKING IN THE COMMUNITIES IT SERVES TO ACCOMPLISH ITS GOALS IT WORKS ACTIVELY WITH ITS AFFILIATE HEALTH CARE ORGANIZATIONS CCHS CONTINUES TO FOCUS ON PROVIDING THE BEST CARE POSSIBLE AND IN REINVESTING INTO THE COMMUNITY CCHS ALSO PROMOTES WELLNESS BY SPONSORING PROGRAMS AND EVENTS IN LOCAL COMMUNITIES THAT FOCUS ON HEALTHY EATING AND EXERCISE, AND BY CONDUCTING SCREENINGS FOR CONDITIONS SUCH AS HIGH BLOOD PRESSURE |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 7, REPORTS FILED WITH STATES | MN |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 41-1813221
**Name:** CENTRACARE HEALTH SYSTEM

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

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

| Form and Line Reference | Explanation |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 3J CCH'S CHNA PROCESS ALSO CONSIDERED SECONDARY DATA FROM THE DARTMOUTH ATLAS, ROBERT WOOD JOHNSON, MINNESOTA DEPARTMENT OF HEALTH, US CENSUS BUREAU, MINNESOTA HOSPITAL ASSOCIATION, ST CLOUD AREA UNITED WAY, CATHOLIC CHARITIES OF THE DIOCESE OF ST CLOUD, MINNESOTA SENIOR FEDERATION, PUBLIC HEALTH DEPARTMENTS FROM APPROPRIATE COUNTIES AND ADDITIONAL FEDERAL AND STATE ENTITIES THE CHNA WAS INFORMED BY A COLLABORATIVE AND ONGOING COMMUNITY HEALTH SURVEY JOINTLY FUNDED AND MANAGED WITH A NUMBER OF AREA COUNTIES WHO WERE JOINTLY CONDUCTING COMMUNITY SURVEYS TO INFORM THEIR COMMUNITY HEALTH ASSESSMENTS IN SUPPORT OF DEVELOPMENT OF THEIR COMMUNITY HEALTH IMPROVEMENT PLANS LACK OF CURRENT PUBLIC HEALTH DATA WAS A SIGNIFICANT INFORMATION GAP IN THE CHNA AS THE SURVEY COULD NOT BE COMPLETED IN TIME TO INCLUDE ITS DATA IN THE CCH CHNA CCH HAS COMMITTED TO A CONTINUING EFFORT WITH PUBLIC HEALTH OFFICIALS TO JOINTLY DEVELOP PRIORITIES WITH THE COUNTIES AS A PART OF ITS ACTION PLANS |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 3J CENTRACARE HEALTH - PAYNESVILLE BECAME PART OF THE CENTRACARE HEALTH SYSTEM (CCHS) GROUP ON OCTOBER 1, 2013 CCHS CONDUCTED ITS MOST RECENT CHNA JOINTLHY WITH ALL OF ITS 501(C)(3) HOSPITALS AS OF THE END OF ITS FISCAL YEAR 2013 (6/30/2013) BECAUSE PAYNESVILLE WAS NOT PART OF THE CCH GROUP AS OF 6/30/2013 IT WAS NOT INCLUDED IN THE MOST RECENT CHNA PAYNESVILLE WILL CONDUCT ITS FIRST COMMUNITY HEALTH NEEDS ASSESSMENT IN FY 2016 |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 5 IN ADDITION TO MAKING ITS CHNA AVAILABLE TO THE PUBLIC ON ITS WEB SITE AND AT ITS BUSINESS OFFICE, CCH HAS SHARED COPIES OF THE CHNA WITH COUNTY PUBLIC HEALTH OFFICIALS AND, INTERNALLY, WITH INDIVIDUALS WORKING ON QUALITY IMPROVEMENT AND COMMUNITY HEALTH INITIATIVES CCH HAS ALSO PUBLISHED CONTACT INFORMATION FOR ITS DIRECTOR OF COMMUNITY & GOVERNMENT RELATIONS TO RESPOND TO QUESTIONS OR CONCERNS ABOUT THE CHNA THE DIRECTOR HAS ALSO PRESENTED RESULTS OF THE CHNA TO COMMUNITY GROUPS AND TO REPRESENTATIVES OF LOCAL FUNDING GROUPS |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 6A CCH CONDUCTED ITS CHNA JOINTLY WITH ALL OF ITS 501(C)(3) HOSPITALS