

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public
Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047
2017
Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 07-01-2017, and ending 06-30-2018

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

C Name of organization
CFHS HOLDINGS INC

Doing business as
CEDARS-SINAI MARINA DEL REY HOSPITAL

Number and street (or P O box if mail is not delivered to street address) Room/suite
4650 LINCOLN BLVD

City or town, state or province, country, and ZIP or foreign postal code
MARINA DEL REY, CA 90292

D Employer identification number
20-1645949

E Telephone number
(310) 448-7881

G Gross receipts \$ 109,325,916

F Name and address of principal officer
JEFFREY SMITH
8700 BEVERLY BLVD
LOS ANGELES, CA 90048

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.MARINAHOSPITAL.COM

K Form of organization Corporation Trust Association Other ▶

L Year of formation 2004 **M** State of legal domicile CA

Part I Summary

1 Briefly describe the organization's mission or most significant activities
TO PROVIDE COMPASSIONATE, HIGH QUALITY HEALTHCARE

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

3 Number of voting members of the governing body (Part VI, line 1a)	7
4 Number of independent voting members of the governing body (Part VI, line 1b)	6
5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	802
6 Total number of volunteers (estimate if necessary)	6
7a Total unrelated business revenue from Part VIII, column (C), line 12	0
7b Net unrelated business taxable income from Form 990-T, line 34	185,609

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	1,814,768	2,508,408
9 Program service revenue (Part VIII, line 2g)	93,101,152	106,396,752
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	8,957	665
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	376,227	420,091
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	95,301,104	109,325,916
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	38,000	55,000
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)	56,488,992	53,341,459
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	50,104,942	57,927,477
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	106,631,934	111,323,936
19 Revenue less expenses Subtract line 18 from line 12	-11,330,830	-1,998,020

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	70,051,453	71,606,899
21 Total liabilities (Part X, line 26)	54,681,706	58,235,172
22 Net assets or fund balances Subtract line 21 from line 20	15,369,747	13,371,727

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

Signature of officer _____ Date 2019-05-14
MARY KATHRYN HAMMACK TREASURER
Type or print name and title _____

Paid Preparer Use Only
Print/Type preparer's name KARA ADAMS Preparer's signature KARA ADAMS Date _____
Check if self-employed PTIN P00023315
Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ 34-6565596
Firm's address ▶ 18101 VON KARMAN AVENUE SUITE 1700 Phone no (949) 794-2300
IRVINE, CA 92612

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

* TO PROVIDE COMPASSIONATE, HIGH QUALITY HEALTHCARE FOR RESIDENTS IN MARINA DEL REY AND SURROUNDING BEACH COMMUNITIES AND THE WESTSIDE OF LOS ANGELES(SEE SCHEDULE O FOR CONTINUATION)(CONTINUED FROM PAGE 2)* TO BE RECOGNIZED FOR MEDICAL EXCELLENCE IN SPINE, ORTHOPEDICS, SURGICAL WEIGHT LOSS, MINIMALLY INVASIVE SURGERY, NON-INVASIVE CARDIOLOGY, AND GENERAL ACUTE MEDICAL CARE

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 \$ 90,667,574 including grants of \$ 55,000) (Revenue \$ 106,816,843)
See Additional Data

4b (Code) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code) (Expenses \$ including grants of \$) (Revenue \$)

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

4e Total program service expenses ▶ 90,667,574

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)? <i>If "Yes," complete Schedule A</i>	Yes	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		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? <i>If "Yes," complete Schedule C, Part II</i>		No
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? <i>If "Yes," complete Schedule C, Part III</i>		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? <i>If "Yes," complete Schedule D, Part I</i>		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? <i>If "Yes," complete Schedule D, Part II</i>		No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		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? <i>If "Yes," complete Schedule D, Part IV</i>		No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>		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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>		No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>		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? <i>If "Yes," complete Schedule D, Part IX</i>		No
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		No
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		No
14a Did the organization maintain an office, employees, or agents outside of the United States?		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? <i>If "Yes," complete Schedule F, Parts I and IV</i>		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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		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? <i>If "Yes," complete Schedule G, Part I</i> (see instructions)		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? <i>If "Yes," complete Schedule G, Part II</i>		No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		No

Part IV Checklist of Required Schedules (continued)

		Yes	No
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	Yes	
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	Yes	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		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? <i>If "Yes," complete Schedule J</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part I</i>		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? <i>If "Yes," complete Schedule L, Part II</i>		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? <i>If "Yes," complete Schedule L, Part III</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		No
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		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? <i>If "Yes," complete Schedule L, Part IV</i>		No
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		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? <i>If "Yes," complete Schedule R, Part I</i>		No
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	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)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	Yes	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		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? <i>If "Yes," complete Schedule R, Part VI</i>		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	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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, charitable contributions, and organizational details.

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 [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (7), 1b (6), 2, 3, 4, 5, 6, 7a, 7b, 8, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 (CA), 18 (Own website, Another's website, Upon request, Other), 19, 20 (MARY KATHRYN HAMMACK 4640 ADMIRALTY WAY SUITE 650 MARINA DEL REY, CA 90292 (310) 448-7881).

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			
(1) STEVEN KREMS MD BOARD MEMBER	5 00 0 00	X						0	0	0
(2) THOMAS M PRISELAC CHAIR	5 00 75 00	X						0	3,627,555	1,373,150
(3) MARC H RAPAPORT BOARD MEMBER	5 00 18 00	X						0	0	0
(4) NICKOLAS TOMASIC MD BOARD MEMBER	5 00 0 00	X						0	0	0
(5) LESLIE VERMUT BOARD MEMBER	5 00 8 00	X						0	0	0
(6) THOMAS J WAFER JR BOARD MEMBER	5 00 0 00	X						0	0	0
(7) WALTER ZIFKIN BOARD MEMBER	5 00 0 00	X						0	0	0
(8) MARK GAVENS CEO	6 00 61 00			X				0	1,724,078	212,630
(9) MARY KATHRYN HAMMACK CFO/TREASURER	50 00 5 00			X				247,779	0	9,251
(10) PAULETTE HEITMEYER COO	50 00 1 00			X				0	448,894	9,583
(11) SHARON MARTINEZ SECRETARY	50 00 1 00			X				100,318	0	711
(12) SHAWN BOND PHYSICIAN ASSISTANT	50 00 0 00					X		227,831	0	7,986
(13) CATHY OHNSTAD CHIEF NURSING OFFICER	50 00 0 00					X		203,060	0	9,846
(14) JEFFREY WALLACE ASSISTANT ADMINISTRATOR	50 00 0 00					X		194,160	0	17,559
(15) PERCY CUPEN DIRECTOR OF QUALITY MANAGEMENT	50 00 0 00					X		201,598	0	3,149
(16) KIMBERLY BOTWIN DIRECTOR PHARMACY	40 00 0 00					X		201,146	0	306

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a					
	b Membership dues . . .	1b					
	c Fundraising events . . .	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	2,508,408				
	g Noncash contributions included in lines 1a-1f \$ _____						
	h Total. Add lines 1a-1f		2,508,408				
Program Service Revenue		Business Code					
	2a NET PATIENT REVENUE	622110	61,592,917	61,592,917			
	b MEDICARE AND MEDICAL	622110	41,031,376	41,031,376			
	c QAF REVENUE	622110	3,772,459	3,772,459			
	d _____						
	e _____						
	f All other program service revenue						
g Total. Add lines 2a-2f		106,396,752					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)						
	4 Income from investment of tax-exempt bond proceeds		665			665	
	5 Royalties						
	6a Gross rents	(i) Real	(ii) Personal				
		b Less rental expenses					
		c Rental income or (loss)					
		d Net rental income or (loss)					
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		b Less cost or other basis and sales expenses					
		c Gain or (loss)					
		d Net gain or (loss)					
	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						
	b Less cost of goods sold	b					
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue	Business Code						
11a OTHER REVENUE	622110	420,091	420,091				
b _____							
c _____							
d All other revenue							
e Total. Add lines 11a-11d		420,091					
12 Total revenue. See Instructions		109,325,916	106,816,843	0	665		

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.	55,000	55,000		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	359,011	261,360	97,651	
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.	37,312,667	27,019,184	10,293,483	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	448,416	324,711	123,705	
9 Other employee benefits.	11,812,554	8,553,813	3,258,741	
10 Payroll taxes.	3,408,811	2,468,419	940,392	
11 Fees for services (non-employees)				
a Management.	5,188,993	4,151,194	1,037,799	
b Legal.	1,478		1,478	
c Accounting.	1,635		1,635	
d Lobbying.				
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).	9,819,596	8,087,754	1,731,842	
12 Advertising and promotion.	325,123	243,842	81,281	
13 Office expenses.				
14 Information technology.	1,887,738	1,321,417	566,321	
15 Royalties.				
16 Occupancy.				
17 Travel.	98,164	24,541	73,623	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	12,270	6,258	6,012	
20 Interest.	12,702		12,702	
21 Payments to affiliates.	295,963	295,963		
22 Depreciation, depletion, and amortization.	5,870,045	4,696,036	1,174,009	
23 Insurance.	1,114,333	835,750	278,583	
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 PROSTHESIS/IMPLANTS	8,535,921	8,535,921		
b QAF EXPENSES	7,503,760	7,503,760		
c OTHER MEDICAL SUPPLIES	7,260,842	7,260,842		
d DRUGS/PHARMACEUTICALS	2,551,955	2,551,955		
e All other expenses	7,446,959	6,469,854	977,105	
25 Total functional expenses. Add lines 1 through 24e.	111,323,936	90,667,574	20,656,362	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	4,865,994	1	7,247,732
	2 Savings and temporary cash investments	291,267	2	736,853
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	13,513,907	4	12,739,866
	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		7	
	8 Inventories for sale or use	1,355,955	8	1,388,178
	9 Prepaid expenses and deferred charges	11,500,292	9	14,395,625
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	47,406,359		
	b Less accumulated depreciation	12,307,714		
		38,524,038	10c	35,098,645
	11 Investments—publicly traded securities		11	
	12 Investments—other securities See Part IV, line 11		12	
	13 Investments—program-related See Part IV, line 11		13	
	14 Intangible assets		14	
15 Other assets See Part IV, line 11		15		
16 Total assets. Add lines 1 through 15 (must equal line 34)	70,051,453	16	71,606,899	
Liabilities	17 Accounts payable and accrued expenses	15,211,037	17	8,822,603
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	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	1,996,743	23	1,303,244
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	37,473,926	25	48,109,325
	26 Total liabilities. Add lines 17 through 25	54,681,706	26	58,235,172
Net Assets or Fund Balances	27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. Unrestricted net assets	15,369,747	27	13,371,727
	28 Temporarily restricted net assets		28	
	29 Permanently restricted net assets		29	
	30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. 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	15,369,747	33	13,371,727
	34 Total liabilities and net assets/fund balances	70,051,453	34	71,606,899

