

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

# Return of Organization Exempt From Income Tax

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

Do not enter social security numbers on this form as it may be made public

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047  
**2018**  
Open to Public Inspection

**A For the 2019 calendar year, or tax year beginning 07-01-2018, and ending 06-30-2019**

**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) 823-8911

**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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	7
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	6
<b>5</b> Total number of individuals employed in calendar year 2018 (Part V, line 2a)	807
<b>6</b> Total number of volunteers (estimate if necessary)	6
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	0
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 34	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	2,508,408	61,160,650
<b>9</b> Program service revenue (Part VIII, line 2g)	106,396,752	125,117,992
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	665	0
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	420,091	393,485
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	109,325,916	186,672,127
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1–3)	55,000	80,000
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	53,341,459	66,670,060
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	57,927,477	54,267,723
<b>18</b> Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	111,323,936	121,017,783
<b>19</b> Revenue less expenses Subtract line 18 from line 12	-1,998,020	65,654,344
	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	71,606,899	128,759,169
<b>21</b> Total liabilities (Part X, line 26)	58,235,172	58,773,098
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	13,371,727	69,986,071

**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: 2020-07-15

NOLLY DAVE-SACHDEV CHIEF FINANCIAL OFFICER  
Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> 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 IRVINE, CA 92612			Phone no (949) 794-2300	

**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 \$ 97,562,502 including grants of \$ 80,000 ) (Revenue \$ 125,511,477 )  
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 ▶ 97,562,502

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response. Rows include questions 1 through 22 regarding organizational requirements, such as political activities, lobbying, and financial reporting.

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

		Yes	No
<b>23</b>	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> . . . . .	23	Yes
<b>24a</b>	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> . . . . .	24a	No
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	24b	
<b>c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	24c	
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	24d	
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> 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> . . . . .	25a	No
<b>b</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> . . . . .	25b	No
<b>26</b>	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> . . . . .	26	No
<b>27</b>	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> . . . . .	27	No
<b>28</b>	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)		
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28a	No
<b>b</b>	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	28b	No
<b>c</b>	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> . . . . .	28c	No
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	29	Yes
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	30	No
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	31	No
<b>32</b>	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> . . . . .	32	No
<b>33</b>	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> . . . . .	33	No
<b>34</b>	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> . . . . .	34	Yes
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes
<b>b</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> . . . . .	35b	Yes
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . .	36	No
<b>37</b>	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> . . . . .	37	No
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	38	Yes

**Part V Statements Regarding Other IRS Filings and Tax Compliance**

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

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . . . .	1a	75
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	1b	0
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	1c	Yes

<p><b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .</p>	<b>2a</b>	807		
<p><b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b>If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)</p>			<b>2b</b>	Yes
<p><b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .</p>			<b>3a</b>	No
<p><b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .</p>			<b>3b</b>	
<p><b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .</p>			<b>4a</b>	No
<p><b>b</b> If "Yes," enter the name of the foreign country <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)</p>				
<p><b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .</p>			<b>5a</b>	No
<p><b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>			<b>5b</b>	No
<p><b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .</p>			<b>5c</b>	
<p><b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .</p>			<b>6a</b>	No
<p><b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .</p>			<b>6b</b>	
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>				
<p><b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .</p>			<b>7a</b>	No
<p><b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .</p>			<b>7b</b>	
<p><b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .</p>			<b>7c</b>	No
<p><b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .</p>	<b>7d</b>			
<p><b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>			<b>7e</b>	No
<p><b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .</p>			<b>7f</b>	No
<p><b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .</p>			<b>7g</b>	
<p><b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .</p>			<b>7h</b>	
<b>8 Sponsoring organizations maintaining donor advised funds.</b>				
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .</p>			<b>8</b>	
<p><b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .</p>			<b>9a</b>	
<p><b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .</p>			<b>9b</b>	
<b>10 Section 501(c)(7) organizations.</b> Enter				
<p><b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .</p>	<b>10a</b>			
<p><b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	<b>10b</b>			
<b>11 Section 501(c)(12) organizations.</b> Enter				
<p><b>a</b> Gross income from members or shareholders . . . . .</p>	<b>11a</b>			
<p><b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) . . . . .</p>	<b>11b</b>			
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?				
<p><b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	<b>12b</b>			
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>				
<p><b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O</p>			<b>13a</b>	
<p><b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .</p>	<b>13b</b>			
<p><b>c</b> Enter the amount of reserves on hand . . . . .</p>	<b>13c</b>			
<p><b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .</p>			<b>14a</b>	No
<p><b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .</p>			<b>14b</b>	
<p><b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .</p>			<b>15</b>	No
<p><b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .</p>			<b>16</b>	No

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



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year; 1b Enter the number of voting members included in line 1a, above, who are independent; 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?; 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?; 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?; 5 Did the organization become aware during the year of a significant diversion of the organization's assets?; 6 Did the organization have members or stockholders?; 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?; 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?; 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following; 8a The governing body?; 8b Each committee with authority to act on behalf of the governing body?; 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.

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

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed; 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply; 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records.

**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	5,614,039	766,587
(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	1,853,624	144,759
(9) MARY KATHRYN HAMMACK CFO/TREASURER	50 00 5 00			X				258,436	0	19,548
(10) SHARON MARTINEZ SECRETARY	50 00 1 00			X				98,413	0	4,939
(11) JEFFREY SMITH MD JD MMM CEO	6 00 60 00			X				0	648,941	10,045
(12) PAULETTE HEITMEYER COO	50 00 1 00				X			0	472,504	14,960
(13) JOANNE LAGUNA-KENNEDY CNO	26 00 25 00				X			6,538	347,069	24,110
(14) SHAWN BOND PHYSICIAN ASSISTANT	50 00 0 00					X		227,817	0	30,621
(15) CATHY OHNSTAD CNO	50 00 0 00					X		221,659	0	22,898
(16) MARGARET MORGAN DIRECTOR OF HUMAN RESOURCES	50 00 0 00					X		198,930	0	19,350
(17) JEFFREY WALLACE ASSISTANT ADMINISTRATOR	50 00 0 00					X		195,663	0	20,678

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

Table with columns (A) Name and Title, (B) Average hours per week, (C) Position, (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, (F) Estimated amount of other compensation.

Summary rows for Sub-Total, Total from continuation sheets, and Total (add lines 1b and 1c).

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization 130

Questions 3, 4, and 5 regarding compensation reporting with Yes/No columns.