AS OF THE END OF ITS FISCAL 2013 THOSE FACILITIES INCLUDED ST CLOUD HOSPITAL, CENTRACARE HEALTH - MELROSE, CENTRACARE HEALTH - LONG PRAIRIE AND CENTRACARE HEALTH - SAUK CENTRE EACH HOSPITAL PREPARED INDIVIDUAL ACTION PLANS TO THE CHNA BASED ON SPECIFIC INPUT FROM THOSE COMMUNITIES |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 7D IN ADDITION TO MAKING ITS CHNA AVAILABLE TO THE PUBLIC ON ITS WEB SITE AND AT ITS BUSINESS OFFICE, CCH HAS SHARED COPIES OF THE CHNA WITH COUNTY PUBLIC HEALTH OFFICIALS AND, INTERNALLY, WITH INDIVIDUALS WORKING ON QUALITY IMPROVEMENT AND COMMUNITY HEALTH INITIATIVES CCH HAS ALSO PUBLISHED CONTACT INFORMATION FOR ITS DIRECTOR OF COMMUNITY & GOVERNMENT RELATIONS TO RESPOND TO QUESTIONS OR CONCERNS ABOUT THE CHNA THE DIRECTOR HAS ALSO PRESENTED RESULTS OF THE CHNA TO COMMUNITY GROUPS AND TO REPRESENTATIVES OF LOCAL FUNDING GROUPS |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 2 EFFECTIVE OCTOBER 1, 2013, CENTRACARE AND PAYNESVILLE AREA HEALTH CARE SYSTEM EXECUTED A LEASE AND AFFILIATION AGREEMENT AND FORMED CENTRACARE HEALTH - PAYNESVILLE, LLC (DBA CCH - PAYNESVILLE), A MINNESOTA LIMITED LIABILITY COMPANY WITH CENTRACARE AS ITS SOLE MEMBER |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 11 THE NEEDS IDENTIFIED BY THE CHNA ARE CURRENTLY IN ORGANIZATIONAL WORK PLANS AND ARE UNDER IMPLEMENTATION TO PRIORITIZE IDENTIFIED NEEDS, CHNA ADVISORY TASK FORCE MEMBERS DEVISED A SET OF CRITERIA THE CRITERIA USED WERE COMMUNITY IMPACT, POTENTIAL FOR CHANGE, ECONOMIC FEASIBILITY, COMMUNITY ASSETS, AND VALUE AND MISSION THE PRIORITIZATION PROCESS IDENTIFIED THE FOLLOWING SIX, BROAD COMMUNITY HEALTH ISSUES 1 - ACCESS TO PRIMARY CARE2 - CULTURALLY COMPETENT CARE3 - HEART DISEASE MORBIDITY AND MORTALITY (PRIMARILY IN BENTON COUNTY)4 - LINGUISTICALLY COMPETENT CARE5 - MENTAL HEALTH SERVICES6 - STROKE MORBIDITY AND MORTALITY (PRIMARILY BENSON COUNTY) ST CLOUD HOPSITAL WILL MAITAIN ITS ENGAGEMENTS WITH THE CHNA ADVISORY TASK FORCE TO ENSURE EFFECTIVE COLLABORATION AND COMMUNICATION WITH THE OTHER CENTRACARE HOSPITALS THE CHNA ADVISORY TASK FORCE WILL CONTINUE TO MEET DURING THE THREE-YEAR PERIOD IN WHICH THE IMPLEMENTATION STRATEGY WILL UNFOLD DURING THIS TIME THE GROUP WILL - IDENTIFY WHAT OTHER COMMUNITY ORGANIZATIONS ARE DOING IN REGARD TO HEALTH PRIORITY AREAS,- DEVELOP SPECIFIC GOALS AND METRICS TO MONITOR AND MEASURE PROGRESS AND OUTCOMES,- COMMUNICATE SHORT-TERM AND LONG-TERM RESULTS OF ACTION PLANS WITHIN THE COMMUNITY BASED ON THE FINDINGS AND PRIORITIES ESTABLISHED BY THE CHNA, AND AFTER HAVING REVIEWED THE COMMUNITY BENEFITS ACTIVITIES THAT CURRENTLY EXIST, ST CLOUD HOSPITAL WILL CONTINUE TO SUPPORT THE SYSTEM-WIDE INITIATIVES OUTLINED BELOW AND WILL PARTICIPATE IN LOCALIZED ADAPTIONS (AS DESCRIBED IN THE ACTION STEPS) OF THESE PROGRAMS WITH REGARD TO THE SPECIFIC NEEDS OF THE COMMUNITY SERVED BY THE HOSPITAL TO SEE THE SPECIFIC ACTION PLAN FOR EACH OF THE SIX PRIORITY HEALTH AREAS SEE THE