Part XI Reconciliation 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	109,325,916
2	Total expenses (must equal Part IX, column (A), line 25)	2	111,323,936
3	Revenue less expenses Subtract line 2 from line 1	3	-1,998,020
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	15,369,747
5	Net unrealized gains (losses) on investments	5	
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	0
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	13,371,727

Part XII Financial Statements and Reporting

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

	Yes	No
<p>1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____</p> <p>If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O</p>		
<p>2a Were the organization's financial statements compiled or reviewed by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>		No
<p>b Were the organization's financial statements audited by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	Yes	
<p>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?</p> <p>If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O</p>	Yes	
<p>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?</p>		No
<p>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</p>		

Additional Data

Software ID:

Software Version:

EIN: 20-1645949

Name: CFHS HOLDINGS INC

Form 990 (2017)

Form 990, Part III, Line 4a:

CFHS HOLDINGS, INC , DOING BUSINESS AS CEDARS-SINAI MARINA DEL REY HOSPITAL ("THE HOSPITAL"), IS A 133-BED NONPROFIT HOSPITAL AND AFFILIATE OF CEDARS-SINAI THE HOSPITAL IS FULLY ACCREDITED WITH THE NATIONALLY RECOGNIZED JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (TJC) FOR SAFE AND EFFECTIVE QUALITY CARE WE HAVE THE FOLLOWING INPATIENT AND OUTPATIENT SERVICES 24-HOUR EMERGENCY CARE INCLUDING TELESTROKE SERVICES IN COLLABORATION WITH CEDARS-SINAI NEUROSURGEONS, ICU, TELEMETRY, INPATIENT AND OUTPATIENT DIAGNOSTIC SERVICES, AND THE MOST ADVANCED SURGICAL TECHNOLOGY AVAILABLE, CAREFULLY PERFORMED UNDER THE SUPERVISION AND SKILLED HANDS OF OUR WORLD-CLASS PHYSICIANS, NURSES, AND ALLIED HEALTH CARE PROFESSIONALS (SEE SCHEDULE O FOR CONTINUATION)(CONTINUED FROM PAGE 2)HOSPITAL SERVICES -24-HOUR EMERGENCY CARE-TELEMEDICINE STROKE PROGRAM IN THE EMERGENCY DEPARTMENT-INTENSIVE CARE UNIT-TELEMETRY/MEDICAL SURGICAL UNITS (CARDIAC MONITORED BEDS) -INPATIENT AND OUTPATIENT CARE-INPATIENT AND OUTPATIENT DIAGNOSTIC SERVICES - IMAGING, GASTROINTESTINAL, LABORATORY, AND CARDIOLOGY-OUTPATIENT BARIATRIC CLINIC-OUTPATIENT SPINE CLINIC-MINIMALLY INVASIVE SURGICAL SERVICES UTILIZING THE MAKO STRYKER ORTHOPAEDIC ROBOT AND THE DA VINCI ROBOT (FOR HERNIA, APPENDECTOMY, GALLBLADDER, COLON, ANTI-REFLUX, BARIATRIC, SPINE, TOTAL HIP, TOTAL KNEE CASES) HOSPITAL STATISTICS EMPLOYEES 802PHYSICIANS WITH HOSPITAL PRIVILEGES 433SURGEONS WITH HOSPITAL PRIVILEGES 185NUMBER OF SURGERIES ANNUALLY 4,078NUMBER OF ER VISITS ANNUALLY 32,097PAYOR % - HMO/PPO (50%), MEDICARE (35%), MEDI-CAL (4%), COMMERCIAL/OTHER (8%), SELF-PAY/CHARITY (3%)HOSPITAL OPERATIONS CEDARS-SINAI MARINA DEL REY HOSPITAL UPGRADED THE CLINICAL ELECTRONIC MEDICAL RECORD SYSTEM AND CONVERTED TO EPIC IN MAY OF 2017 THERE WERE CONTINUED ENHANCEMENTS TO THE REPORTING CAPABILITIES IN 2018 AND THE UPGRADED TECHNOLOGY AND REPORTING CAPABILITIES HAVE IMPROVED THE PHYSICIANS AND CLINICAL STAFF ABILITY TO VIEW PRIOR VISIT RECORDS, ENHANCE PATIENT SAFETY VIA ALERTS, INCREASE DATA ANALYSIS AND DECREASED THE AMOUNT OF LABOR FOR SCANNING OF PAPER DOCUMENTS AND ANALYSIS OF DATA COMMUNITY SUPPORT AND ENGAGEMENT HIGHLIGHTS - OUR TWO OUTPATIENT CLINICS ARE NATIONALLY RECOGNIZED AS LEADING SURGICAL CENTERS OF CARE THE MARINA SPINE CENTER IS A MULTIDISCIPLINARY CENTER OFFERING COMPREHENSIVE SPINE SERVICES, FROM EVALUATION AND DIAGNOSIS TO SURGERY AND REHABILITATION AN ADDITIONAL SPINE SURGEON WAS ADDED TO THE CLINIC STAFF IN 2018 OUR MARINA WEIGHT LOSS CENTER, WHICH HAS A TOTAL OF 12 SURGEONS, IS ACCREDITED BY THE METABOLIC AND BARIATRIC SURGERY ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM (MBSAQIP) FOR EXCELLENCE - CEDARS-SINAI MARINA DEL REY HOSPITAL IS THE ONLY HOSPITAL LOCATED WITHIN LOS ANGELES' 11TH DISTRICT, AND WE ARE ACTIVELY INVOLVED IN COUNCILMAN MIKE BONIN'S HOMELESS INITIATIVE, VENICE FORWARD IN ADDITION, WE HAVE JOINED FORCES WITH OUR COMMUNITY PARTNERS (VENICE FAMILY CLINIC, ST JOSEPH CENTER, AND OPCC THE PEOPLE CONCERN) TO HELP STEM THE HOMELESS CRISIS ON THE WESTSIDE PLANS FOR FY2019 INCLUDE IMPLEMENTING A HOMELESS FACILITATOR/NAVIGATOR IN THE EMERGENCY ROOM AT MDRH THROUGH COLLABORATION WITH "THE PEOPLE CONCERN AND CSMC TO FACILITATE AND COORDINATE THE POST-DISCHARGE HOMELESS PATIENTS' MEDICAL AND HOUSING NEEDS - CEDARS-SINAI MARINA DEL REY HOSPITAL LEADERSHIP ENGAGES WITH THE COMMUNITY IN A VARIETY OF WAYS FACILITY STAFF REPRESENT THE HOSPITAL AT THE FOLLOWING LOCAL COMMUNITY EVENTS AND COLLABORATIVES *HOST COMMUNITY DANCE FITNESS CLASSES ON SITE *HOST COMMUNITY YOGA CLASSES ON SITE *HOST COMMUNITY TAI CHI CLASSES ON SITE *PARTICIPATE IN THE LOCAL ROTARY AND CHAMBER OF COMMERCE *PARTICIPATE IN L A COUNCIL MEMBER MIKE BONIN'S VENICE FORWARD COLLABORATIVE *VENICE FAMILY CLINIC *VENICE MARINA COUNCIL *DEL REY NEIGHBORHOOD COUNCIL AND DEL REY HEALTH FAIR *PACIFIC DIVISION BLOCK CAPTAINS MEETING *VENICE NEIGHBORHOOD COUNCIL - BOARD MEETING *MAR VISTA NEIGHBORHOOD FAIR *THE PEOPLE CONCERN (FORMERLY OPCC) *ST JOSEPH CENTER - CES (COORDINATED ENTRY SYSTEM) *LAX COASTAL CHAMBER OF COMMERCE *4TH OF JULY COMMUNITY PARADE IN WESTCHESTERSPECIFIC HOSPITAL STAFF ATTEND MONTHLY OR QUARTERLY MEETINGS IN ADDITION TO THE SPECIAL EVENTS - CEDARS-SINAI MARINA DEL REY HOSPITAL ADOPTS FAMILIES DURING THE HOLIDAY SEASON THROUGH SEVERAL OF THE ABOVE AGENCIES AND HOSPITAL LEADERSHIP ACTIVELY PARTICIPATES IN OTHER FUND-RAISING COMMUNITY EVENTS THROUGH BOTH MONETARY AND EMPLOYEE SUPPORT PROGRAM ACCOMPLISHMENTS/DEVELOPMENT - CEDARS-SINAI MARINA DEL REY HOSPITAL IN COLLABORATION WITH CEDARS-SINAI MEDICAL CENTER (CSMC) NEUROLOGY DEPARTMENT HAS BEEN UTILIZING TELEMEDICINE IN THE EMERGENCY ROOM SINCE FEBRUARY 2017 TO SUCCESSFULLY DIAGNOSE STROKE, EXPEDITE DIAGNOSIS AND TREATMENT IN 2018, AN ADDITIONAL TELEMEDICINE ROBOT WAS ADDED TO THE FACILITY ICU TO ENHANCE NEURO SERVICES IN COLLABORATION WITH CEDARS NEUROLOGY DEPARTMENT SINCE INCEPTION OF THE PROGRAM IN 2017 AND THROUGH 2018, 91 PATIENTS EXHIBITING ACUTE STROKE SYMPTOMS HAVE RECEIVED TELE-STROKE CONSULTATIONS VIA THE INTOUCH CAMERA 34 OF THOSE PATIENTS WERE TRANSFERRED TO CSMC FOR HIGHER LEVEL OF CARE (15 WERE IDENTIFIED AS HAVING AN ACUTE STROKE, RECEIVED TPA, AND WERE TRANSFERRED TO CSMC) 53 REMAINED AT MDRH FOR TREATMENT MDRH, IN COLLABORATION WITH CSMC, IS SEEKING TO OBTAIN THE AMERICAN HEART/AMERICAN STROKE ASSOCIATION AND THE JOINT COMMISSION PRIMARY STROKE CENTER CERTIFICATION WITH A TARGET GOAL FOR SUBMISSION IN 2019 -ADDITIONAL SPECIALTY PHYSICIANS ARE ROTATING THROUGH A SPECIALTY CLINIC ADJACENT TO THE HOSPITAL TO COVER SPECIALTIES NOT PREVIOUSLY OFFERED AT CEDARS-SINAI MARINA DEL REY HOSPITAL THESE SERVICES PROVIDED BY CEDARS FOUNDATION PHYSICIANS INCLUDE ENT, GYN, CARDIOLOGY, GI, AND NEUROLOGY THE SPECIALISTS ALTERNATE DAYS OF THE WEEK MAKING FOLLOW-UP APPOINTMENTS FOR PATIENTS SEEN AS INPATIENTS IN THE HOSPITAL EASIER WHICH ALSO HELPS REDUCE READMISSIONS AND IS CONVENIENT FOR THE PATIENTS IN OUR COMMUNITY -THE HOSPITAL PARTICIPATED IN THE COMPREHENSIVE JOINT PROGRAM INITIATIVE WITH OUR ORTHO PHYSICIANS AND STAFF PATIENT EDUCATION PROGRAMS WERE DEVELOPED TO IMPROVE THE PATIENT EXPERIENCE FEEDBACK FROM THE COMMUNITY HAS BEEN POSITIVE -THE HOSPITAL IN COLLABORATION WITH CEDARS SINAI MEDICAL FOUNDATION EAR, NOSE, AND THROAT PHYSICIANS (DR GENE LIU) PURCHASED SPECIALIZED ENT SURGICAL EQUIPMENT TO PROVIDE THOSE SERVICES TO OUR COMMUNITY BEGINNING IN 2017 AND EXPANDED THE INSTRUMENTATION IN 2018