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization Report compensation for the calendar year ending with or within the organization's tax year

Table for independent contractors with columns (A) Name and business address, (B) Description of services, (C) Compensation.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 24



**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . .	<b>1a</b>				
	<b>b</b> Membership dues . . .	<b>1b</b>				
	<b>c</b> Fundraising events . . .	<b>1c</b>				
	<b>d</b> Related organizations	<b>1d</b>	58,200,000			
	<b>e</b> Government grants (contributions)	<b>1e</b>				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	2,960,650			
	<b>g</b> Noncash contributions included in lines 1a - 1f \$		58,200,000			
<b>h Total.</b> Add lines 1a-1f . . . . .		61,160,650				
<b>Program Service Revenue</b>	<b>2a</b> NET PATIENT REVENUE	Business Code				
		622110	78,350,518	78,350,518		
	<b>b</b> MEDICARE AND MEDICAL	622110	46,767,474	46,767,474		
	<b>c</b>					
	<b>d</b>					
	<b>e</b>					
	<b>f</b> All other program service revenue					
<b>g Total.</b> Add lines 2a-2f . . . . .		125,117,992				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .					
	<b>4</b> Income from investment of tax-exempt bond proceeds					
	<b>5</b> Royalties . . . . .					
	<b>6a</b> Gross rents	(i) Real				
		(ii) Personal				
		<b>b</b> Less rental expenses				
		<b>c</b> Rental income or (loss)				
	<b>d</b> Net rental income or (loss) . . . . .					
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities				
		(ii) Other				
		<b>b</b> Less cost or other basis and sales expenses				
		<b>c</b> Gain or (loss)				
	<b>d</b> Net gain or (loss) . . . . .					
	<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>				
		<b>b</b> Less direct expenses . . . . .	<b>b</b>			
<b>c</b> Net income or (loss) from fundraising events . . . . .						
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>					
	<b>b</b> Less direct expenses . . . . .	<b>b</b>				
	<b>c</b> Net income or (loss) from gaming activities . . . . .					
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>					
	<b>b</b> Less cost of goods sold . . . . .	<b>b</b>				
	<b>c</b> Net income or (loss) from sales of inventory . . . . .					
Miscellaneous Revenue	Business Code					
<b>11a</b> OTHER REVENUE	622110	393,485	393,485			
<b>b</b>						
<b>c</b>						
<b>d</b> All other revenue . . . . .						
<b>e Total.</b> Add lines 11a-11d . . . . .		393,485				
<b>12 Total revenue.</b> See Instructions . . . . .		186,672,127	125,511,477	0	0	

**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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	80,000	80,000		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	604,667	499,166	105,501	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
<b>7</b> Other salaries and wages.	48,289,620	34,905,187	13,384,433	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	1,242,295	899,546	342,749	
<b>9</b> Other employee benefits.	12,820,041	9,282,992	3,537,049	
<b>10</b> Payroll taxes.	3,713,437	2,688,900	1,024,537	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.	2,648,651	2,118,921	529,730	
<b>b</b> Legal.	73,049		73,049	
<b>c</b> Accounting.	9,210		9,210	
<b>d</b> Lobbying.				
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	8,633,693	7,091,921	1,541,772	
<b>12</b> Advertising and promotion.	482,695	362,021	120,674	
<b>13</b> Office expenses.				
<b>14</b> Information technology.	919,690	643,783	275,907	
<b>15</b> Royalties.				
<b>16</b> Occupancy.				
<b>17</b> Travel.	48,660	12,165	36,495	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	36,487	18,608	17,879	
<b>20</b> Interest.	3,793		3,793	
<b>21</b> Payments to affiliates.	2,295,605	2,295,605		
<b>22</b> Depreciation, depletion, and amortization.	3,804,502	3,043,602	760,900	
<b>23</b> Insurance.	1,183,995	887,996	295,999	
<b>24</b> 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):				
<b>a</b> UBI TAXES	131,142	131,142		
<b>b</b> PROSTHESIS/IMPLANTS	10,082,072	10,082,072		
<b>c</b> QAF EXPENSES	6,706,969	6,706,969		
<b>d</b> OTHER MEDICAL SUPPLIES	6,128,473	6,128,473		
<b>e</b> All other expenses	11,079,037	9,683,433	1,395,604	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	121,017,783	97,562,502	23,455,281	0
<b>26</b> 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
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	7,247,732	<b>1</b>	13,134,190
	<b>2</b> Savings and temporary cash investments . . . . .	736,853	<b>2</b>	710,403
	<b>3</b> Pledges and grants receivable, net . . . . .		<b>3</b>	
	<b>4</b> Accounts receivable, net . . . . .	12,739,866	<b>4</b>	18,692,095
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L . . . . .		<b>5</b>	
	<b>6</b> 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 . . . . .		<b>6</b>	
	<b>7</b> Notes and loans receivable, net . . . . .		<b>7</b>	
	<b>8</b> Inventories for sale or use . . . . .	1,388,178	<b>8</b>	1,204,066
	<b>9</b> Prepaid expenses and deferred charges . . . . .	14,395,625	<b>9</b>	12,806,306
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 98,324,324		
	<b>b</b> Less accumulated depreciation	<b>10b</b> 16,112,215	35,098,645	<b>10c</b> 82,212,109
	<b>11</b> Investments—publicly traded securities . . . . .		<b>11</b>	
	<b>12</b> Investments—other securities See Part IV, line 11 . . . . .		<b>12</b>	
	<b>13</b> Investments—program-related See Part IV, line 11 . . . . .		<b>13</b>	
	<b>14</b> Intangible assets . . . . .		<b>14</b>	
	<b>15</b> Other assets See Part IV, line 11 . . . . .		<b>15</b>	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	71,606,899	<b>16</b>	128,759,169	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	8,822,603	<b>17</b>	11,628,137
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .		<b>19</b>	
	<b>20</b> Tax-exempt bond liabilities . . . . .		<b>20</b>	
	<b>21</b> Escrow or custodial account liability Complete Part IV of Schedule D		<b>21</b>	
	<b>22</b> 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 . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	1,303,244	<b>23</b>	1,303,244
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	
	<b>25</b> 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	48,109,325	<b>25</b>	45,841,717
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	58,235,172	<b>26</b>	58,773,098
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	13,371,727	<b>27</b>	69,986,071
	<b>28</b> Temporarily restricted net assets . . . . .		<b>28</b>	
	<b>29</b> Permanently restricted net assets		<b>29</b>	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b> Total net assets or fund balances . . . . .	13,371,727	<b>33</b>	69,986,071	
<b>34</b> Total liabilities and net assets/fund balances . . . . .	71,606,899	<b>34</b>	128,759,169	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	186,672,127
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	121,017,783
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	65,654,344
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	13,371,727
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-9,040,000
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	69,986,071

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990  Cash  Accrual  Other \_\_\_\_\_  
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?  
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- 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

	Yes	No
<b>2a</b>		No
<b>2b</b>	Yes	
<b>2c</b>	Yes	
<b>3a</b>		No
<b>3b</b>		

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

Form 990 (2018)