FULL IMPLEMENTATION STRATEGY FOR FISCAL YEAR 2013 - 2015 LOCATED ON THE WEBSITE AT WWW CENTRACARE COM/APP/FILES/PUBLIC/1547/IMPLEMENTATION-STRATEGY PER GUIDANCE FROM THE IRS, REGULATION 1 501(R)-3(C), THE CHNA FOR CCH ELECTED NOT TO DIRECTLY ADDRESS SEVERAL DETERMINANTS OF HEALTH THAT IT IDENTIFIED IN ITS PROCESS WHICH WERE NOT WITHIN THE ORGANIZATION'S CAPABILITIES OR CORE COMPETENCIES EXAMPLES OF ISSUES NOT SPECIFICALLY ADDRESSED IN THE CHNA ACTION PLANS INCLUDE HIGH SCHOOL GRADUATION RATES, AFFORDABLE HOUSING OR SUPPORTED HOUSING (CCH DID SUPPORT AN EFFORT OF THE CITY OF ST CLOUD TO CONDUCT A HOUSING ASSESSMENT AS A RESULT OF THE CHNA PROCESS AND IS ALREADY THE LARGEST AREA PROVIDER OF SUPPORTED HOUSING DUE TO ITS EXTENSIVE CHEMICAL DEPENDENCY PROGRAMS AND SENIOR HOUSING PROGRAMS ) |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 16I PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE CHARITY CARE INFORMATION EITHER VIA A TELEPHONE CALL OR A LETTER |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 16I PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE CHARITY CARE INFORMATION EITHER VIA A TELEPHONE CALL OR A LETTER |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 18D THE ORGANIZATION EMPLOYS THE USE OF COLLECTION AGENCIES TO COLLECT A PATIENT'S BALANCE AFTER THOSE EFFORTS ARE EXHAUSTED, THE ORGANIZATION DOES UTILIZE LAWSUITS AND LIENS ON RESIDENCES AS WELL |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 18D THE ORGANIZATION EMPLOYS THE USE OF COLLECTION AGENCIES TO COLLECT A PATIENT'S BALANCE AFTER THOSE EFFORTS ARE EXHAUSTED, THE ORGANIZATION DOES UTILIZE LAWSUITS AND LIENS ON RESIDENCES AS WELL |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 19D THE ORGANIZATION CONTRACTS WITH SEVERAL COLLECTION AGENCIES TO ATTEMPT TO COLLECT PATIENT BALANCES |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 19D THE ORGANIZATION CONTRACTS WITH SEVERAL COLLECTION AGENCIES TO ATTEMPT TO COLLECT PATIENT BALANCES |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 20E OUR CREDIT COLLECTION AGENCIES ARE REQUIRED TO PROVIDE CHARITY CARE INFORMATION AS PART OF THEIR COLLECTION PROCESS PRIOR TO ANY CONSIDERATION OF LEGAL ACTION AGAINST A PATIENT |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 20E OUR CREDIT COLLECTION AGENCIES ARE REQUIRED TO PROVIDE CHARITY CARE INFORMATION AS PART OF THEIR COLLECTION PROCESS PRIOR TO ANY CONSIDERATION OF LEGAL ACTION AGAINST A PATIENT |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | PART V, SECTION B, LINE 22D PER AGREEMENT WITH THE MINNESTOA ATTORNEY GENERAL, THE ORGANIZATION PROVIDES A DISCOUNT TO THE UNINSURED EQUAL TO THE AVERAGE DISCOUNT OF OUR LARGEST (BY VOLUME) NON-GOVERNMENTAL PAYOR |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE | PART V, SECTION B, LINE 22D PER AGREEMENT WITH THE MINNESTOA ATTORNEY GENERAL, THE ORGANIZATION PROVIDES A DISCOUNT TO THE UNINSURED EQUAL TO THE AVERAGE DISCOUNT OF OUR LARGEST (BY VOLUME) NON-GOVERNMENTAL PAYOR |