SCHEDULE A
(Form 990 or 990-EZ)

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.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization
CFHS HOLDINGS INC

Employer identification number

20-1645949

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ))
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 8 A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10 An organization that normally receives (1) more than 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)
- 11 An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
 - f Enter the number of supported organizations _____
 - g Provide the following information about the supported organization(s)

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

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

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

Section A. Public Support

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

Section B. Total Support

	Calendar year (or fiscal year beginning in) ►	(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					12	

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

Section C. Computation of Public Support Percentage

14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2016 Schedule A, Part II, line 14	15	

- 16a 33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- b 33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►
- 17a 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- b 10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ►
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

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? <i>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.</i>		
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? <i>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.</i>		

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)? <i>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).</i>		

Section D. All Type III Supporting Organizations

		Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

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	<input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c	<input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2	Activities Test Answer (a) and (b) below.		
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? <i>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.</i>		
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? <i>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.</i>		
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? <i>Provide details in Part VI.</i>		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI)		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 20-1645949

Name: CFHS HOLDINGS INC

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

Facts And Circumstances Test

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements
▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2017
Open to Public Inspection

Name of the organization
CFHS HOLDINGS INC

Employer identification number
20-1645949

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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

Preservation of land for public use (e g , recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

	Held at the End of the Year	
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? Yes No

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

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

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

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|--|--------|
| c Beginning balance | |
| d Additions during the year | |
| e Distributions during the year | |
| f Ending balance | |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
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 on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | | |
|--|------------|-----------|
| (i) unrelated organizations | Yes | No |
| 3a(i) | | |
| (ii) related organizations | | |
| 3a(ii) | | |
| b If "Yes" on 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" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		27,560,638	3,840,204	23,720,434
c Leasehold improvements				
d Equipment		15,332,824	5,865,647	9,467,177
e Other		4,512,897	2,601,863	1,911,034
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				35,098,645

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

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

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

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

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

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

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

(a) Description of liability	(b) Book value
(1) Federal income taxes	
DUE TO/FROM RELATED ORGANIZATION	35,770,443
MALPRACTICE RESERVES	2,802,000
WORKERS COMP RESERVES	3,921,000
CAPITAL LEASES	103,408
ACCRUED PAYROLL	5,512,474
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	48,109,325

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Additional Data

Software ID:

Software Version:

EIN: 20-1645949

Name: CFHS HOLDINGS INC

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	THE FOLLOWING STATEMENT IS TAKEN FROM THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS OF CEDARS-SINAI HEALTH SYSTEM THAT INCLUDES CFHS HOLDINGS, INC THE ORGANIZATION COMPLETED AN ANALYSIS OF ITS TAX POSITIONS, IN ACCORDANCE WITH ASC 740, INCOME TAXES, AND DETERMINED THAT THERE ARE NO UNCERTAIN TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN THE ORGANIZATION HAS RECOGNIZED NO INTEREST OR PENALTIES RELATED TO UNCERTAIN TAX POSITIONS THE ORGANIZATION IS SUBJECT TO ROUTINE AUDITS BY THE TAXING JURISDICTIONS, HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS THE ORGANIZATION BELIEVES IT IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR YEARS PRIOR TO 2015

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service
Name of the organization
 CFHS HOLDINGS INC

Hospitals

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

Employer identification number
 20-1645949

OMB No 1545-0047
2017
Open to Public Inspection

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 <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> 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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	3a Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other _____ 45000 0000000000 %	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 eligible 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)			167,091		167,091	0 150 %
b Medicaid (from Worksheet 3, column a)			24,241,461	11,410,706	12,830,755	11 530 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			24,408,552	11,410,706	12,997,846	11 680 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			40,418		40,418	0 040 %
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			50,000		50,000	0 040 %
j Total. Other Benefits			90,418		90,418	0 080 %
k Total. Add lines 7d and 7j			24,498,970	11,410,706	13,088,264	11 760 %

Part III 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			5,000		5,000	0 %
8 Workforce development						
9 Other						
10 Total			5,000		5,000	0 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	36,465,552
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	57,966,687
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-21,501,135
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: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> 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

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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				
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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?

1

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)

See Additional Data Table	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

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)
MARINA DEL REY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

Community Health Needs Assessment		Yes	No
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?		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		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 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 17</u>		
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 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.MARINAHOSPITAL.COM/COMMUNITY</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> 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	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>HTTPS //WWW.MARINAHOSPITAL.COM/COMMUNITY</u>	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
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)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

MARINA DEL REY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>450 000000000000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> 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? 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)	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //WWW MARINAHOSPITAL COM/FINANCIAL-OVERVIEW/ASSISTANCE</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>HTTPS //WWW MARINAHOSPITAL COM/FINANCIAL-OVERVIEW/ASSISTANCE</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>HTTPS //WWW MARINAHOSPITAL COM/FINANCIAL-OVERVIEW/ASSISTANCE</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> 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	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)**Billing and Collections**

MARINA DEL REY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

		Yes	No	
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	Yes	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a	<input type="checkbox"/> Reporting to credit agency(ies)			
b	<input type="checkbox"/> Selling an individual's debt to another party			
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	<input type="checkbox"/> Actions that require a legal or judicial process			
e	<input type="checkbox"/> Other similar actions (describe in Section C)			
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged	19		No
a	<input type="checkbox"/> Reporting to credit agency(ies)			
b	<input type="checkbox"/> Selling an individual's debt to another party			
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	<input type="checkbox"/> Actions that require a legal or judicial process			
e	<input type="checkbox"/> Other similar actions (describe in Section C)			
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)			
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs			
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations			
e	<input type="checkbox"/> Other (describe in Section C)			
f	<input type="checkbox"/> 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? If "No," indicate why	21	Yes	
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b	<input type="checkbox"/> The hospital facility's policy was not in writing			
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	<input type="checkbox"/> Other (describe in Section C)			

Part V Facility Information *(continued)*

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

MARINA DEL REY HOSPITAL

Name of hospital facility or letter of facility reporting group _____

22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** The hospital facility used a prospective Medicare or Medicaid method

23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

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?

If "Yes," explain in Section C

	Yes	No
23		No
24		No

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? 3

Name and address	Type of Facility (describe)
1 1 - MARINA DEL REY HOSPITAL 4658 LINCOLN BLVD MARINA DEL REY, CA 90292	OUTPATIENT SERVICES - GEN/LAB/RADIOLOGY/MRI/CT SCANNER
2 2 - MARINA DEL REY HOSPITAL 4640 ADMIRALTY WAY STE 600 MARINA DEL REY, CA 90292	OUTPATIENT SERVICES - SPINE CENTER
3 3 - MARINA DEL REY HOSPITAL 4644 LINCOLN BLVD STE 450 MARINA DEL REY, CA 90292	OUTPATIENT SERVICES - BARIATRICS CENTER
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	FINANCIAL ASSISTANCE AND MEDI-CAL COSTS AS A PERCENTAGE OF TOTAL HOSPITAL EXPENSES WERE DETERMINED BASED ON THE RATIO OF TOTAL FINANCIAL ASSISTANCE AND MEDI-CAL REVENUE OVER TOTAL CHARGES DURING THE FISCAL YEAR ENDING ON 6/30/2018
PART II, COMMUNITY BUILDING ACTIVITIES	THE HOSPITAL IS INVOLVED IN COMMUNITY BUILDING ACTIVITIES WHICH PROMOTE THE HEALTH OF THE COMMUNITIES IT SERVES COMMUNITY CONCERNS, SUCH AS HEALTH IMPROVEMENT, ARE ADDRESSED THE HOSPITAL WORKS WITH OTHER TAX-EXEMPT ORGANIZATIONS TO PROMOTE HEALTH AND WELLNESS AND DISEASE PREVENTION THESE ACTIVITIES ARE NOT INCLUDED ELSEWHERE ON SCHEDULE H