**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 THE HOSPITAL IS FULLY ACCREDITED WITH THE NATIONALLY RECOGNIZED JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS FOR SAFE AND EFFECTIVE QUALITY CARE ("THE JOINT COMMISSION") THE HOSPITAL HAS THE FOLLOWING INPATIENT AND OUTPATIENT SERVICES 24-HOUR EMERGENCY CARE INCLUDING TELESTROKE SERVICES IN COLLABORATION WITH NEUROSURGEONS FROM CEDARS-SINAI MEDICAL CENTER (CSMC), ICU, TELEMETRY, INPATIENT AND OUTPATIENT DIAGNOSTIC SERVICES AND ADVANCED SURGICAL TECHNOLOGY, CAREFULLY PRACTICED UNDER THE SUPERVISION AND SKILLED HANDS OF WORLD-CLASS PHYSICIANS, NURSES AND ALLIED HEALTH CARE PROFESSIONALS (SEE SCHEDULE O FOR CONTINUATION)(CONTINUED FROM PAGE 2)HOSPITAL SERVICES -24-HOUR EMERGENCY SERVICES-TELEMEDICINE STROKE PROGRAM IN THE EMERGENCY ROOM-INTENSIVE CARE UNIT-TELEMETRY/MEDICAL SURGICAL UNITS (CARDIAC MONITORED BEDS)-INPATIENT AND OUTPATIENT DIAGNOSTIC SERVICES (LAB, IMAGING, GI, CARDIOLOGY)-OUTPATIENT BARIATRIC CLINIC (THE MARINA WEIGHT LOSS CENTER)-OUTPATIENT SPINE CLINIC (THE MARINA SPINE CENTER)-MINIMALLY INVASIVE SURGICAL SERVICES (FOR HERNIA, APPENDECTOMY, GALLBLADDER, COLON, ANTI REFLUX, BARIATRIC, SPINE, TOTAL HIP, TOTAL KNEE CASES), UTILIZING THE DA VINCI ROBOT AND THE MAKO STRYKER ORTHO ROBOT HOSPITAL STATISTICS EMPLOYEES 807PHYSICIANS WITH HOSPITAL PRIVILEGES 467SURGEONS WITH HOSPITAL PRIVILEGES 120NUMBER OF SURGERIES ANNUALLY 4,057NUMBER OF ER VISITS ANNUALLY 36,046PAYOR % - MEDICARE 31 5%, MEDI-CAL 3 9%, COMMERCIAL AND MANAGED CARE 53 4%, SELF PAY AND OTHER 11 2%HOSPITAL OPERATIONS THE HOSPITAL UPGRADED THE CLINICAL ELECTRONIC MEDICAL RECORD SYSTEM AND CONVERTED TO THE EPIC EHR IN MAY OF 2017 THERE WERE CONTINUED ENHANCEMENTS TO THE REPORTING CAPABILITIES IN 2019 AND THE UPGRADED TECHNOLOGY AND REPORTING CAPABILITIES HAVE IMPROVED THE ABILITY OF PHYSICIANS AND CLINICAL STAFF TO VIEW PRIOR VISIT RECORDS, ENHANCE PATIENT SAFETY VIA ALERTS, INCREASE DATA ANALYSIS AND HAS 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 THE MARINA WEIGHT LOSS CENTER ACCREDITATED 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 IS ACTIVELY INVOLVED IN COUNCILMAN MIKE BONIN'S HOMELESS INITIATIVE, "VENICE FORWARD" IN ADDITION, THE HOSPITAL HAS JOINED FORCES WITH COMMUNITY PARTNERS (VENICE FAMILY CLINIC, ST JOSEPH CENTER, AND OPCC "THE PEOPLE CONCERN") TO HELP STEM THE HOMELESS CRISIS ON THE WESTSIDE IN FY2019 THE HOSPITAL IMPLEMENTED A HOMELESS FACILITATOR/NAVIGATOR IN THE HOSPITAL'S EMERGENCY ROOM 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 ON A CONSISTENT BASIS FACILITY STAFF REPRESENT THE HOSPITAL AT THE FOLLOWING LOCAL COMMUNITY EVENTS AND COLLABORATIVES \*HOST COMMUNITY YOGA 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 DAY HEALTH FAIR \*VENICE NEIGHBORHOOD COUNCIL - BOARD MEETING \*THE PEOPLE CONCERN (FORMERLY OPCC) \*ST JOSEPH CENTER - CES (COORDINATED ENTRY SYSTEM) \*LAX COASTAL CHAMBER OF COMMERCE \*LMU ROCK, ROLL & RUN IN SUPPORT OF LAX COASTAL EDUCATION FOUNDATION \*INCLUSIVITY MATTERS GALA \*LAPD PACIFIC DIVISION TOY DRIVE \*VILLA MARINA BLOCK PARTY \*EL SEGUNDO DISASTER PREPAREDNESS DAY SPECIFIC 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 AGENCIS 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 CSMC NEUROLOGY DEPARTMENT HAS BEEN UTILIZING TELEMEDICINE IN THE EMERGENCY ROOM SINCE FEBRUARY 2017 TO SUCCESSFULLY DIAGNOSE STROKE AND EXPEDITE TREATMENT ADDITIONALLY, THE HOSPITAL 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 2020 - ADDITIONAL SPECIALTY PHYSICIANS ARE ROTATING THROUGH A SPECIALTY CLINIC ADJACENT TO THE HOSPITAL TO COVER SPECIALTIES NOT PREVIOUSLY OFFERED AT THE HOSPITAL THESE SERVICES PROVIDED BY CSMC FOUNDATION PHYSICIANS INCLUDE ENT, GYN, CARDIOLOGY, GI, AND NEUROLOGY THE SPECIALISTS ALTERNATE DAYS OF THE WEEK MAKING FOLLOW-UP APPOINTMENTS FOR PATIENTS WHO HAVE BEEN SEEN AS INPATIENTS IN THE HOSPITAL, EASIER THIS ALSO HELPS REDUCE READMISSIONS AND IS CONVENIENT FOR THE PATIENTS IN THE COMMUNITY

**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.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

**2018**

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

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

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2  A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8  A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9  An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university \_\_\_\_\_
- 10  An organization that normally receives (1) more than 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		
<b>Total</b>						

**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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	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)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc (see instructions)					<b>12</b>	

**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**

<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b>	

- 16a 33 1/3% support test—2018.** 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—2017.** 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—2018.** 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—2017.** 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>9</b>	Amounts from line 6						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b>	Add lines 10a and 10b						
<b>11</b>	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b>	<b>Total support.</b> (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**

<b>15</b>	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b>	Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

<b>17</b>	Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2018.** 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—2017.** 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
<b>1</b>	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
	<b>1</b>		
<b>2</b>	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 <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
	<b>2</b>		
<b>3a</b>	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		
	<b>3a</b>		
<b>b</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 <b>Part VI</b> when and how the organization made the determination.		
	<b>3b</b>		
<b>c</b>	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.		
	<b>3c</b>		
<b>4a</b>	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.		
	<b>4a</b>		
<b>b</b>	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
	<b>4b</b>		
<b>c</b>	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 <b>Part VI</b> 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.		
	<b>4c</b>		
<b>5a</b>	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 <b>Part VI</b> , 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).		
	<b>5a</b>		
<b>b</b>	<b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
	<b>5b</b>		
<b>c</b>	<b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
	<b>5c</b>		
<b>6</b>	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 <b>Part VI</b> .		
	<b>6</b>		
<b>7</b>	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).		
	<b>7</b>		
<b>8</b>	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).		
	<b>8</b>		
<b>9a</b>	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 <b>Part VI</b> .		
	<b>9a</b>		
<b>b</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 <b>Part VI</b> .		
	<b>9b</b>		
<b>c</b>	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 <b>Part VI</b> .		
	<b>9c</b>		
<b>10a</b>	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.		
	<b>10a</b>		
<b>b</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.)		
	<b>10b</b>		

**Part IV Supporting Organizations** (continued)

		Yes	No
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	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>b</b>	A family member of a person described in (a) above?		
<b>c</b>	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
<b>1</b>	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>		
<b>2</b>	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
<b>1</b>	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
<b>1</b>	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?		
<b>2</b>	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>		
<b>3</b>	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**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> )		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).		
<b>2</b>	Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>	Yes	No
<b>b</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>		
<b>3</b>	Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>b</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**

- 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.