**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 |
|---|---|
| PART V, SECTION B, LINE 16 | FINANCIAL ASSISTANCE POLICY WEBSITE AVAILABILITY |

**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 |
|---|---|
| CENTRACARE HEALTH - MONTICELLO PART V, SECTION B, LINE 16B WEBSITE | WWW CENTRACARE COM |

**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 |
|---|---|
| CENTRACARE HEALTH - PAYNESVILLE PART V, SECTION B, LINE 16B WEBSITE | WWW CENTRACARE COM |

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**Schedule J** (Form 990)

Department of the Treasury
Internal Revenue Service

# Compensation Information

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

▶ **Complete if the organization answered "Yes" to 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

**2014**

**Open to Public Inspection**

Name of the organization
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

## 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 in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items<br>☐ First-class or charter travel ☐ Housing allowance or residence for personal use<br>☐ Travel for companions ☐ Payments for business use of personal residence<br>☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees<br>☐ 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** | | |
| **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<br>☑ Compensation committee ☑ Written employment contract<br>☑ Independent compensation consultant ☑ Compensation survey or study<br>☑ Form 990 of other organizations ☑ Approval by the board or compensation committee | | | |
| **4** | During the year, did any person listed in 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** | Yes | |
| **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 in 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," to line 5a or 5b, describe in Part III | | | |
| **6** | For persons listed in 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** | Yes | |
| | If "Yes," to line 6a or 6b, describe in Part III | | | |
| **7** | For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III | **7** | | No |
| **8** | Were any amounts reported in 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" to 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 in 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 in 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, LINES 4A-B | MARSHALL SMITH, FORMER CEO OF MONTICELLO HOSPITAL, RECEIVED A $260,000 SEVERANCE PAYMENT IN 2014 THE CORPORATIONS' EXECUTIVES ARE ELIGIBLE TO PARTICIPATE IN BENEFIT PLANS WHICH INCLUDE TAX DEFERRRED NON-QUALIFIED INVESTMENT ACCOUNTS THESE PLANS MAY PROVIDE, BUT ARE NOT CERTAIN TO PROVIDE, FOR PAYMENT OF TAX DEFERRED COMPENSATION TO THESE EXECUTIVES AT SOME TIME IN THE FUTURE THE EXECUTIVE HAS NO LEGAL RIGHT TO THESE DOLLARS UNTIL, AND UNLESS, CERTAIN FUTURE EVENTS OCCUR IN ACCORDANCE WITH THE INSTRUCTIONS TO THE FORM 990, THE AMOUNTS LISTED IN SECTION VII AND IN SCHEDULE J REFLECT THIS TAX DEFERRED COMPENSATION THIS COMPENSATION IS POTENTIALLY REPORTED TWICE ON THE FORM 990 ONCE WHEN THE COMPENSATION IS DEFERRED OR ACCRUED AND AGAIN IF IT IS PAID TO THE EXECUTIVE THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE NON-QUALIFIED PLAN TERENCE R PLADSON - PAID $151,734, ACCRUED $223,433 GREGORY R KLUGHERZ - PAID $87,558, ACCRUED $104,953 PAUL R HARRIS - PAID $34,588, ACCRUED $52,699 GERRY G GILBERTSON - PAID $33,701, ACCRUED $22,113 DANIEL J SWENSON - PAID $14,331, ACCRUED $21,593 MARK J LARKIN - PAID $12,867, ACCRUED $23,259 DELANO A CHRISTIANSON - PAID $0, ACCRUED $21,396 MARY ELLEN WELLS - PAID $0, ACCRUED $40,645 DENNIS C MILEY - PAID $0, ACCRUED $42,809 JOSEPH D HELLIE - PAID $0, ACCRUED $18,015 ALLEN HORN, MD - PAID $210,009, ACCRUED $0 |
| PART I, LINE 6 | THE ORGANIZATION PROVIDES INCENTIVE COMPENSATION TO DESIGNATED INDIVIDUALS BASED ON FOUR DISCRETE AREAS A COMPARISON BETWEEN BUDGETED AND ACTUAL NET OPERATING INCOME FOR CENTRACARE CLINIC OR CENTRACARE HEALTH SYSTEM, ACHIEVEMENT OF IMPROVEMENT IN PATIENT SATISFACTION GOALS AS COMPARED TO NATIONAL AND BASELINE RANKINGS, ACHIEVEMENT OF IMPROVEMENT IN OVERALL EMPLOYMENT ENGAGEMENT SCORES, AND ACHIEVEMENT OF UP TO THREE INDIVIDUAL GOALS WHICH ARE TIED TO THE CENTRACARE SYSTEM'S STRATEGIC PLAN THE INCENTIVE COMPENSATION PAID OUT IS NOT A PORTION OR PERCENTAGE OF ACTUAL NET EARNINGS OF ANY CENTRACARE HEALTH SYSTEM AFFILIATE, HOWEVER NET EARNINGS GOALS ARE REQUIRED TO BE MET BEFORE INCENTIVE COMPENSATION IS PAID |

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 41-1813221
**Name:** CENTRACARE HEALTH SYSTEM