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	PATIENT SERVICE REVENUE, NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS, IS REDUCED BY THE PROVISION FOR BAD DEBTS, AND ACCOUNTS RECEIVABLE IS REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS THE HOSPITAL ESTABLISHES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED ON MANY FACTORS, INCLUDING PAYER MIX, AGE OF RECEIVABLES, HISTORICAL CASH COLLECTION EXPERIENCE, AND OTHER RELEVANT INFORMATION A SIGNIFICANT PORTION OF THE HOSPITAL'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR SERVICES PROVIDED, AND A SIGNIFICANT PORTION OF THE HOSPITAL'S INSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR CO-PAYMENTS AND DEDUCTIBLES THUS, THE HOSPITAL RECORDS A PROVISION FOR BAD DEBTS RELATED TO THESE INSURED AND UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED THE HOSPITAL WRITES DOWN THE EXPECTED REIMBURSEMENT AFTER REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED
PART III, LINE 4	AUDITED FINANCIAL STATEMENTS - PAGE 13PART III, LINE 6 MEDICARE ALLOWABLE COSTS AS A PERCENTAGE OF TOTAL HOSPITAL EXPENSES WERE DETERMINED BASED ON THE RATIO OF TOTAL MEDICARE REVENUE OVER TOTAL CHARGES DURING THE FISCAL YEAR ENDING ON 6/30/2018

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	IT IS OUR BELIEF THAT ALL OF THE \$21,501,135 SHORTFALL SHOULD BE CONSIDERED AS COMMUNITY BENEFIT THE IRS COMMUNITY BENEFIT STANDARD INCLUDES THE PROVISION OF CARE TO THE ELDERLY AND MEDICARE PATIENTS MEDICARE SHORTFALLS MUST BE ABSORBED BY THE HOSPITAL IN ORDER TO CONTINUE TREATING THE ELDERLY IN OUR COMMUNITY THE HOSPITAL PROVIDES CARE REGARDLESS OF THIS SHORTFALL AND THEREBY RELIEVES THE FEDERAL GOVERNMENT OF THE BURDEN OF PAYING THE FULL COST FOR MEDICARE BENEFICIARIES CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED AND RELIEVES A GOVERNMENT BURDEN AS THESE PATIENTS TYPICALLY HAVE LOW AND/OR FIXED INCOMES MEDICARE DOES NOT PROVIDE SUFFICIENT REIMBURSEMENT TO COVER THE COST OF PROVIDING CARE FOR THESE PATIENTS
PART III, LINE 9B	REASONABLE EFFORTS BASED ON BILLING STATEMENT NOTIFICATION AND AMOUNTS NOT ELIGIBLE THE HOSPITAL NOTIFIES PATIENTS OF ITS FINANCIAL ASSISTANCE PROGRAMS BEFORE INITIATING ANY EXTRAORDINARY COLLECTION ACTIONS THE HOSPITAL REFRAINS FROM INITIATING EXTRAORDINARY COLLECTION ACTIONS FOR AT LEAST 120 DAYS FROM THE DATE THE HOSPITAL BILLS FOR THE CARE IF THE PATIENT HAS NOT SUBMITTED AN APPLICATION OR THE HOSPITAL HAS DETERMINED THE PATIENT IS NOT ELIGIBLE FOR FINANCIAL ASSISTANCE BASED ON THE PATIENT'S APPLICATION AT LEAST 30 DAYS BEFORE FIRST INITIATING ANY EXTRAORDINARY COLLECTION ACTIONS, THE HOSPITAL PROVIDES THE PATIENT WITH A WRITTEN NOTICE INDICATING FINANCIAL ASSISTANCE IS AVAILABLE, IDENTIFYING THE EXTRAORDINARY COLLECTION ACTION THAT THE HOSPITAL INTENDS TO INITIATE TO OBTAIN PAYMENT, AND STATING A DEADLINE AFTER WHICH SUCH EXTRAORDINARY COLLECTION ACTIONS MAY BE INITIATED (WHICH DATE IS NOT EARLIER THAN 30 DAYS AFTER THE DATE THAT THE WRITTEN NOTICE IS PROVIDED) THE NOTICE INCLUDES A PLAIN LANGUAGE SUMMARY OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN ADDITION TO ALL WRITTEN NOTICES, PRIOR TO INITIATING ANY EXTRAORDINARY COLLECTION ACTIONS, THE HOSPITAL MAKES A REASONABLE EFFORT TO VERBALLY NOTIFY THE PATIENT ABOUT THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY AND ABOUT HOW THE PATIENT MAY OBTAIN ASSISTANCE THROUGH THE APPLICATION PROCESS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS CONDUCTED IN FISCAL YEAR ENDED 6/30/18 SEE NARRATIVE FOR SCHEDULE H, PART V, SECTION B, LINE 3J
PART VI, LINE 3	THE HOSPITAL PROVIDES THE FOLLOWING NOTICES REGARDING FULL AND PARTIAL FINANCIAL ASSISTANCE FOR THE FINANCIALLY QUALIFIED PATIENTS A) POSTED SIGNAGE - NOTICE OF THE FINANCIAL ASSISTANCE POLICY IS POSTED IN THE FOLLOWING LOCATIONS THE EMERGENCY DEPARTMENT, THE ADMITTING DEPARTMENT, CENTRALIZED AND DECENTRALIZED REGISTRATION AREAS AND OTHER OUTPATIENT SETTINGS B) NOTICES HAND-DELIVERED TO PATIENTS - DURING THE REGISTRATION OR ADMISSION PROCESS (OR OTHERWISE PRIOR TO DISCHARGE), PATIENTS ARE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND CEDARS-SINAI MARINA DEL REY'S FINANCIAL ASSISTANCE PROGRAMS PATIENTS ARE ASKED TO ACKNOWLEDGE RECEIPT OF THIS VIA AN ELECTRONIC SIGNATURE C) PATIENT STATEMENT NOTICES - ON THE PATIENT BILLING STATEMENTS, THE HOSPITAL PROVIDES A DESCRIPTION OF ITS FINANCIAL ASSISTANCE POLICY AND PROGRAMS, ALONG WITH INFORMATION ABOUT HOW TO APPLY FOR FINANCIAL ASSISTANCE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	PLEASE SEE COMMUNITY SERVICE AREA AND DEMOGRAPHICS INFORMATION IN THE NARRATIVE FOR SCHEDULE H, PART V, SECTION B, LINE 3J IN ADDITION, THERE ARE FIVE OTHER HOSPITALS THAT SERVE THE SAME COMMUNITY AS CEDARS-SINAI MARINA DEL REY HOSPITAL
PART VI, LINE 5	CEDARS-SINAI MARINA DEL REY HOSPITAL IS DRIVEN BY ITS MISSION TO STRIVE TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY BY GIVING BACK TO THE COMMUNITY IN THE FORM OF HEALTH CARE AND OTHER COMMUNITY SERVICES THE HOSPITAL PROVIDES BOTH QUANTIFIABLE AND NON-QUANTIFIABLE CONTRIBUTIONS TO THE COMMUNITY, SUCH AS INCREASING PARTICIPATION IN LOCAL EFFORTS TO COMBAT HOMELESSNESS IN THE COMMUNITY AND INCURRING UNREIMBURSED COST OF DIRECT MEDICAL CARE FOR THE POOR AND UNDERSERVED OF THE COMMUNITY IN ADDITION, THE HOSPITAL DISTRIBUTED GRANTS TO ST JOSEPH'S CENTER AND VENICE FAMILY CLINIC, BOTH SIGNIFICANT COMMUNITY PROVIDERS OF HOMELESS SERVICES IN THE MARINA DEL REY SERVICE AREA ANY SURPLUS FUNDS ARE REINVESTED INTO THE ORGANIZATION TO FURTHER SUPPORT THE COMMUNITY

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	<p>THE HOSPITAL IS AN AFFILIATE OF CEDARS-SINAI HEALTH SYSTEM THE 133-BED SURGICAL HOSPITAL IS FULLY ACCREDITED THROUGH THE JOINT COMMISSION FOR SAFE AND EFFECTIVE QUALITY CARE BY CONCENTRATING FOUR AREAS OF EXPERTISE SPINE, WEIGHT LOSS, ORTHOPEDICS, AND MINIMALLY INVASIVE SURGERY, THE HOSPITAL IS ABLE TO PROVIDE EXCELLENT CARE IN AN INTIMATE, PERSONAL AND CONVENIENT SETTING THE HOSPITAL IS COMMITTED TO THE FOLLOWING * COMMITMENT TO THE COMMUNITY PROVIDING EXCELLENT AND PROMPT ACUTE MEDICAL SERVICES AND 24/7 EMERGENCY ROOM CARE * TALENTED CUSTOMER SERVICE-DRIVEN TEAM BELIEVES KINDNESS IS JUST AS IMPORTANT AS STATE-OF-THE-ART MEDICAL TECHNOLOGY * NATIONALLY RECOGNIZED PHYSICIANS RECOGNIZED FOR CLINICAL EXCELLENCE AND DEVOTED TO DELIVERING COMPASSIONATE, RESPONSIVE CARE THE HOSPITAL'S MISSION * TO PROVIDE COMPASSIONATE, HIGH QUALITY HEALTHCARE FOR RESIDENTS IN MARINA DEL REY AND SURROUNDING BEACH COMMUNITIES AND THE WESTSIDE OF LOS ANGELES * TO BE RECOGNIZED FOR MEDICAL EXCELLENCE IN SPINE, ORTHOPEDICS, SURGICAL WEIGHT LOSS, MINIMALLY INVASIVE SURGERY, NON-INVASIVE CARDIOLOGY AND GENERAL ACUTE MEDICAL CARE THE HOSPITAL'S BOARD OF DIRECTORS PROVIDES ORGANIZATIONAL LEADERSHIP IN FOSTERING THE COMMITMENT TO COMMUNITY BENEFIT THE BOARD OF DIRECTORS FUNCTIONS AS AN OVERSIGHT AND POLICY-MAKING BODY FOR THE HOSPITAL'S COMMUNITY BENEFIT COMMITMENTS, EFFORTS AND STRATEGIC ALIGNMENT WITH COMMUNITY NEEDS DURING THE TAX YEAR, THE HOSPITAL'S COMMUNITY BENEFIT EXPENSE TOTALED \$13,088,264 DIVIDED AMONG THE FOLLOWING CATEGORIES * UNREIMBURSED COST OF DIRECT MEDICAL CARE FOR THE POOR AND UNDERSERVED - \$12,997,846 (CHARITY CARE - \$167,091, UNREIMBURSED COST CARING FOR MEDICAL PATIENTS - \$12,830,755) (EXCLUDES THE UNREIMBURSED COST OF CARING FOR MEDICARE PATIENTS) COMMUNITY BENEFIT PROGRAMS, INCLUDING CHARITABLE DONATIONS - \$90,418 DURING THE TAX YEAR, TORRANCE MEMORIAL OFFICIALLY JOINED THE AFFILIATION TORRANCE MEMORIAL INCLUDES THE 470-BED TORRANCE MEMORIAL MEDICAL CENTER, A MULTISPECIALTY PHYSICIAN GROUP, AN INDEPENDENT PHYSICIAN ASSOCIATION, AND AN ACCOUNTABLE CARE ORGANIZATION, WHICH COLLECTIVELY INCLUDE MORE THAN 500 PHYSICIANS IT ALSO HAS SEVERAL OUTPATIENT CENTERS LOCATED THROUGHOUT THE SOUTH BAY REGION THE AFFILIATION ENABLES EACH INSTITUTION TO CONTINUE THE UNIQUE RELATIONSHIPS EACH HAS WITH THE COMMUNITIES IT SERVES, WHILE PROVIDING A PLATFORM FOR A WIDE VARIETY OF COLLABORATIONS TO BETTER SERVE THE REGION</p>
PART VI, LINE 7, REPORTS FILED WITH STATES	CA