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by .035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<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)**

<b>Section D - Distributions</b>	<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ) See instructions	
<b>7 Total annual distributions.</b> Add lines 1 through 6	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ) See instructions	
<b>9</b> Distributable amount for 2018 from Section C, line 6	
<b>10</b> Line 8 amount divided by Line 9 amount	

<b>Section E - Distribution Allocations (see instructions)</b>	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2018</b>	<b>(iii) Distributable Amount for 2018</b>
<b>1</b> Distributable amount for 2018 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
<b>3</b> Excess distributions carryover, if any, to 2018			
<b>a</b> From 2013. . . . .			
<b>b</b> From 2014. . . . .			
<b>c</b> From 2015. . . . .			
<b>d</b> From 2016. . . . .			
<b>e</b> From 2017. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2018 distributable amount			
<b>i</b> Carryover from 2013 not applied (see instructions)			
<b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b> Distributions for 2018 from Section D, line 7			
\$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2018 distributable amount			
<b>c</b> Remainder Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
<b>6</b> Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
<b>7 Excess distributions carryover to 2019.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7			
<b>a</b> Excess from 2014. . . . .			
<b>b</b> Excess from 2015. . . . .			
<b>c</b> Excess from 2016. . . . .			
<b>d</b> Excess from 2017. . . . .			
<b>e</b> Excess from 2018. . . . .			

## 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.**  
**► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.**

OMB No 1545-0047  
**2018**  
**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
<b>1</b> Total number at end of year		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> Aggregate value at end of year		
<b>5</b> 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
<b>6</b> 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	
<b>a</b> Total number of conservation easements	<b>2a</b>	
<b>b</b> Total acreage restricted by conservation easements	<b>2b</b>	
<b>c</b> Number of conservation easements on a certified historic structure included in (a)	<b>2c</b>	
<b>d</b> Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	<b>2d</b>	

**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 |
|--|--------|
| <b>c</b> Beginning balance             |        |
| <b>d</b> Additions during the year     |        |
| <b>e</b> Distributions during the year |        |
| <b>f</b> 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
<b>1a</b> Beginning of year balance . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> 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
- |  |     |    |
|--|-----|----|
| <b>(i)</b> unrelated organizations . . . . .   | Yes | No |
| <b>(ii)</b> related organizations . . . . .  |     |    |
| <b>b</b> If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . |     |    |
- 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
<b>1a</b> Land . . . . .		49,160,000		49,160,000
<b>b</b> Buildings . . . . .		27,560,638	5,220,504	22,340,134
<b>c</b> Leasehold improvements		126,458	10,538	115,920
<b>d</b> Equipment . . . . .		16,720,457	8,125,230	8,595,227
<b>e</b> Other . . . . .		4,756,771	2,755,943	2,000,828
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				82,212,109

**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)		
<b>Total.</b> (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)		
<b>Total.</b> (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)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15 )	

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
DUE TO/FROM RELATED ORGANIZATION	31,452,572
MALPRACTICE RESERVES	3,063,000
WORKERS COMP RESERVES	4,966,000
CAPITAL LEASES	35,365
ACCRUED PAYROLL	6,324,780
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	45,841,717

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.

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

**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.

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

**Part XIII** Supplemental Information *(continued)*

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 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

# Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**  
 ▶ **Attach to Form 990.**  
 ▶ **Go to [www.irs.gov/Form990EZ](http://www.irs.gov/Form990EZ) for instructions and the latest information.**

OMB No 1545-0047  
2018  
**Open to Public Inspection**

**Name of the organization**  
 CFHS HOLDINGS INC

**Employer identification number**  
 20-1645949

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> 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			
<b>3</b> 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			
<b>a</b> 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 _____ %	<b>3a</b>	Yes	
<b>b</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 %	<b>3b</b>	Yes	
<b>c</b> 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			
<b>4</b> 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"?	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>	Yes	
<b>c</b> 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?	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	Yes	

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

	(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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			385,848		385,848	0 320 %
<b>b</b> Medicaid (from Worksheet 3, column a)			25,428,394	9,835,200	15,593,194	12 890 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			25,814,242	9,835,200	15,979,042	13 210 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			168,035		168,035	0 140 %
<b>f</b> Health professions education (from Worksheet 5)						
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			75,000		75,000	0 060 %
<b>j Total.</b> Other Benefits			243,035		243,035	0 200 %
<b>k Total.</b> Add lines 7d and 7j			26,057,277	9,835,200	16,222,077	13 410 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			5,000		5,000	0 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
<b>10 Total</b>			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?		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.		
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.		
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	39,552,227
6	Enter Medicare allowable costs of care relating to payments on line 5.	6	55,024,663
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-15,472,436
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
9b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI.	9b	Yes

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

**Part V Facility Information****Section A. Hospital Facilities**

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

How many hospital facilities did the organization operate during the tax year?

**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)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
 CEDARS-SINAI 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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	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
<b>2</b>	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
<b>3</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 18</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</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
<b>7</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, PAGE 8</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 18</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, PAGE 8</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	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		
<b>12a</b>	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>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	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)**

CEDARS-SINAI 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			
<b>13</b>	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	<b>13</b> Yes	
<b>a</b>	<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>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	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)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>HTTPS //WWW MARINAHOSPITAL COM/FINANCIAL-OVERVIEW/ASSISTANCE</u>		
<b>b</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>		
<b>c</b>	<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>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<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		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		



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

CEDARS-SINAI MARINA DEL REY HOSPITAL

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

		Yes	No	
<b>17</b>	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	
<b>18</b>	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			
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<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			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>f</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
<b>19</b>	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
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)			
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party			
<b>c</b>	<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			
<b>d</b>	<input type="checkbox"/> Actions that require a legal or judicial process			
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)			
<b>20</b>	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)			
<b>a</b>	<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>b</b>	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
<b>c</b>	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
<b>d</b>	<input checked="" type="checkbox"/> Made presumptive eligibility determinations			
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)			
<b>f</b>	<input type="checkbox"/> None of these efforts were made			

**Policy Relating to Emergency Medical Care**

<b>21</b>	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	
<b>a</b>	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
<b>b</b>	<input type="checkbox"/> The hospital facility's policy was not in writing			
<b>c</b>	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
<b>d</b>	<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)**

CEDARS-SINAI 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
<b>23</b>		No
<b>24</b>		No

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

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

Form and Line Reference	Explanation
See Add'l Data	

**Part V Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 3

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

**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 6/30/2019
PART I, LINE 7, COLUMN (F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$ 28,262

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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
PART III, LINE 2	AS A RESULT OF THE ADOPTION OF ASC 606, THE HOSPITAL IS REPORTING IMPLICIT PRICE CONCESSIONS, WHICH IS ESTABLISHED BASED ON MANY FACTORS, INCLUDING PAYER MIX, AGE OF RECEIVABLES, HISTORICAL CASH COLLECTION EXPERIENCE, AND OTHER RELEVANT INFORMATION, AND BAD DEBT, WHICH IS DUE TO CREDIT ISSUES NOT ASSESSED AT THE DATE OF SERVICE

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 4	AUDITED FINANCIAL STATEMENTS - PAGE 14PART 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 6/30/2019
PART III, LINE 8	IT IS OUR BELIEF THAT ALL OF THE \$15,472,436 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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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
PART VI, LINE 2	A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS CONDUCTED IN FISCAL YEAR ENDED 6/30/19 SEE NARRATIVE FOR SCHEDULE H, PART V, SECTION B, LINE 3J



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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 PUBLICIZING THE POLICY THE HOSPITAL WIDELY PUBLICIZES ITS FINANCIAL ASSISTANCE POLICY AND PROGRAMS, INCLUDING DISTRIBUTION TO TARGETED COMMUNITY ORGANIZATIONS, AMONG A VARIETY OF OTHER MEANS, TO ALERT THE HOSPITAL'S COMMUNITY TO THE AVAILABILITY OF FINANCIAL ASSISTANCE THE FINANCIAL ASSISTANCE POLICY, THE APPLICATION FORM AND THE PLAIN LANGUAGE SUMMARY ARE AVAILABLE ON THE HOSPITAL'S WEBSITE AT <a href="https://www.marinahospital.com/financial-overview/assistance">HTTPS //WWW MARINAHOSPITAL COM/FINANCIAL-OVERVIEW/ASSISTANCE</a>
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 THREE OTHER HOSPITALS THAT SERVE THE SAME COMMUNITY AS CEDARS-SINAI MARINA DEL REY HOSPITAL