### 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 (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable 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 in prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| TERENCE R PLADSON MD, PRESIDENT/CEO | (I) | 876,657 | 199,174 | 172,292 | 242,933 | 20,998 | 1,512,054 | 151,734 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| THOMAS W LEITHER MD, DIRECTOR & SURGEON | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 355,795 | 56,285 | 2,541 | 19,164 | 24,978 | 458,763 | 0 |
| ROBERT STOCKER MD, DIRECTOR & OB/GYN | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 531,441 | 100,578 | 3,059 | 19,500 | 754 | 655,332 | 0 |
| GREGORY R KLUGHERZ, TREASURER/CFO | (I) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (II) | 442,053 | 87,461 | 112,888 | 120,553 | 20,175 | 783,130 | 87,558 |
| PAUL R HARRIS, CORPORATE SECRETARY | (I) | 331,254 | 62,700 | 37,658 | 66,572 | 35,552 | 533,736 | 34,588 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GERRY G GILBERTSON, ADMINISTRATOR-MELROSE | (I) | 172,933 | 30,799 | 53,683 | 34,166 | 24,484 | 316,065 | 33,701 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DANIEL J SWENSON, ADMINISTRATOR-LONG PRAIRIE | (I) | 190,266 | 36,574 | 16,346 | 32,336 | 25,182 | 300,704 | 14,331 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DELANO A CHRISTANSON, ADMINISTRATOR - SAUK CENTR | (I) | 179,415 | 29,216 | 3,539 | 37,440 | 27,105 | 276,715 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARY E WELLS, ADMINISTRATOR - MONTICELLO | (I) | 225,191 | 42,750 | 4,138 | 46,133 | 9,669 | 327,881 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| JOSEPH D HELLIE, VICE PRESIDENT | (I) | 197,385 | 22,167 | 2,027 | 28,123 | 26,589 | 276,291 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DENNIS C MILEY, ADMINISTRATOR-PAYNESVILLE | (I) | 200,163 | 28,899 | 3,319 | 48,004 | 14,175 | 294,560 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| JOSEPH M BLONSKI MD, PHYSICIAN | (I) | 285,622 | 2,816 | 10,878 | 19,203 | 22,751 | 341,270 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARK J LARKIN, VICE PRESIDENT OF DEVELOPMENT | (I) | 227,329 | 44,096 | 15,140 | 41,871 | 30,642 | 359,078 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARY V PHIPPS, DIRECTOR | (I) | 202,486 | 18,208 | 9,055 | 16,924 | 26,053 | 272,726 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ALLEN HORN MD, PHYSICIAN RELATIONS | (I) | 117,775 | 1,506 | 210,010 | 3,708 | 129 | 333,128 | 210,009 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MARSHALL SMITH, FORMER OFFICER (CEO-MONTICELLO) | (I) | 0 | 0 | 263,600 | 0 | 0 | 263,600 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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**Schedule K (Form 990)**

Department of the Treasury
Internal Revenue Service

# Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part 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

**2014**

**Open to Public Inspection**

Name of the organization
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

## 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 | THE CITY OF ST CLOUD | 41-6005515 | 78916VBB5 | 08-10-2009 | 201,078,369 | HEALTH CARE REVENUE BONDS 2008D | | X | | X | | X |
| B | THE CITY OF ST CLOUD | 41-6005515 | 78916VBX7 | 02-03-2010 | 187,558,690 | HEALTH CARE REVENUE BONDS 2010AB | | X | | X | | X |
| C | THE CITY OF ST CLOUD | 41-6005515 | | 12-28-2011 | 10,000,000 | HEALTH CARE REVENUE BONDS 2011A | | X | | X | | X |
| D | THE CITY OF ST CLOUD | 41-6005515 | | 12-28-2011 | 31,445,000 | HEALTH CARE REVENUE BONDS 2011B | | X | | X | | X |

## Part II Proceeds

| | | A | B | C | D |
|---|---|---|---|---|---|
| 1 | Amount of bonds retired | 121,425,000 | 47,760,000 | | |
| 2 | Amount of bonds legally defeased | | | | |
| 3 | Total proceeds of issue | 201,078,369 | 187,558,690 | 10,000,000 | 31,445,000 |
| 4 | Gross proceeds in reserve funds | 1,408,277 | 11,776,763 | | |
| 5 | Capitalized interest from proceeds | | | | |
| 6 | Proceeds in refunding escrows | | | | |
| 7 | Issuance costs from proceeds | 1,954,596 | 2,076,662 | 150,000 | |
| 8 | Credit enhancement from proceeds | | | | |
| 9 | Working capital expenditures from proceeds | | | | |
| 10 | Capital expenditures from proceeds | 192,377,062 | | 9,850,000 | |
| 11 | Other spent proceeds | | | | 31,445,000 |
| 12 | Other unspent proceeds | | | | |
| 13 | Year of substantial completion | 2013 | 2010 | 2015 | 2012 |

| | | 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 | | | X | X | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | X | | X | | X | | X |
| 16 | Has the final allocation of proceeds been made? | X | | X | | | X | X | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | X | | X | |

## Part III Private Business Use

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

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

| | | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 3a | Are there any management or service contracts that may result in private business use of bond-financed property? | | X | | X | | 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? | | | | | | | | |
| c | Are there any research agreements that may result in private business use of bond-financed property? | X | | X | | 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 | | 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 % | | 0 % | | 1 470 % | | 0 630 % | |
| 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 ▶ | 0 400 % | | 2 060 % | | 0 % | | 0 % | |
| 6 | Total of lines 4 and 5 | 0 400 % | | 2 060 % | | 1 470 % | | 0 630 % | |
| 7 | Does the bond issue meet the private security or payment test? | | X | | X | | 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 | | 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 | | 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 | | X | | X |
| 2 | If "No" to line 1, did the following apply? | | | | | | | | |
| a | Rebate not due yet? | | X | | X | X | | X | |
| b | Exception to rebate? | | X | | X | | X | | X |
| c | No rebate due? | X | | X | | | 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 | | X | | X |
| 4a | Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | X | | X | | 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 | | 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 | | X | | X |
| 7 | Has the organization established written procedures to monitor the requirements of section 148? | X | | X | | 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 | | 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 THE CITY OF ST CLOUD DATE THE REBATE COMPUTATION WAS PERFORMED 07/08/2014 ISSUER NAME THE CITY OF ST CLOUD DATE THE REBATE COMPUTATION WAS PERFORMED 06/20/2014 |