Schedule H (Form 990) 2017

Additional Data**Software ID:****Software Version:****EIN:** 20-1645949**Name:** CFHS HOLDINGS INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities		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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	MARINA DEL REY HOSPITAL 4650 LINCOLN BLVD MARINA DEL REY, CA 90292 WWW.MARINAHOSPITAL.COM 930000096	X	X					X			

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
MARINA DEL REY HOSPITAL	<p>PART V, SECTION B, LINE 3J THE CHNA HELPS TO IDENTIFY THE UNMET HEALTH NEEDS OF THE COMMUNITIES SERVED BY CEDARS-SINAI MARINA DEL REY HOSPITAL AND PROVIDES A FRAMEWORK FOR PRIORITIZING HOW THE HOSPITAL WILL ADDRESS UNMET COMMUNITY NEEDS THROUGH THE PROVISION OF COMMUNITY HEALTH SERVICES CEDARS-SINAI MARINA DEL REY'S COMMUNITY HEALTH NEEDS ASSESSMENT FOR JULY 1, 2017 THROUGH JUNE 30, 2020 WAS APPROVED BY ITS GOVERNING BODY ON MAY 23, 2018 COMMUNITY BENEFIT SERVICE AREA CEDARS-SINAI MARINA DEL REY HOSPITAL IS LOCATED AT 4650 LINCOLN BLVD, MARINA DEL REY, CA, 90292 THE HOSPITAL'S SERVICE AREA ENCOMPASSES EIGHT ZIP CODES IN THE CITIES OF CULVER CITY, MAR VISTA, MARINA DEL REY, PLAYA DEL REY, PLAYA VISTA, SANTA MONICA, VENICE, AND WESTCHESTER THIS AREA IS LOCATED IN LOS ANGELES COUNTY SERVICE PLANNING AREA 5 (SPA 5) COMMUNITY DEMOGRAPHICS - THE POPULATION OF THE CEDARS-SINAI MARINA DEL REY HOSPITAL (CSMDRH) SERVICE AREA IS 230,101 - THE PERCENTAGE OF YOUTH, AGE 0-17, IN THE SERVICE AREA IS 15.5%, WHICH IS LOWER THAN THE COUNTY (23.1%) OR THE STATE (23.8%) - OVER HALF OF THE POPULATION (53.9%) IN THE HOSPITAL SERVICE AREA IS WHITE HISPANIC OR LATINOS ACCOUNT FOR 21.8% OF THE AREA POPULATION, ASIANS 12.2% AND BLACK OR AFRICAN AMERICANS 7.1% - TWO-THIRDS OF THE RESIDENTS IN THE SERVICE AREA SPEAK ENGLISH ONLY (66.8%), WHILE 16.9% OF THE POPULATION SPEAKS SPANISH ONLY SOCIAL AND ECONOMIC FACTORS - AMONG AREA RESIDENTS, 11.8% ARE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL (FPL) AND 24.7% ARE AT 200% OF FPL OR BELOW (LOW-INCOME) - THE MEDIAN HOUSEHOLD INCOME FOR THE CSMDRH SERVICE AREA IS \$81,083 - IN JULY 2017, THE UNEMPLOYMENT RATE IN THE AREA RANGED FROM 3.2% IN MARINA DEL REY TO 5.5% IN LOS ANGELES - IN THE SERVICE AREA, 63.4% OF THE POPULATION HAS A COLLEGE DEGREE, WHICH IS HIGHER THAN THE COUNTY (37.2%) AND THE STATE (39.2%) - CULVER CITY UNIFIED (93.7%) AND SANTA MONICA-MALIBU UNIFIED (90.7%) HAVE HIGH GRADUATION RATES THESE DISTRICTS EXCEEDED THE HEALTHY PEOPLE 2020 OBJECTIVE FOR HIGH SCHOOL GRADUATION OF 87% ACCESS TO HEALTH CARE - THE HOSPITAL SERVICE AREA REPORTS 88.2% INSURANCE COVERAGE COVERAGE RATES RANGE FROM A LOW OF 87.5% IN CULVER CITY (ZIP CODE 90230) TO A HIGH OF 94.8% IN PLAYA VISTA (ZIP CODE 90094) - 80.7% OF RESIDENTS OF SPA 5 HAVE A REGULAR SOURCE FOR CARE, COMPARED TO 84.7% FOR THE COUNTY AND 86% FOR THE STATE - A BARRIER TO ACCESSING CARE IS THE LACK OF SPECIALTY CARE PRACTITIONERS LOCALLY AVAILABLE - SENIORS IN SPA 5 HAVE A USUAL SOURCE OF CARE AT A HIGHER PERCENTAGE THAN FOUND IN THE COUNTY OR STATE HOWEVER, 12.7% OF SENIORS, AGES 65-74, REPORTED A DELAY IN CARE COMPARED TO 8.9% IN THE COUNTY AND 7.7% IN THE STATE - COMMUNITY STAKEHOLDERS NOTED THAT THE LARGE HOMELESS POPULATION IN THE NEIGHBORHOOD HAS LIMITED ACCESS TO PREVENTIVE CARE SERVICES LEADING CAUSES OF DEATH - HEART DISEASE AND CANCER ARE THE TOP TWO CAUSES OF DEATH IN THE SERVICE AREA, FOLLOWED BY ALZHEIMER'S DISEASE AND STROKE CHRONIC DISEASES - AMONG ADULT</p>

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
MARINA DEL REY HOSPITAL	<p>S IN SPA 5, 10 8% IDENTIFIED THEMSELVES AS EXPERIENCING FAIR OR POOR HEALTH COMPARED TO 21 9% AT THE COUNTY LEVEL - 6 6% OF ADULTS IN SPA 5 HAVE BEEN DIAGNOSED WITH DIABETES AND 8 7% HAVE PREDIABETES - 5 9% OF ADULTS IN SPA 5 HAVE BEEN DIAGNOSED WITH HEART DISEASE - A C O-MORBIDITY FACTOR FOR DIABETES AND HEART DISEASE IS HYPERTENSION (HIGH BLOOD PRESSURE) I N SPA 5, 22 4% OF RESIDENTS HAVE HIGH BLOOD PRESSURE - 14 6% OF RESIDENTS IN SPA 5 HAVE BE EN DIAGNOSED WITH ASTHMA, WHICH IS HIGHER THAN THE COUNTY RATE OF 12 8% HOMELESSNESS - FRO M 2016 TO 2017, SPA 5 EXPERIENCED AN 18% INCREASE IN THE NUMBER OF HOMELESS INDIVIDUALS - THE RATE OF CHRONICALLY HOMELESS ROSE TO 32 9% IN 2017, COMPARED TO 28 4% IN 2016 - ONE-TH IRD OF THE HOMELESS POPULATION (33 3%) IDENTIFY AS HAVING A MENTAL ILLNESS - THE HOSPITAL SERVICE AREA REPORTS A HIGHER LEVEL OF HOMELESS VETERANS (18 6%) WHEN COMPARED TO HOMELESS VETERANS IN LOS ANGELES COUNTY (8%) - COMMUNITY INPUT NOTED THAT THE COMPLEXITY OF HOMELE SNESS CHALLENGES LOCAL PROVIDERS LACK OF AFFORDABLE HOUSING, THE TRANSIENT NATURE OF THE POPULATION, MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES, COMMUNITY INTOLERANCE, AND A SHORTA GE OF WRAP-AROUND AND SUPPORT SERVICES MENTAL HEALTH - IN THE HOSPITAL SERVICE AREA, 5 2% OF ADULTS EXPERIENCED SERIOUS PSYCHOLOGICAL DISTRESS IN THE PAST YEAR - STIGMA AROUND MENT AL HEALTH CONTINUES TO BE A BARRIER TO ACCESSING CARE - 8 9% OF ADULTS IN SPA 5 HAD SERIOU SLY CONSIDERED SUICIDE, WHICH IS LOWER THAN THE COUNTY (9 5%) AND STATE (9 6%) RATES - COM MUNITY INPUT NOTED THAT BARRIERS AROUND MENTAL HEALTH INCLUDED A LACK OF PRACTITIONERS AN D PREVENTIVE PRACTICES, AS WELL AS THE COST OF CARE, WHICH IS OFTEN NOT COVERED BY INSURAN CE OVERWEIGHT AND OBESITY - IN THE HOSPITAL SERVICE AREA, 4 4% OF CHILDREN AND 42 6% OF TE ENS ARE OVERWEIGHT 30 5% OF SENIORS IN SPA 5 ARE OVERWEIGHT - ALMOST THREE-QUARTERS OF LA TINO RESIDENTS IN SPA 5 (74 6%) ARE OVERWEIGHT OR OBESE 46 2% OF WHITE ADULTS AND 44 2% O F AFRICAN AMERICAN ADULTS IN SPA 5 ARE OVERWEIGHT OR OBESE AMONG ASIANS, 17 7% ARE OVERWE IGH T OR OBESE - IN THE HOSPITAL SERVICE AREA, 15 4% OF CHILDREN AND 15% OF ADULTS CONSUME FAST FOOD THREE OR MORE TIMES A WEEK - 57 8% OF TEENS IN SPA 5 CONSUMED TWO OR MORE SERVIN GS OF FRUIT A DAY, LESS THAN THE PERCENTAGE OF TEENS IN THE COUNTY (70 9%) - 31% OF TEENS IN SPA 5 ENGAGED IN NO PHYSICAL ACTIVITY DURING THE WEEK, COMPARED TO 16 8% OF TEENS IN LA COUNTY, AND 14 8% IN THE STATE - A BARRIER TO ENGAGING IN OUTSIDE ACTIVITY NOTED BY THE C OMMUNITY IS THE LACK OF PUBLIC GREEN OR OPEN SPACES OTHER THAN THE BEACHES PREVENTIVE PRAC TICES - CULVER CITY UNIFIED SCHOOL DISTRICT (96 4%) AND SANTA MONICA - MALIBU UNIFIED SCHO OL DISTRICT (88 8%) OF CHILDREN ENTERED KINDERGARTEN IN THE 2015-2016 YEAR WITH UP-TO-DATE IMMUNIZATIONS, COMPARED TO COUNTY (91 4%) AND STATE (92 9%) - OVERALL, 38% OF SPA 5 RESID ENTS OBTAINED A FLU VACCINATION IN 2015, THE HEALTHY PEOPLE 2020 OBJECTIVE IS FOR 70% OF T HE POPULATION TO RECEIVE A FLU</p>