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 5	<p>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 THE HOSPITAL IS GOVERNED BY A BOARD OF DIRECTORS THAT IS COMPRISED OF MEMBERS OF THE COMMUNITY FURTHERMORE, THE COMMUNITIES ARE SERVED BY AN OPEN MEDICAL STAFF ALSO, ANY SURPLUS FUNDS ARE REINVESTED INTO THE ORGANIZATION TO FURTHER SUPPORT THE COMMUNITY</p>
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 \$16,222,077 DIVIDED AMONG THE FOLLOWING CATEGORIES * UNREIMBURSED COST OF DIRECT MEDICAL CARE FOR THE POOR AND UNDERSERVED - \$15,979,042 (CHARITY CARE - \$385,848, UNREIMBURSED COST CARING FOR MEDICAL PATIENTS - \$15,593,194) (EXCLUDES THE UNREIMBURSED COST OF CARING FOR MEDICARE PATIENTS) COMMUNITY BENEFIT PROGRAMS, INCLUDING CHARITABLE DONATIONS - \$243,035</p>

## 990 Schedule H, Supplemental Information

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

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 20-1645949

**Name:** CFHS HOLDINGS INC

## Form 990 Schedule H, Part V Section A. Hospital Facilities

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	CEDARS-SINAI 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
CEDARS-SINAI 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 HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT FOR JULY 1, 2018 THROUGH JUNE 30, 2021 WAS APPROVED BY ITS GOVERNING BODY ON MAY 29, 2019 COMMUNITY BENEFIT SERVICE AREACEDARS-SINAI MARINA DEL REY HOSPITAL (CSMDRH) 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, PL AYA VISTA, SANTA MONICA, VENICE AND WESTCHESTER PORTIONS OF THE SERVICE AREA ARE SERVED BY LOS ANGELES CITY COUNCIL DISTRICT 11 THE SERVICE AREA IS LOCATED IN LOS ANGELES COUNTY SERVICE PLANNING AREA 5 (SPA 5) CSMDRH TRACKS ZIP CODES OF ORIGIN FOR PATIENT ADMISSIONS THE SERVICE AREA WAS DETERMINED FROM THE ZIP CODES THAT REFLECT A MAJORITY OF PATIENT ADMISSIONS FROM THE LOCAL GEOGRAPHIC AREA CEDARS-SINAI MARINA DEL REY'S COMMUNITY BENEFIT SERVICE AREA (CURRENT)THE POPULATION OF THE CEDARS-SINAI MARINA DEL REY HOSPITAL (CSMDRH) SERVICE AREA IS 232,436 FROM 2011 TO 2016, THE POPULATION INCREASED BY 4 4%, HIGHER THAN THE 2 8% INCREASE IN POPULATION COUNTYWIDE RACE/ETHNICITYTHE POPULATION CHARACTERISTICS FOR CEDARS-SINAI MARINA DEL REY'S COMMUNITY BENEFIT SERVICE AREA (CURRENT) ARE AS FOLLOWS WHITE (54 2%), HISPANIC/LATINO (21 7%), ASIAN (12 2%),BLACKS/AFRICAN AMERICAN (6 7%), AMERICAN INDIAN/ALASKA NATIVE ( 1%), NATIVE HAWAIIAN/PACIFIC ISLANDER ( 1%), OTHER (4 9%)AGELESS THAN 18 YEARS (15 2%), 18-24 (9 3%), 25-64 (61 8%), GREATER THAN 65 YEARS (13 7%)GENDERFEMALE (50 4%), MALE (49 6%)CITIZENSHIPIN THE SERVICE AREA, 24% OF THE RESIDENTS ARE FOREIGN BORN, AND 48 3% OF THESE FOREIGN BORN ARE NOT CITIZENS VETERANS4 1% OF THE RESIDENTS IN THE CSMDRH SERVICE AREA ARE VETERANS SOCIOECONOMIC STATUSTHE CENSUS BUREAU ANNUALLY UPDATES OFFICIAL POVERTY POPULATION STATISTICS FOR 2016, THE FEDERAL POVERTY LEVEL (FPL) WAS AN ANNUAL INCOME OF \$11,880 FOR ONE PERSON AND \$24,300 FOR A FAMILY OF FOUR AMONG AREA RESIDENTS, 9 8% ARE AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL (FPL) AND 23 2% ARE AT 200% OF FPL OR BELOW (LOW INCOME) RESIDENTS LIVING BELOW THE POVERTY LINE IN CSMDRH SERVICE AREA (23 2%), LOS ANGELES COUNTY (39 6%)POVERTY LEVELS OF CHILDREN, SENIORS, AND FEMALES HEAD OF HOUSEHOLD WITH CHILDREN IN CSMDRH SERVICE AREA (22 2%), LOS ANGELES COUNTY (38 3%)UNEMPLOYMENTTHE UNEMPLOYMENT RATES OF THOSE CITIES WHOSE RATES WERE REPORTED FOR THE SERVICE AREA A RANGE FROM 3 3% IN CULVER CITY TO 4 4% IN SANTA MONICA LOS ANGELES COUNTY HAS AN UNEMPLOYMENT RATE OF 4 7% HOUSEHOLDSIN THE SERVICE AREA THERE ARE 104,045 HOUSEHOLDS AND 111,822 HOUSING UNITS OVER THE LAST FIVE YEARS, THE POPULATION GREW BY 4 4% AND HOUSEHOLDS GREW BY 1 0% THE AREA LOST HOUSING</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
CEDARS-SINAI MARINA DEL REY HOSPITAL	<p>UNITS FROM 2012 TO 2016 (-0.2%) AND VACANT UNITS DECREASED BY 14.3%. HOME OWNERSHIP ALSO DECREASED, WITH 5.3% FEWER UNITS OCCUPIED BY OWNERS, WHILE RENTER-OCCUPIED UNITS INCREASED BY 5.7%. HOUSEHOLD INCOME: THE MEDIAN HOUSEHOLD INCOME IN THE SERVICE AREA IS \$82,364 AND THE AVERAGE HOUSEHOLD INCOME IS \$114,757. EDUCATIONAL ATTAINMENT: AMONG AREA ADULTS, AGES 25 AND OLDER, ONLY 7.5% LACK A HIGH SCHOOL DIPLOMA. 10.4% OF ADULTS ARE HIGH SCHOOL GRADUATES AND 64% OF AREA ADULTS ARE COLLEGE GRADUATES. DATA COLLECTION: SECONDARY DATA WE RE COLLECTED FROM A VARIETY OF LOCAL, COUNTY AND STATE SOURCES TO PRESENT COMMUNITY DEMOGRAPHICS, SOCIAL DETERMINANTS OF HEALTH, HEALTH CARE ACCESS, LEADING CAUSES OF DEATH, ACUTE AND CHRONIC DISEASE, HEALTH BEHAVIORS, MENTAL HEALTH, SUBSTANCE USE AND MISUSE, AND PREVENTIVE PRACTICES. WHEN AVAILABLE, DATA SETS ARE PRESENTED IN THE CONTEXT OF LOS ANGELES COUNTY AND CALIFORNIA TO HELP FRAME THE SCOPE OF AN ISSUE AS IT RELATES TO THE BROADER COMMUNITY SOURCES OF DATA. INCLUDE THE U.S. CENSUS AMERICAN COMMUNITY SURVEY, CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, CALIFORNIA HEALTH INTERVIEW SURVEY, LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH, THINK HEALTH LA, COUNTY HEALTH RANKINGS, CALIFORNIA DEPARTMENT OF EDUCATION, CALIFORNIA OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT AND CALIFORNIA DEPARTMENT OF JUSTICE, AMONG OTHERS. SECONDARY DATA FOR THE SERVICE AREA WERE COLLECTED AND DOCUMENTED IN DATA TABLES WITH NARRATIVE EXPLANATION. THE TABLES PRESENT THE DATA INDICATOR, THE GEOGRAPHIC AREA REPRESENTED, THE DATA MEASUREMENT (E.G. RATE, NUMBER, OR PERCENT), COUNTY AND STATE COMPARISONS (WHEN AVAILABLE), THE DATA SOURCE, DATA YEAR AND AN ELECTRONIC LINK TO THE DATA SOURCE. ANALYSIS OF SECONDARY DATA INCLUDES AN EXAMINATION AND REPORTING OF HEALTH DISPARITIES FOR SOME HEALTH INDICATORS. THE REPORT INCLUDES BENCHMARK COMPARISONS THAT MEASURE THE DATA FINDINGS AS COMPARED TO HEALTHY PEOPLE 2020 OBJECTIVES, WHERE APPROPRIATE. HEALTHY PEOPLE 2020 OBJECTIVES ARE A NATIONAL INITIATIVE TO IMPROVE THE PUBLIC'S HEALTH BY PROVIDING