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# Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

## Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part 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

**2014**

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

## 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 | THE CITY OF ST CLOUD | 41-6005515 | 78916VCZ1 | 11-19-2014 | 48,876,925 | HEALTH CARE REVENUE BONDS 2014B | | X | | X | | X |
| B | THE CITY OF ST CLOUD | 41-6005515 | | 08-01-2014 | 128,310,000 | HEALTH CARE REVENUE BONDS 2014B | | X | | X | | X |

## Part II Proceeds

| | | A | B | C | D |
|---|---|---|---|---|---|
| 1 | Amount of bonds retired | | | | |
| 2 | Amount of bonds legally defeased | | | | |
| 3 | Total proceeds of issue | 48,876,925 | 128,310,000 | | |
| 4 | Gross proceeds in reserve funds | | | | |
| 5 | Capitalized interest from proceeds | | | | |
| 6 | Proceeds in refunding escrows | | | | |
| 7 | Issuance costs from proceeds | 550,981 | | | |
| 8 | Credit enhancement from proceeds | | | | |
| 9 | Working capital expenditures from proceeds | | | | |
| 10 | Capital expenditures from proceeds | | 1,643,396 | | |
| 11 | Other spent proceeds | 48,325,944 | 11,331,000 | | |
| 12 | Other unspent proceeds | | 13,356,603 | | |
| 13 | Year of substantial completion | 2010 | | | |

| | | 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? | | | | | | | | |
| 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 % | | 0 % | | | | |
| 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 ▶ | | 2 210 % | | 0 560 % | | | | |
| 6 | Total of lines 4 and 5 | | 2 210 % | | 0 560 % | | | | |
| 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 | | | | | | | |

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

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

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

**Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.**
**▶ Attach to Form 990 or 990-EZ.**
**▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

**2014**

**Open to Public Inspection**

| Name of the organization | Employer identification number |
|---|---|
| CENTRACARE HEALTH SYSTEM | 41-1813221 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 11 | |
| FORM 990, PART VI, SECTION B, LINE 12C | THE BOARD MEMBERS ARE REQUIRED TO REVIEW AND SIGN A CONFLICT OF INTEREST QUESTIONNAIRE TWI CE A YEAR ALL STAFF SIGN CONFLICTS OF INTEREST FORMS ON AN ANNUAL BASIS THE QUESTIONNAIR ES ARE REVIEWED BY THE CORPORATE COMPLIANCE OFFICER AS WELL AS THE CORPORATE COMPLIANCE GR OUP (A COMPLIANCE COMMITTEE WHICH INCLUDES INTERNAL MEMBERS AND OUTSIDE COUNSEL) THE RESP ONSES TO THE QUESTIONNAIRES ARE THEN REVIEWED WITH THE EXECUTIVE COMMITTEE OF THE BOARD T HE CORPORATE COMPLIANCE OFFICER IS RESPONSIBLE FOR MONITORING CONFLICTS OF INTERESTS RELAT ED TO BOARD AND STAFF AND TO ALERT AFFECTED PARTIES WHEN A CONFLICT ARISES WHEN AN ACTUAL CONFLICT ARISES, THE AFFECTED PARTY IS ASKED TO RECUSE HIM/HER SELF FROM THE DECISION MAK ING PROCESS THE CORPORATE COMPLIANCE OFFICER ATTENDS BOARD MEETINGS AND SPECIFIED BOARD C OMMITTEE MEETINGS WHERE CONFLICT ISSUES MAY ARISE. |
| FORM 990, PART VI, SECTION B, LINE 15 | THE COMPENSATION AND BENEFITS OF THE PRESIDENT AND THE VICE PRESIDENTS (NON-MEDICAL PROVID ERS) ARE SUBJECT TO FULL COMPENSATION AND BENEFITS COMPARABILITY STUDIES CONDUCTED BIENNIA LLY BY A THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT HOWEVER, THE COMPENSATION PORTIO N OF THE STUDY IS REVIEWED ANNUALLY BY THE CONSULTANT AND UPDATED FOR COMPENSATION COMMITT EE AND BOARD OF DIRECTORS REVIEW AND APPROVAL |
| FORM 990, PART VI, SECTION C, LINE 19 | GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE NOT REQUIRE D BY LAW TO BE MADE AVAILABLE TO THE PUBLIC AND CENTRACARE HEALTH SYSTEM DOES NOT MAKE THE M AVAILABLE |
| FORM 990, PART IX, LINE 11G | MISCELLANEOUS PROGRAM SERVICE EXPENSES 12,917,128 MANAGEMENT AND GENERAL EXPENSES 1,244, 174 FUNDRAISING EXPENSES 62,932 TOTAL EXPENSES 14,224,234 CONTRACTED SERVICES/PURCH SVC S PROGRAM SERVICE EXPENSES 7,007,722 MANAGEMENT AND GENERAL EXPENSES 689,377 FUNDRAISIN G EXPENSES 272,206 TOTAL EXPENSES 7,969,305 |
| FORM 990, PART XI, LINE 9 | PENSION PLAN ADJUSTMENT -9,444 NET EQUITY TRANSFERS BTWN RELATED ORGS 20,289,294 CAPITAL CONTRIBUTION 43,939 NON-CONTROLLING INTEREST DISTRIBUTION -800,000 NON-CONTROLLING INTE REST NET INCOME 1,079,114 |