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
MARINA DEL REY HOSPITAL	<p>SHOT AMONG SPA 5 RESIDENTS AGES 65 AND OLDER, 67 7% RECEIVED A FLU SHOT - 61 2% OF SENIORS IN SPA 5 HAVE RECEIVED THE PNEUMONIA VACCINE THE HEALTHY PEOPLE 2020 OBJECTIVE IS FOR 90% OF ADULTS AGES 65 AND OLDER TO BE VACCINATED - IN SPA 5, 88 7% OF WOMEN OBTAINED A PAP SMEAR IN THE PAST THREE YEARS AND 85 3% OF WOMEN HAVE OBTAINED A MAMMOGRAM IN THE PAST TWO YEARS SENIOR HEALTH - FALLS ARE THE LEADING CAUSE OF INJURY AMONG OLDER ADULTS 27 8% OF SENIORS IN SPA 5 REPORTED FALLING AT LEAST ONCE IN THE PAST YEAR - COMMUNITY INPUT NOTED BARRIERS TO HEALTH CARE FOR SENIORS INCLUDED HIGH RENTS, VULNERABILITY TO ISOLATION, LIMITED TRANSPORTATION RESOURCES, AND NOT ENOUGH RESOURCES FOR SUPPORTIVE LIVING SUBSTANCE ABUSE - 10 8% OF ADULTS IN SPA 5 ARE CURRENT SMOKERS, COMPARED TO 12 2% IN THE COUNTY AND 12 8% IN THE STATE - AMONG TEENS IN SPA 5, 24% HAVE SMOKED AN ELECTRONIC (VAPORIZER) CIGARETTE, COMPARED TO 6 9% IN THE COUNTY AND 7 5% IN THE STATE - 43 3% OF TEENS IN SPA 5 HAVE TRIED ALCOHOL, COMPARED TO 21 9% IN THE COUNTY AND 23% IN THE STATE - BARRIERS TO CARE FOR SUBSTANCE ABUSE IDENTIFIED BY THE COMMUNITY INCLUDED LIMITED DETOX OPTIONS AND WAIT LISTS FOR TREATMENT CENTERS IDENTIFICATION OF SIGNIFICANT HEALTH NEEDS THE ANALYSIS OF SECONDARY DATA YIELDED A PRELIMINARY LIST OF SIGNIFICANT HEALTH NEEDS WHICH THEN INFORMED PRIMARY DATA COLLECTION THE PRIMARY DATA COLLECTION PROCESS HELPED TO VALIDATE SECONDARY DATA FINDINGS THE FOLLOWING SIGNIFICANT COMMUNITY HEALTH NEEDS WERE DETERMINED - ACCESS TO HEALTH CARE- CHRONIC DISEASES- HOMELESSNESS- MENTAL HEALTH- OVERWEIGHT AND OBESITY- PREVENTIVE PRACTICES- SENIOR HEALTH- SUBSTANCE ABUSE THE STAKEHOLDERS WERE ASKED TO RANK THE HEALTH NEEDS ACCORDING TO HIGHEST LEVEL OF IMPORTANCE IN THE COMMUNITY AMONG THE INTERVIEWEES, MENTAL HEALTH, HOMELESSNESS, AND ACCESS TO HEALTH CARE WERE RANKED AS THE TOP PRIORITY NEEDS IN THE SERVICE AREA THE SIGNIFICANT HEALTH NEEDS ARE LISTED IN PRIORITY ORDER 1 MENTAL HEALTH 2 HOMELESSNESS 3 ACCESS TO HEALTH CARE 4 SUBSTANCE ABUSE 5 CHRONIC DISEASES 6 OVERWEIGHT AND OBESITY 7 PREVENTIVE PRACTICES 8 SENIOR HEALTH PART V, SECTION B, LINE 3E THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA</p>

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
MARINA DEL REY HOSPITAL	PART V, SECTION B, LINE 5 IN CONDUCTING CEDARS-SINAI MARINA DEL REY'S CHNA, THE HOSPITAL FACILITY TOOK 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 TARGETED INTERVIEWS WERE USED TO GATHER INFORMATION AND OPINIONS FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL INTERVIEWS WERE COMPLETED IN OCTOBER AND NOVEMBER, 2017 COMMUNITY STAKEHOLDERS IDENTIFIED BY CSMDRH WERE CONTACTED AND ASKED TO PARTICIPATE IN THE NEEDS ASSESSMENT INTERVIEWEES INCLUDED INDIVIDUALS WHO ARE LEADERS AND REPRESENTATIVES OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS, OR LOCAL HEALTH OR OTHER DEPARTMENTS OR AGENCIES THAT HAVE INFORMATION RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY INPUT WAS OBTAINED FROM THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH THE IDENTIFIED STAKEHOLDERS WERE INVITED BY EMAIL TO PARTICIPATE IN A PHONE INTERVIEW

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
MARINA DEL REY HOSPITAL	<p>PART V, SECTION B, LINE 11 HEALTH NEEDS WERE IDENTIFIED IN THE CHNA AND SUBSEQUENTLY PRIORITIZED BY COMMUNITY STAKEHOLDERS FROM THE PRIORITIZED HEALTH NEEDS, CEDARS-SINAI MARINA DEL REY HOSPITAL (CSMDRH) CHOSE HEALTH FOCUS AREAS TAKING ACCOUNT CSMDRH'S CAPACITY TO IMPACT COMMUNITY NEEDS, THE STRENGTH OF COMMUNITY PARTNERSHIPS AND THE ALIGNMENT WITH CEDARS-SINAI'S ORGANIZATIONAL STRATEGIC PLANNING EFFORTS HEALTH FOCUS AREAS ACCESS TO CARE - COMMUNITY BENEFIT EFFORTS FOCUS ON PROGRAMS, PARTNERSHIPS AND STRATEGIES THAT INCREASE ACCESS TO PRIMARY CARE, PREVENTIVE CARE AND ACCESS TO MENTAL HEALTH CARE SERVICES HOMELESSNESS - COMMUNITY BENEFIT EFFORTS FOCUS ON PROGRAMS, PARTNERSHIPS AND STRATEGIES THAT INCREASE ACCESS TO PRIMARY CARE, MENTAL HEALTH CARE, SUBSTANCE ABUSE SERVICES AND COMMUNITY-BASED HEALTH CARE SERVICES FOR PERSONS EXPERIENCING HOMELESSNESS ALIGNMENT WITH PUBLIC HEALTH COMMUNITY HEALTH IMPROVEMENT PLAN CSMDRH IS COMMITTED TO ALIGNING ITS IMPLEMENTATION STRATEGY WITH THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH COMMUNITY HEALTH IMPROVEMENT PLAN CSMDRH'S IMPLEMENTATION STRATEGY CONCENTRATES ON "PRIORITY AREA 1 INCREASE PREVENTION TO IMPROVE HEALTH" OF THE COMMUNITY HEALTH IMPROVEMENT PLAN FOR LOS ANGELES COUNTY GOAL 1 2 FOR THIS PRIORITY AREA INCREASE ACCESS TO CARE (MEDICAL, CLINICAL PREVENTIVE SERVICES, MENTAL HEALTH AND DENTAL) CORRESPONDS TO THE CSMDRH IMPLEMENTATION STRATEGY'S HEALTH FOCUS AREAS EVALUATION OF IMPACT THE HEALTH FOCUS AREAS IDENTIFIED ABOVE WERE DETERMINED THROUGH DATA COLLECTION, ANALYSIS AND A PRIORITIZATION PROCESS THAT INCORPORATED COMMUNITY INPUT DUE TO THE QUANTITY AND SCOPE OF THE COMMUNITY'S HEALTH NEEDS IDENTIFIED, IT IS NECESSARY TO IDENTIFY FOCUS AREAS AND TO ENSURE THAT THE COMMUNITY BENEFIT INITIATIVES ARE EFFECTIVE IN IMPROVING THE HEALTH OF VULNERABLE POPULATIONS IN SUPPORT OF OUR MISSION TO IMPROVE THE HEALTH OF THE COMMUNITY, CSMDRH HAS COMMITTED TO ONGOING PROGRAM EVALUATION TO ENSURE MAXIMUM IMPACT OF OUR COMMUNITY BENEFIT STRATEGIES CSMDRH WILL INCORPORATE EVALUATION RESULTS INTO PROGRAM STRATEGY, PLANNING AND IMPLEMENTATION HEALTH NEEDS THE HOSPITAL WILL NOT ADDRESS THERE WERE SIGNIFICANT HEALTH NEEDS IDENTIFIED IN THE CHNA THAT DID NOT MEET THE CRITERIA FOR DEVELOPING AND IMPLEMENTING A HEALTH FOCUS AREA AND, AS A RESULT, ARE NOT ADDRESSED IN THIS IMPLEMENTATION STRATEGY THIS IS NOT INTENDED TO MINIMIZE THE IMPORTANCE OF THOSE HEALTH NEEDS, IT IS A REALITY OF HAVING A STRATEGIC FOCUS ON EFFECTIVENESS TO IMPROVE COMMUNITY HEALTH THE HEALTH NEEDS THAT WERE IDENTIFIED IN THE CHNA BUT NOT INCLUDED IN THE HEALTH FOCUS AREAS FOR THIS IMPLEMENTATION STRATEGY ARE CHRONIC DISEASES, OVERWEIGHT AND OBESITY, AND SENIOR HEALTH CSMDRH WILL CONTINUE TO LOOK FOR OPPORTUNITIES TO ADDRESS COMMUNITY NEEDS WHERE WE CAN MAKE A MEANINGFUL CONTRIBUTION</p>