MEASURABLE OBJECTIVES AND GOALS THAT ARE APPLICABLE AT NATIONAL, STATE, AND LOCAL LEVELS. SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED FROM SECONDARY DATA USING THE SIZE OF THE PROBLEM (RELATIVE PORTION OF POPULATION AFFLICTED BY THE PROBLEM) AND THE SERIOUSNESS OF THE PROBLEM (IMPACT AT INDIVIDUAL, FAMILY, AND COMMUNITY LEVELS) TO DETERMINE SIZE OR SERIOUSNESS OF THE PROBLEM, THE HEALTH NEED INDICATORS IDENTIFIED IN THE SECONDARY DATA WERE MEASURED AGAINST BENCHMARK DATA, SPECIFICALLY, COUNTY RATES, STATE RATES AND/OR HEALTHY PEOPLE 2020 OBJECTIVES. INDICATORS RELATED TO THE HEALTH NEEDS, WHICH PERFORMED POORLY AGAINST ONE OR MORE OF THESE BENCHMARKS MET THIS CRITERION TO BE CONSIDERED A HEALTH NEED. THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE DETERMINED: *ACCESS TO HEALTH CARE*ASTHMA*CANCER*DIABETES*HEART DISEASE AND STROKE*HOUSING AND HOMELESSNESS*MENTAL HEALTH*OVERWEIGHT AND OBESITY*PREVENTIVE PRACTICE</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
<p>CEDARS-SINAI MARINA DEL REY HOSPITAL</p>	<p>ES (SCREENINGS, VACCINES)*SENIOR HEALTH*SUBSTANCE USE AND MISUSE THE LIST OF SIGNIFICANT HEALTH NEEDS INFORMED PRIMARY DATA COLLECTION THE PRIMARY DATA COLLECTION PROCESS WAS DESIGNED TO VALIDATE SECONDARY DATA FINDINGS, IDENTIFY ADDITIONAL COMMUNITY ISSUES, SOLICIT INFORMATION ON DISPARITIES AMONG SUBPOPULATIONS, ASCERTAIN COMMUNITY ASSETS TO ADDRESS NEEDS AND DISCOVER GAPS IN RESOURCES ACUTE AND CHRONIC DISEASES THE PERCENT OF ADULTS DIAGNOSED WITH DIABETES IN SERVICE AREA CITIES (WHERE DATA WERE AVAILABLE) AND LA CITY COUNCIL DISTRICT 11 RANGED FROM A LOW OF 5% IN CITY COUNCIL DISTRICT 11 TO A HIGH OF 7% IN CULVER CITY AMONG ADULTS IN SPA 5, 6 3% HAVE BEEN DIAGNOSED WITH DIABETES, AND 6 9% WITH PRE-DIABETES FOR ADULTS WITH DIABETES, 74 7% IN SPA 5 FELT VERY CONFIDENT THEY COULD CONTROL THE IR DIABETES, WHILE 7 2% WERE NOT AT ALL CONFIDENT DIAGNOSES NUMBERS ARE LOWER, AND CONFIDENCE HIGHER, IN SPA 5 THAN IN LOS ANGELES COUNTY HIGH BLOOD PRESSURE A CO-MORBIDITY FACTOR FOR DIABETES AND HEART DISEASE IS HYPERTENSION (HIGH BLOOD PRESSURE) IN SPA 5, 24 3% OF ADULTS ARE DIAGNOSED WITH HIGH BLOOD PRESSURE OF THOSE DIAGNOSED WITH HIGH BLOOD PRESSURE, 69 9% REPORTED TAKING MEDICATION TO MANAGE THEIR HIGH BLOOD PRESSURE IN SPA 5, 27 3% OF LATINO ADULTS INDICATED THEY HAVE HIGH BLOOD PRESSURE, THIS IS HIGHER THAN THE RATES OF HIGH BLOOD PRESSURE REPORTED AMONG LATINOS IN LA COUNTY AND CALIFORNIA 29 4% OF AFRICAN-AMERICANS, 23 9% OF WHITES, AND 19 9% OF SPA 5 ASIANS REPORTED HIGH BLOOD PRESSURE, THESE RATES ARE LOWER THAN COUNTY AND STATE RATES HEART DISEASES 3% OF ADULTS IN SPA 5 REPORTED THEY HAVE BEEN DIAGNOSED WITH HEART DISEASE AMONG ADULTS DIAGNOSED WITH HEART DISEASE, 88 7% IN SPA 5 WERE GIVEN A MANAGEMENT CARE PLAN BY A HEALTH CARE PROVIDER SPA 5 HAS HIGHER RATES OF HEART DISEASE AMONG AFRICAN AMERICANS (7 1%) THAN WERE REPORTED IN THE COUNTY AND STATE (5 8%) LOWER RATES OF HEART DISEASE WERE REPORTED BY ASIANS (1 3%) AND LATINOS (1 8%) ASTHMA IN SPA 5, 13 1% OF THE POPULATION HAS BEEN DIAGNOSED WITH ASTHMA, WHICH IS HIGHER THAN THE COUNTY LEVEL (12 4%) AMONG THOSE WITH ASTHMA, 38 8% IN SPA 5 TAKE DAILY MEDICATION TO CONTROL THEIR SYMPTOMS AMONG YOUTH IN SPA 5, 6 7% HAVE BEEN DIAGNOSED WITH AND CURRENTLY HAVE ASTHMA, AND 23 4% HAD BEEN TO AN ER OR URGENT CARE FOR ASTHMA SYMPTOMS IN THE PAST YEAR CANCER INCIDENCE RATES ARE AVAILABLE AT THE COUNTY LEVEL IN LOS ANGELES COUNTY, CANCER RATES ARE LOWER OVERALL THAN AT THE STATE LEVEL, HOWEVER, THE RATES OF COLORECTAL CANCER (36 3 PER 100,000 PERSONS), UTERINE CANCERS, (25 9 PER 100,000), THYROID CANCER (13 6 PER 100,000 PERSONS), AND OVARIAN CANCER (12 0 PER 100,000) EXCEED THE STATE RATES</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
CEDARS-SINAI MARINA DEL REY HOSPITAL	<p>PART V, SECTION B, LINE 3J RATES OF NEWLY DIAGNOSED BREAST CANCER PER 100,000 FEMALES, RANGED FROM A LOW OF 159.6 PER 100,000 WOMEN IN CULVER CITY TO A HIGH OF 186.0 IN CITY COUNCIL DISTRICT 11. THESE RATES OF BREAST CANCER ARE HIGHER THAN THE COUNTY RATE (140.5 CASES PER 100,000 FEMALES). RATES OF NEWLY DIAGNOSED COLON CANCER PER 100,000 PERSONS, RANGED FROM A LOW OF 32.6 PER 100,000 PERSONS IN LA CITY COUNCIL DISTRICT 11 TO A HIGH OF 46.1 PER 100,000 PERSONS IN CULVER CITY. CULVER CITY'S RATE OF COLON CANCER IS HIGHER THAN COUNTY RATES (37.9 PER 100,000 PERSONS). HIV: THE HIV RATE IN LA COUNTY HAS DECREASED SINCE 2007. IN 2015, 90 CASES OF HIV WERE DIAGNOSED IN SPA 5 (14 PER 100,000 PERSONS). THE RATE OF HIV IN 2015 DECREASED SLIGHTLY FROM 2014 IN SPA 5 AND THE COUNTY. RATES OF NEW HIV DIAGNOSES ARE HIGHEST AMONG MALES, YOUNG ADULTS 20-29, AND BLACKS/AFRICAN AMERICANS IN SPA 5. THE RATE OF PERSONS LIVING WITH HIV IS 378 PER 100,000 PERSONS, WHICH IS BELOW THE COUNTY LEVEL OF 492 PERSONS PER 100,000 LIVING WITH HIV. HEALTH STATUS: AMONG THE RESIDENTS IN SPA 5, 10% RATE THEMSELVES AS BEING IN FAIR OR POOR HEALTH, WHICH IS LESS THAN THE COUNTY RATE OF 21.5%. DISABILITY: IN SPA 5, 21.5% OF ADULTS REPORTED A PHYSICAL, MENTAL OR EMOTIONAL DISABILITY. THE RATE OF DISABILITY IN THE COUNTY WAS 22.6%. IN LA COUNTY, 14.5% OF CHILDREN WERE REPORTED BY THEIR CARETAKERS TO MEET THE CRITERIA OF HAVING A SPECIAL HEALTH CARE NEED. THIS NEGATIVE METRIC WAS REPORTED TO BE HIGHER IN SPA 5 (20.2%). IT IS SUGGESTED THAT CHILDREN LIVING IN HIGHER SOCIOECONOMIC AREAS ARE EVALUATED FOR SPECIAL NEEDS AT HIGHER RATES. 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
CEDARS-SINAI MARINA DEL REY HOSPITAL	PART V, SECTION B, LINE 5 IN CONDUCTING CEDARS-SINAI MARINA DEL REY HOSPITAL'S MOST RECENT 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 FROM NOVEMBER 2018 TO JANUARY 2019 INTERVIEWEES INCLUDED REPRESENTATIVES FROM A WIDE RANGE OF COMMUNITY GROUPS AND ORGANIZATIONS FOCUSED ON THE NEEDS OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS, AS WELL AS REPRESENTATIVES FROM LOCAL GOVERNMENT AGENCIES, INCLUDING THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