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# SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

**2014**

**Open to Public Inspection**

Name of the organization
CENTRACARE HEALTH SYSTEM

**Employer identification number**
41-1813221

**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)** CENTRACARE SURGERY CENTER LLC<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>61-1514974 | SURGICAL CENTER | MN | 6,076,130 | 3,072,107 | CENTRACARE HEALTH SYSTEM |
| **(2)** CENTRACARE HEALTH - MONTICELLO<br>1013 HART BLVD<br>MONTICELLO, MN 55362<br>46-1584944 | HEALTHCARE | MN | 67,505,362 | 61,332,794 | CENTRACARE HEALTH SYSTEM |
| **(3)** CENTRACARE HEALTH - PAYNESVILLE<br>200 W200 WEST FIRST STREET<br>PAYNESVILLE, MN 56362<br>43-3298651 | HEALTHCARE | MN | 37,312,695 | 27,450,763 | CENTRACARE HEALTH SYSTEM |
| **(4)** CENTRAL MINNESOTA HEALTH NETWORK LLC (FKA CIN LLC)<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>47-3924684 | CLINICAL INEGRATED NETWORK | MN | 0 | 0 | CENTRACARE HEALTH SYSTEM |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | (g) No |
|---|---|---|---|---|---|---|---|
| **(1)** ST CLOUD HOSPITAL<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-0695596 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(2)** CENTRACARE HEALTH-MELROSE<br>11 NORTH 5TH AVE WEST<br>MELROSE, MN 56352<br>41-1865315 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(3)** CENTRACARE HEALTH-LONG PRAIRIE<br>20 SE 9TH STREET<br>LONG PRAIRIE, MN 56347<br>41-1924645 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(4)** CENTRACARE HEALTH-SAUK CENTRE<br>425 ELM STREET NORTH<br>SAUK CENTRE, MN 56378<br>45-2438973 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(5)** CENTRAL MINNESOTA EMERGENCY PHYSICIANS<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-1708142 | EMERGENCY PHYSICIANS | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(6)** CENTRACARE CLINIC<br>1200 6TH AVE NORTH<br>ST CLOUD, MN 56303<br>41-1806657 | MULTI-SPECIALTY | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| **(7)** CENTRACARE HEALTH FOUNDATION<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-1855173 | FUNDRAISING | MN | 501(C)(3) | LINE 7 | CENTRACARE HEALTH SYSTEM | 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? | | (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 | |
| **(1)** MONTICELLO CANCER CENTER<br><br>1001 HART BLVD STE 50<br>MONTICELLO, MN 55362<br>26-1909519 | RADIATION & ONCOLOGY SERVICES | MN | CENTRACARE HEALTH SYSTEM - MONTICELLO | RELATED | 17,546,053 | 8,917,590 | | No | | Yes | | 60 000 % |
| **(2)** NORTH STAR SURGICAL SERVICES LLC<br><br>6339 E SPEEDWAY BLVD SUITE 201<br>TUCSON, AZ 85710<br>20-1585814 | LITHOTRIPSY SERVICES | AZ | CENTRACARE HOLDINGS INC | N/A | | | | No | | | No | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512 (b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| **(1)** CENTRACARE PHARMACY SERVICES<br><br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-1620618 | RETAIL PHARMACIES | MN | CENTRACARE HEALTH SYSTEM | C | -623,095 | 3,958,536 | 100 000 % | Yes | |
| **(2)** CENTRACARE HOLDINGSINC<br><br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>47-2688595 | HOLDING COMPANY | MN | CENTRACARE HEALTH SYSTEM | C | 172,363 | 2,366,124 | 100 000 % | Yes | |