**Schedule I
(Form 990)**

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the
Treasury
Internal Revenue Service

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
CFHS HOLDINGS INC

Employer identification number
20-1645949

Part I General Information on Grants and Assistance

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed

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

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

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

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

Part IV Supplemental Information. Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

Return Reference	Explanation
PART I, LINE 2	THE ORGANIZATION CONTRIBUTES TO WELL ESTABLISHED EXEMPT ORGANIZATIONS AND RELIES ON THE GOVERNING BODY OF EACH OF THESE ORGANIZATIONS TO ENSURE THAT GRANT FUNDS DONATED TO EACH AND EVERY ORGANIZATION ARE USED FOR PROPER PURPOSES AND NOT OTHERWISE DIVERTED FROM THE INTENDED USE

Additional Data

Software ID:
Software Version:
EIN: 20-1645949
Name: CFHS HOLDINGS INC

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
VENICE FAMILY CLINIC 604 ROSE AVE VENICE, CA 90291	95-2769432	501(C)(3)	25,000				GRANT FOR INTEGRATED MOBILE HEALTH TEAM
ST JOSEPH CENTER 204 HAMPTON DRIVE VENICE, CA 90291	95-3874381	501(C)(3)	25,000				GRANT FOR COMMUNITY HOMELESS SERVICES

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
							GRANT FOR COMMUNITY HOMELESS SERVICES

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.**

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
CFHS HOLDINGS INC

Employer identification number
20-1645949

Part I Questions Regarding Compensation

	Yes	No								
<p>1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p>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</p>	1b									
<p>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?</p>	2									
<p>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</p> <table border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee									
<p>4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p>	4a	No								
	4b	Yes								
	4c	No								
<p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p> <p>5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III</p>	5a	No								
	5b	No								
<p>6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III</p>	6a	No								
	6b	No								
<p>7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p>	7	No								
<p>8 Were any amounts reported on Form 990, Part VII, paid or accrued 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</p>	8	No								
<p>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	9									

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 THOMAS M PRISELAC CHAIR	(i)	0	0	0	0	0	0	0
	(ii)	1,571,779	1,248,768	807,008	1,347,100	26,050	5,000,705	400,000
2 MARK GAVENS CEO	(i)	0	0	0	0	0	0	0
	(ii)	974,424	473,131	276,523	176,135	36,495	1,936,708	0
3 MARY KATHRYN HAMMACK CFO/TREASURER	(i)	212,239	35,540	0	6,425	2,826	257,030	0
	(ii)	0	0	0	0	0	0	0
4 PAULETTE HEITMEYER COO	(i)	0	0	0	0	0	0	0
	(ii)	292,024	101,323	55,547	8,100	1,483	458,477	0
5 SHAWN BOND PHYSICIAN ASSISTANT	(i)	227,406	425	0	6,856	1,130	235,817	0
	(ii)	0	0	0	0	0	0	0
6 CATHY OHNSTAD CHIEF NURSING OFFICER	(i)	188,097	14,963	0	5,746	4,100	212,906	0
	(ii)	0	0	0	0	0	0	0
7 JEFFREY WALLACE ASSISTANT ADMINISTRATOR	(i)	176,835	17,325	0	15,785	1,774	211,719	0
	(ii)	0	0	0	0	0	0	0
8 PERCY CUPEN DIRECTOR OF QUALITY MANAGEMENT	(i)	182,941	18,657	0	830	2,319	204,747	0
	(ii)	0	0	0	0	0	0	0
9 KIMBERLY BOTWIN DIRECTOR PHARMACY	(i)	198,321	2,825	0	0	306	201,452	0
	(ii)	0	0	0	0	0	0	0

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 3	THE CEO OF CFHS HOLDINGS, INC (DBA CEDARS-SINAI MARINA DEL REY HOSPITAL) IS COMPENSATED BY CEDARS-SINAI MEDICAL CENTER, A RELATED TAX-EXEMPT ORGANIZATION. CEDARS-SINAI MEDICAL CENTER USED THE FOLLOWING METHODS IN ESTABLISHING THE CFHS HOLDINGS, INC CEO'S COMPENSATION: 1) COMPENSATION COMMITTEE, 2) INDEPENDENT COMPENSATION CONSULTANT, 3) WRITTEN EMPLOYMENT CONTRACT, 4) COMPENSATION SURVEY OR STUDY, AND 5) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.
PART I, LINE 4B	THERE ARE TWO NONQUALIFIED DEFERRED COMPENSATION PLANS IN WHICH ONE OR MORE OF THE LISTED PERSONS PARTICIPATE. THE FIRST PLAN IS A DEFERRED COMPENSATION PLAN. THIS IS A "GRANDFATHERED" TRADITIONAL DEFINED BENEFIT PLAN (NO NEW PARTICIPANTS HAVE BEEN ADDED SINCE 1986). THE BENEFIT FORMULA IS A PERCENTAGE OF THE HIGHEST FIVE YEARS AVERAGE ANNUAL SALARY TIMES THE NUMBER OF YEARS OF ELIGIBLE SERVICE, WITH A MAXIMUM CREDITED SERVICE OF 30 YEARS. THE SECOND PLAN IS A SUPPLEMENTAL RETIREMENT ALLOWANCE THAT IS PAYABLE DIRECTLY TO THE PARTICIPANTS EACH QUARTER. THE BENEFIT FORMULA FOR THIS PLAN HAS ANNUAL CONTRIBUTIONS THAT ARE EITHER A PERCENTAGE OF SALARY, OR ARE DESIGNED TO FUND A PERCENTAGE OF THE ESTIMATED FINAL 5-YEAR AVERAGE SALARY. THE FOLLOWING LISTED PERSONS RECEIVED PAYMENTS DURING THE YEAR ENDED DECEMBER 31, 2017 RELATED TO ONE OR BOTH OF THE PLANS REFERENCED ABOVE. THESE PAYMENTS ARE INCLUDED IN SCHEDULE J, PART II AND ARE NOT INCREMENTAL PAYMENTS. THOMAS M PRISELAC 708,909 MARK GAVENS 250,973 PAULETTE HEITMEYER 53,280.

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No 1545-0047

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.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
CFHS HOLDINGS INC

Employer identification number

20-1645949

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	CEDARS-SINAI MEDICAL CENTER IS THE SOLE CORPORATE MEMBER OF CFHS HOLDINGS, INC DOING BUSINESS AS CEDARS-SINAI MARINA DEL REY HOSPITAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	CEDARS-SINAI MEDICAL CENTER, AS THE SOLE CORPORATE MEMBER, ELECTS THE BOARD OF DIRECTORS OF CEDARS-SINAI MARINA DEL REY HOSPITAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	RESERVED RIGHTS OF CEDARS-SINAI MEDICAL CENTER, THE SOLE CORPORATE MEMBER OF CEDARS-SINAI MARINA DEL REY HOSPITAL ("THE HOSPITAL") THE FOLLOWING ACTIONS MUST BE APPROVED OR ACTED UPON BY CEDARS-SINAI MEDICAL CENTER BEFORE BECOMING EFFECTIVE (A) ANY AMENDMENT TO THE ARTICLES OF INCORPORATION OR BYLAWS OF THE HOSPITAL, (B) ANY AMENDMENT TO THE HOSPITAL'S PURPOSE OR MISSION, (C) ANY CHANGE IN THE MEMBERSHIP OR MEMBERSHIP POWERS OF THE HOSPITAL OR ITS SUBSIDIARY, (D) HIRING, ELECTING, REMOVING, OR TERMINATING ANY OF THE OFFICERS OF THE HOSPITAL, (E) REMOVAL AND APPOINTMENT OF DIRECTORS OF THE HOSPITAL, (F) CHANGING THE NUMBER OF DIRECTORS ON THE BOARD OF DIRECTORS, (G) SELECTION AND APPOINTMENT OF THE AUDITORS AND LEGAL COUNSEL OF THE HOSPITAL, (H) ANY SALE OR OTHER DISPOSITION OF ALL OR A SUBSTANTIAL PORTION OF THE ASSETS OF THE HOSPITAL, (I) MERGER, CONSOLIDATION, REORGANIZATION, DIVESTITURE, AFFILIATION, LIQUIDATION, OR DISSOLUTION, (J) BORROWING MONEY AND INCURRING INDEBTEDNESS ON BEHALF OF THE HOSPITAL, (K) APPROVING THE HOSPITAL'S ANNUAL OPERATING AND CAPITAL BUDGETS, (L) DECLARING OR CONSENTING TO THE FILING OF PROCEEDINGS TO DECLARE BANKRUPTCY