**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
CEDARS-SINAI MARINA DEL REY HOSPITAL	PART V, SECTION B, LINE 6A CSMDRH PARTICIPATED IN A COLLABORATIVE PROCESS FOR THE COMMUNITY HEALTH NEEDS ASSESSMENT IN PARTNERSHIP WITH CEDARS-SINAI MEDICAL CENTER, KAISER PERMANENTE WEST LOS ANGELES MEDICAL CENTER, PROVIDENCE SAINT JOHN'S HEALTH CENTER, AND UCLA HEALTH GIVEN THESE HOSPITAL FACILITIES SHARE AN OVERLAPPING SERVICE AREA, A COLLABORATIVE EFFORT REDUCED REDUNDANCIES AND INCREASED DATA COLLECTION EFFICIENCY CEDARS-SINAI MARINA DEL REY HOSPITAL PART V, SECTION B, LINE 7A, CHNA WEBSITE <a href="https://www.marinahospital.com/administration/media/files/mdrh-chna-2019.pdf">HTTPS //WWW MARINAHOSPITAL COM/ADMINISTRATION/MEDIA/FILES/MDRH-CHNA-2019 PDF</a> CEDARS-SINAI MARINA DEL REY HOSPITAL PART V, SECTION B, LINE 10A, IMPLEMENTATION STRATEGY WEBSITE <a href="https://www.marinahospital.com/administration/media/files/2019-2022-csmdrh-implementation-strategy.pdf">HTTPS //WWW MARINAHOSPITAL COM/ADMINISTRATION/MEDIA/FILES/2019-2022-CSMDRH-IMPLEMENTATION-STRATEGY PDF</a>

**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
<p>CEDARS-SINAI MARINA DEL REY HOSPITAL</p>	<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 BASED ON CRITERIA, TAKING INTO 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 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 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 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>

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

Schedule I (Form 990)

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

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

Attach to Form 990.

Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047

2018

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 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

Table with 8 columns: (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. Rows 1-12.

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
COMMUNITY PARTNERS FOR SAFE PLACE FOR YOUTH 1000 NORTH ALAMEDA STREET SUITE 240 240 LOS ANGELES, CA 90012	95-4302067	501(C)(3)	25,000				GRANT FOR COMMUNITY YOUTH HOMELESS SERVICES
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.**

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
VENICE FAMILY CLINIC 604 ROSE AVENUE VENICE, CA 90291	95-2769432	501(C)(3)	25,000				GRANT FOR INTEGRATED MOBILE HEALTH TEAM

**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.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

**2018**

**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
<b>1a</b>	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		
<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)
<b>b</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	<b>1b</b>	
<b>2</b>	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?	<b>2</b>	
<b>3</b>	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		
<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
<b>4</b>	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		
<b>a</b>	Receive a severance payment or change-of-control payment?	<b>4a</b>	No
<b>b</b>	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes
<b>c</b>	Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III	<b>4c</b>	No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>			
<b>5</b>	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		
<b>a</b>	The organization?	<b>5a</b>	No
<b>b</b>	Any related organization? If "Yes," on line 5a or 5b, describe in Part III	<b>5b</b>	No
<b>6</b>	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		
<b>a</b>	The organization?	<b>6a</b>	No
<b>b</b>	Any related organization? If "Yes," on line 6a or 6b, describe in Part III	<b>6b</b>	No
<b>7</b>	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	<b>7</b>	No
<b>8</b>	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	<b>8</b>	No
<b>9</b>	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>	



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

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

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

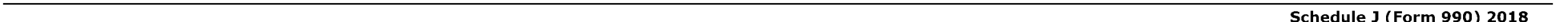
(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table							

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 3	THE 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.