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

| | | Yes | No |
|---|---|---|---|
| **Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule | | | |
| **1** During the tax year, did the 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 | Yes | |
| **b** Gift, grant, or capital contribution to related organization(s) | 1b | | No |
| **c** Gift, grant, or capital contribution from related organization(s) | 1c | | No |
| **d** Loans or loan guarantees to or for related organization(s) | 1d | Yes | |
| **e** Loans or loan guarantees by related organization(s) | 1e | | No |
| **f** Dividends from related organization(s) | 1f | | No |
| **g** Sale of assets to related organization(s) | 1g | | No |
| **h** Purchase of assets from related organization(s) | 1h | | No |
| **i** Exchange of assets with related organization(s) | 1i | | No |
| **j** Lease of facilities, equipment, or other assets to related organization(s) | 1j | | 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 | Yes | |
| **q** Reimbursement paid by related organization(s) for expenses | 1q | Yes | |
| **r** Other transfer of cash or property to related organization(s) | 1r | Yes | |
| **s** Other transfer of cash or property from related organization(s) | 1s | Yes | |

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

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|---|---|---|
| See Additional Data Table | | | |

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

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproprtionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| | | | | | | | | | | | | | |

## Part VII Supplemental Information

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

| Return Reference | Explanation |
|---|---|

## Additional Data

**Software ID:**
**Software Version:**
**EIN:** 41-1813221
**Name:** CENTRACARE HEALTH SYSTEM

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | (g) No |
|---|---|---|---|---|---|---|---|
| (1) ST CLOUD HOSPITAL<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-0695596 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (1) CENTRACARE HEALTH-MELROSE<br>11 NORTH 5TH AVE WEST<br>MELROSE, MN 56352<br>41-1865315 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (2) CENTRACARE HEALTH-LONG PRAIRIE<br>20 SE 9TH STREET<br>LONG PRAIRIE, MN 56347<br>41-1924645 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (3) CENTRACARE HEALTH-SAUK CENTRE<br>425 ELM STREET NORTH<br>SAUK CENTRE, MN 56378<br>45-2438973 | ACUTE/LT CARE | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (4) CENTRAL MINNESOTA EMERGENCY PHYSICIANS<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-1708142 | EMERGENCY PHYSICIANS | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (5) CENTRACARE CLINIC<br>1200 6TH AVE NORTH<br>ST CLOUD, MN 56303<br>41-1806657 | MULTI-SPECIALTY | MN | 501(C)(3) | LINE 3 | CENTRACARE HEALTH SYSTEM | Yes | |
| (6) CENTRACARE HEALTH FOUNDATION<br>1406 6TH AVE N<br>ST CLOUD, MN 56303<br>41-1855173 | FUNDRAISING | MN | 501(C)(3) | LINE 7 | CENTRACARE HEALTH SYSTEM | Yes | |

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|---|---|---|---|
| CENTRACARE HEALTH - LONG PRAIRIE | A | 132,868 | ARMS LENGTH |
| CENTRACARE HEALTH - MELROSE | A | 53,906 | ARMS LENGTH |
| CENTRACARE PHARMACY SERVICES INC | A | 120,191 | ARMS LENGTH |
| CENTRACARE CLINIC | A | 3,911,803 | ARMS LENGTH |
| ST CLOUD HOSPITAL | A | 17,152 | ARMS LENGTH |
| CENTRACARE HEALTH - LONG PRAIRIE | D | 2,302,148 | ARMS LENGTH |
| CENTRACARE CLINIC | O | 412,324 | ARMS LENGTH |
| ST CLOUD HOSPITAL | O | 771,315 | ARMS LENGTH |
| CENTRACARE CLINIC | P | 4,540,491 | ARMS LENGTH |
| ST CLOUD HOSPITAL | P | 1,519,923 | ARMS LENGTH |
| CENTRACARE HEALTH - LONG PRAIRIE | Q | 386,976 | ARMS LENGTH |
| CENTRACARE HEALTH - MELROSE | Q | 393,644 | ARMS LENGTH |
| CENTRACARE HEALTH - SAUK CENTRE | Q | 403,933 | ARMS LENGTH |
| CENTRACARE FOUNDATION | Q | 2,259,678 | ARMS LENGTH |
| CENTRACARE CLINIC | Q | 7,786,271 | ARMS LENGTH |
| ST CLOUD HOSPITAL | Q | 44,334,848 | ARMS LENGTH |
| CENTRACARE CLINIC | R | 2,279,000 | ARMS LENGTH |
| CENTRACARE PHARMACY SERVICES INC | R | 1,195,007 | ARMS LENGTH |
| CENTRACARE HEALTH - LONG PRAIRIE | S | 704,012 | ARMS LENGTH |
| CENTRACARE HEALTH - SAUK CENTRE | S | 352,179 | ARMS LENGTH |
| CENTRACARE HEALTH - MELROSE | S | 3,592,299 | ARMS LENGTH |
| ST CLOUD HOSPITAL | S | 23,542,600 | ARMS LENGTH |