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE REVIEW OF THE FORM 990 INVOLVES VARIOUS MANAGEMENT PERSONNEL INCLUDING THE HOSPITAL'S TREASURER, AND A BIG FOUR ACCOUNTING FIRM THE FORM 990 IS PRESENTED AT A BOARD OF DIRECTORS' MEETING ALLOWING THE ENTIRE BOARD THE OPPORTUNITY TO DISCUSS THE INFORMATION REPORTED

990 Schedule O, Supplemental Information

Return Reference	Explanation
<p>FORM 990, PART VI, SECTION B, LINE 12C</p>	<p>THE PURPOSE OF THE CONFLICTS OF INTEREST POLICY IS TO PROTECT THE INTERESTS OF THE HOSPITAL WHEN IT IS CONTEMPLATING ENTERING INTO A TRANSACTION OR ARRANGEMENT THAT MIGHT BENEFIT THE PRIVATE INTEREST OF AN OFFICER OR DIRECTOR OF THE HOSPITAL OR MIGHT RESULT IN A POSSIBLE EXCESS BENEFIT TRANSACTION THIS POLICY IS INTENDED TO SUPPLEMENT BUT NOT REPLACE ANY APPLICABLE STATE LAWS GOVERNING CONFLICTS OF INTEREST APPLICABLE TO THE HOSPITAL PROCEDURES</p> <p>DUTY TO DISCLOSE - IN CONNECTION WITH ANY ACTUAL OR POSSIBLE CONFLICT OF INTEREST, AN INTERESTED PERSON MUST DISCLOSE THE EXISTENCE OF HIS OR HER FINANCIAL INTEREST AND ALL MATERIAL FACTS RELATING THERETO TO THE DIRECTORS AND MEMBERS OF COMMITTEES WITH BOARD DELEGATED POWERS CONSIDERING THE PROPOSED TRANSACTION OR ARRANGEMENT DETERMINING WHETHER A CONFLICT OF INTEREST EXISTS - AFTER DISCLOSURE OF THE FINANCIAL INTEREST AND ALL MATERIAL FACTS RELATING THERETO, AND AFTER ANY DISCUSSION THEREOF, THE INTERESTED PERSON SHALL LEAVE THE BOARD OR COMMITTEE MEETING WHILE THE FINANCIAL INTEREST IS DISCUSSED AND VOTED UPON THE REMAINING BOARD OR COMMITTEE MEMBERS SHALL DECIDE IF A CONFLICT OF INTEREST EXISTS</p> <p>ANNUAL STATEMENTS EACH DIRECTOR, PRINCIPAL OFFICER AND MEMBER OF A COMMITTEE SHALL ANNUALLY SIGN A STATEMENT WHICH AFFIRMS THAT SUCH PERSON A) HAS RECEIVED A COPY OF THE CONFLICTS OF INTEREST POLICY, B) HAS READ AND UNDERSTANDS THE POLICY, C) HAS AGREED TO COMPLY WITH THE POLICY, AND D) UNDERSTANDS THE HOSPITAL IS CHARITABLE AND IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION IT MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ONE OR MORE OF ITS TAX-EXEMPT PURPOSES</p> <p>PERIODIC REVIEWS TO ENSURE THAT THE HOSPITAL OPERATES IN A MANNER CONSISTENT WITH CHARITABLE PURPOSES AND DOES NOT ENGAGE IN ACTIVITIES THAT COULD JEOPARDIZE ITS TAX-EXEMPT STATUS, THE HOSPITAL SHALL CONDUCT PERIODIC REVIEWS OF THE IMPLEMENTATION OF THE POLICY THE PERIODIC REVIEWS SHALL, AT A MINIMUM, INCLUDE THE FOLLOWING SUBJECTS A) WHETHER COMPENSATION ARRANGEMENTS AND BENEFITS ARE REASONABLE, BASED ON COMPETENT SURVEY INFORMATION, AND THE RESULT OF ARM'S-LENGTH BARGAINING, B) WHETHER PARTNERSHIPS, JOINT VENTURES, AND ARRANGEMENTS WITH MANAGEMENT ORGANIZATIONS, IF ANY, CONFORM TO THE HOSPITAL'S WRITTEN POLICIES, ARE PROPERLY RECORDED, REFLECT REASONABLE INVESTMENT OR PAYMENTS FOR GOODS AND SERVICES, FURTHER CHARITABLE PURPOSES, AND DO NOT RESULT IN INUREMENT, IMPERMISSIBLE PRIVATE BENEFIT, OR IN AN EXCESS BENEFIT TRANSACTION USE OF OUTSIDE EXPERTS WHEN CONDUCTING PERIODIC REVIEWS, THE HOSPITAL MAY, BUT NEED NOT, USE OUTSIDE ADVISORS IF OUTSIDE ADVISORS ARE USED, THEIR USE SHALL NOT RELIEVE THE BOARD OF ITS RESPONSIBILITY FOR ENSURING PERIODIC REVIEWS ARE CONDUCTED</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE HOSPITAL'S CHIEF EXECUTIVE OFFICER IS COMPENSATED BY THE HOSPITAL'S SOLE CORPORATE MEMBER, CEDARS-SINAI MEDICAL CENTER. THE EXECUTIVE PERSONNEL COMMITTEE OF CEDARS-SINAI MEDICAL CENTER REVIEWS AND APPROVES THE CHIEF EXECUTIVE OFFICER'S COMPENSATION. SINCE THE HOSPITAL DOES NOT COMPENSATE ITS CHIEF EXECUTIVE OFFICER, THE RESPONSE TO THIS QUESTION IS NO, IN ACCORDANCE WITH SPECIFIC INSTRUCTIONS FROM THE INTERNAL REVENUE SERVICE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S AUDITED CONSOLIDATED FINANCIAL STATEMENTS ARE ATTACHED TO ITS FORM 990 THE CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS ARE NOT AVAILABLE TO THE PUBLIC

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE HOSPITAL'S FINANCIAL STATEMENTS WERE AUDITED ON A CONSOLIDATED BASIS WITH ITS PARENT FOR FISCAL YEAR ENDED JUNE 30, 2018 THE OVERSIGHT OF THE AUDIT WAS PERFORMED BY ITS PARENT'S AUDIT COMMITTEE

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2017

Open to Public Inspection

- ▶ 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.

Department of the Treasury
Internal Revenue Service

Name of the organization
CFHS HOLDINGS INC

Employer identification number

20-1645949

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

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

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

See Additional Data Table

(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	No

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.

See Additional Data Table

(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) Disproportionate 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	

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) CENTINELA FREEMAN HOLDINGS INC 4650 LINCOLN BLVD MARINA DEL REY, CA 90292 59-3811890	REAL ESTATE RENTALS	CA	N/A	C				Yes	
(2) OPTIMATRIX HEALTH SOLUTIONS INC 6500 WILSHIRE BLVD 9TH FLOOR LOS ANGELES, CA 90048 95-4522779	INACTIVE	CA	N/A	C				Yes	
(3) OTOHARMONICS CORPORATION 411 SW 6TH AVE PORTLAND, OR 97204 46-1119421	HEALTHCARE PRODUCT DEVELOPMENT	DE	N/A	C				Yes	

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)CENTINELA FREEMAN HOLDINGS INC	K	2,263,729	FAIR MARKET VALUE
(2)CENTINELA FREEMAN HOLDINGS INC	Q	2,366,394	FAIR MARKET VALUE

Part VII **Supplemental Information**

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

Additional Data

Software ID:
Software Version:
EIN: 20-1645949
Name: CFHS HOLDINGS INC

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	No
8700 BEVERLY BOULEVARD LOS ANGELES, CA 90048 95-1644600	ACUTE-CARE, TEACHING AND RESEARCH HOSPITAL	CA	501 (C) (3)	LINE 3	CEDARS-SINAI HEALTH SYSTEM	Yes	
15821 VENTURA BLVD STE 520 ENCINO, CA 91436 95-4772979	PROMOTE, SUPPORT, AND DEVELOP EDUCATIONAL, AND SCIENTIFIC RESEARCH	CA	501 (C) (3)	LINE 7	CEDARS-SINAI MEDICAL CENTER	Yes	
15821 VENTURA BLVD STE 520 ENCINO, CA 91436 95-4457756	PROVISION OF MEDICAL CARE, TEACHING, AND RESEARCH	CA	501 (C) (3)	LINE 12A, I	CEDARS-SINAI MEDICAL CENTER	Yes	
6801 PARK TERRACE STE 500 LOS ANGELES, CA 90045 95-4707606	EDUCATION AND RESEARCH RELATED TO ORTHOPEDIC MEDICINE	CA	501 (C) (3)	LINE 7	CEDARS-SINAI MEDICAL CARE FOUNDATION	Yes	
2020 SANTA MONICA BLVD 4TH FL SANTA MONICA, CA 90404 95-4789926	EDUCATION AND RESEARCH RELATED TO ORTHOPEDIC AND NEUROLOGIC CONDITIONS	CA	501 (C) (3)	PF	CEDARS-SINAI MEDICAL CARE FOUNDATION	Yes	
8700 BEVERLY BLVD LOS ANGELES, CA 90048 30-0990905	SUPPORT SPECIFIED NONPROFIT HEALTHCARE ORGANIZATIONS	CA	501 (C) (3)	LINE 12C, III-FI	N/A		No
3330 LOMITA BLVD TORRANCE, CA 90505 95-3528452	FUNDRAISING	CA	501 (C) (3)	LINE 7	TORRANCE HEALTH ASSOCIATION	Yes	
3330 LOMITA BLVD TORRANCE, CA 90505 95-1644042	HEALTH SERVICES	CA	501 (C) (3)	LINE 3	TORRANCE HEALTH ASSOCIATION	Yes	
3330 LOMITA BLVD TORRANCE, CA 90505 33-0073515	HEALTH SERVICES	CA	501 (C) (3)	LINE 12B, II	CEDARS-SINAI HEALTH SYSTEM	Yes	