<b>Return Reference</b>	<b>Explanation</b>
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 CERTAIN INDIVIDUALS ALSO RECEIVED PAYOUTS FROM AMOUNTS ACCRUED IN PRIOR YEARS IN ADDITION, TWO INDIVIDUALS HAVE RETENTION INCENTIVES WHICH HAD CLIFF-VESTING DATES IN 2018 THE FOLLOWING LISTED PERSONS RECEIVED PAYMENTS DURING THE YEAR ENDED DECEMBER 31, 2018 RELATED TO ONE OR BOTH OF THE PLANS REFERENCED ABOVE THESE PAYMENTS ARE INCLUDED IN SCHEDULE J, PART II AND ARE NOT INCREMENTAL PAYMENTS MARK GAVENS 519,367 PAULETTE HEITMEYER 58,493 JOANNE LAGUNA-KENNEDY 12,282 THOMAS M PRISELAC 2,612,809 JEFFREY SMITH, MD, JD, MMM 8,827



# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 20-1645949

**Name:** CFHS HOLDINGS INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
THOMAS M PRISELAC CHAIR	(i)	0	0	0	0	0	0	0
	(ii)	1,683,048	1,207,942	2,723,049	741,876	24,711	6,380,626	2,187,500
MARK GAVENS CEO	(i)	0	0	0	0	0	0	0
	(ii)	865,663	457,127	530,834	118,199	26,560	1,998,383	125,000
MARY KATHRYN HAMMACK CFO/TREASURER	(i)	218,625	38,944	867	6,648	12,900	277,984	0
	(ii)	0	0	0	0	0	0	0
JEFFREY SMITH MD JD MMM CEO	(i)	0	0	0	0	0	0	0
	(ii)	276,114	364,000	8,827	0	10,045	658,986	0
PAULETTE HEITMEYER COO	(i)	0	0	0	0	0	0	0
	(ii)	301,990	109,227	61,287	12,800	2,160	487,464	0
JOANNE LAGUNA-KENNEDY CNO	(i)	6,538	0	0	0	0	6,538	0
	(ii)	284,762	37,080	25,227	8,603	15,507	371,179	0
SHAWN BOND PHYSICIAN ASSISTANT	(i)	227,392	425	0	6,858	23,763	258,438	0
	(ii)	0	0	0	0	0	0	0
CATHY OHNSTAD CNO	(i)	199,033	21,993	633	0	22,898	244,557	0
	(ii)	0	0	0	0	0	0	0
MARGARET MORGAN DIRECTOR OF HUMAN RESOURCES	(i)	177,867	20,274	789	5,450	13,900	218,280	0
	(ii)	0	0	0	0	0	0	0
JEFFREY WALLACE ASSISTANT ADMINISTRATOR	(i)	175,328	19,647	688	5,258	15,420	216,341	0
	(ii)	0	0	0	0	0	0	0
JOSEPH BOTROS SERVICE LINE DIRECTOR	(i)	171,127	19,912	236	411	13,479	205,165	0
	(ii)	0	0	0	0	0	0	0

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No 1545-0047  
**2018**  
**Open to Public Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
CFHS HOLDINGS INC

Employer identification number  
20-1645949

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . . .				
2 Art—Historical treasures . . . . .				
3 Art—Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities—Publicly traded . . . . .				
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .	X	1	58,200,000	VALUATION REPORT
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ ( _____ )				
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

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

29	
----	--

30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

	Yes	No
30a		No
31		No
32a		No

b If "Yes," describe the arrangement in Part II

31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

b If "Yes," describe in Part II

33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

**Part II Supplemental Information.**

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

Return Reference	Explanation
PART I, COLUMN (B)	THE ORGANIZATION IS REPORTING IN PART 1, COLUMN (B) THE NUMBER OF CONTRIBUTIONS RECEIVED

**SCHEDULE O**  
(Form 990 or 990-EZ)**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

**2018**  
**Open to Public Inspection**

Department of the Treasury

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**

<b>Return Reference</b>	<b>Explanation</b>
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**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 11B	THE REVIEW OF THE FORM 990 INVOLVES VARIOUS MANAGEMENT PERSONNEL, INCLUDING THE HOSPITAL'S CHIEF FINANCIAL OFFICER, CEDARS-SINAI MEDICAL CENTER'S SENIOR VICE-PRESIDENT/CHIEF FINANCIAL OFFICER AND GENERAL COUNSEL, 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</p> <p>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</p> <p>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**

<b>Return Reference</b>	<b>Explanation</b>
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**

<b>Return Reference</b>	<b>Explanation</b>
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**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART XI, LINE 9	DIFFERENCE IN FMV AND BOOK VALUE OF NONCASH CONTRIBUTION -9,040,000

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
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, 2019 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

**2018**

**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.**  
 ▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

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
<b>(1)</b> CENTINELA FREEMAN HOLDINGS INC 8700 BEVERLY BLVD STE TSB-290 LOS ANGELES, CA 90048 59-3811890	REAL ESTATE HOLDINGS	CA	N/A	C				Yes	
<b>(2)</b> OPTIMATRIX HEALTH SOLUTIONS INC 6500 WILSHIRE BLVD 9TH FLOOR LOS ANGELES, CA 90048 95-4522779	INACTIVE	CA	N/A	C				Yes	
<b>(3)</b> 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

<b>1</b> 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?		<b>Yes</b>	<b>No</b>
<b>a</b>	Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .		No
<b>b</b>	Gift, grant, or capital contribution to related organization(s) . . . . .		No
<b>c</b>	Gift, grant, or capital contribution from related organization(s) . . . . .	Yes	
<b>d</b>	Loans or loan guarantees to or for related organization(s) . . . . .		No
<b>e</b>	Loans or loan guarantees by related organization(s) . . . . .		No
<b>f</b>	Dividends from related organization(s) . . . . .		No
<b>g</b>	Sale of assets to related organization(s) . . . . .		No
<b>h</b>	Purchase of assets from related organization(s) . . . . .		No
<b>i</b>	Exchange of assets with related organization(s) . . . . .		No
<b>j</b>	Lease of facilities, equipment, or other assets to related organization(s) . . . . .		No
<b>k</b>	Lease of facilities, equipment, or other assets from related organization(s) . . . . .	Yes	
<b>l</b>	Performance of services or membership or fundraising solicitations for related organization(s) . . . . .		No
<b>m</b>	Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	Yes	
<b>n</b>	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .		No
<b>o</b>	Sharing of paid employees with related organization(s) . . . . .		No
<b>p</b>	Reimbursement paid to related organization(s) for expenses . . . . .	Yes	
<b>q</b>	Reimbursement paid by related organization(s) for expenses . . . . .	Yes	
<b>r</b>	Other transfer of cash or property to related organization(s) . . . . .		No
<b>s</b>	Other transfer of cash or property from related organization(s) . . . . .	Yes	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)CENTINELA FREEMAN HOLDINGS INC	C	58,200,000	FAIR MARKET VALUE
(2)CENTINELA FREEMAN HOLDINGS INC	K	2,295,605	FAIR MARKET VALUE
(3)CENTINELA FREEMAN HOLDINGS INC	Q	1,454,208	FAIR MARKET VALUE

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) 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		Yes	No	

**Part VII**    **Supplemental Information**

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

<b>Return Reference</b>	<b>Explanation</b>

# 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	
23326 HAWTHORNE BLVD STE 300 TORRANCE, CA 90505 33-0073515	HEALTH SERVICES	CA	501 (C) (3)	LINE 12B, II	CEDARS-SINAI HEALTH SYSTEM	Yes	

