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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2019 , and ending 06-30-2020

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

C Name of organization
CENTRACARE HEALTH SYSTEM

Doing business as

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

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

D Employer identification number
41-1813221

E Telephone number
(320) 251-2700

G Gross receipts $ 459,656,536

F Name and address of principal officer:
KENNETH D HOLMEN MD
1406 6TH AVENUE NORTH
ST CLOUD, MN 56303

H(a) Is this a group return for subordinates? ☐ Yes ☑ No
H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.CENTRACARE.COM

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

L Year of formation: 1995

M State of legal domicile: MN

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
INTEGRATED MULTI-ORGANIZATIONAL HEALTH CARE SYSTEM DESIGNED TO PROVIDE ACCESS TO QUALITY HEALTH CARE SERVICES AT AN AFFORDABLE PRICE.

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	20
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	14
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	5,765
6	Total number of volunteers (estimate if necessary)	**6**	876
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	8,445,149
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	308,334

			Prior Year	Current Year
Revenue	**8**	Contributions and grants (Part VIII, line 1h)	3,676,019	24,207,642
	9	Program service revenue (Part VIII, line 2g)	382,942,376	418,145,994
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	6,661,511	2,823,191
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	9,271,798	5,308,294
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	402,551,704	450,485,121
Expenses	**13**	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	149,920	297,725
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	206,406,426	222,752,782
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	183,066,564	204,194,839
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	389,622,910	427,245,346
	19	Revenue less expenses. Subtract line 18 from line 12	12,928,794	23,239,775

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	**20**	Total assets (Part X, line 16)	516,087,917	537,648,015
	21	Total liabilities (Part X, line 26)	315,760,094	274,950,980
	22	Net assets or fund balances. Subtract line 21 from line 20	200,327,823	262,697,035

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

****** 2021-05-12
Signature of officer Date

MICHAEL A BLAIR CFO/TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2021-05-12		P01599614

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

Firm's address ▶ 801 NICOLLET MALL WEST TOWER STE 1200 MINNEAPOLIS, MN 554022526 | Phone no. (612) 332-4300

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III **Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:

WE'RE HERE FOR YOUR WHOLE LIFE TO LISTEN, THEN SERVE, TO GUIDE AND HEAL BECAUSE HEALTH MEANS EVERYTHING.

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 $ 127,418,109 including grants of $ 180,125) (Revenue $ 145,573,318)

See Additional Data

4b (Code:) (Expenses $ 130,506,166 including grants of $ 93,177) (Revenue $ 157,775,584)

See Additional Data

4c (Code:) (Expenses $ 61,219,333 including grants of $ 18,900) (Revenue $ 73,339,894)

See Additional Data

(Code:) (Expenses $ 33,300,727 including grants of $ 5,523) (Revenue $ 41,457,198)

CENTRACARE HEALTH - PAYNESVILLE HOSPITAL IS CONSIDERED A DISREGARDED ENTITY FOR PURPOSES OF 990 REPORTING, THUS IT IS INCLUDED WITH THIS 990 FILING. CENTRACARE HEALTH - PAYNESVILLE HOSPITAL IS A 25 BED CRITICAL ACCESS HOSPITAL. IN FISCAL YEAR 2020 THEY HAD 2,384 PATIENT DAYS, 40,199 OUTPATIENT VISITS AND 3,640 EMERGENCY ROOM VISITS. IN FISCAL YEAR 2020, PAYNESVILLE GENERATED $41,457,198 OF PROGRAM REVENUE AND $33,300,727 OF PROGRAM EXPENSE.

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

(Expenses $ 33,300,727 including grants of $ 5,523) (Revenue $ 41,457,198)

4e **Total program service expenses ▶** 352,444,335

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI.	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	Yes	
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*(see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	

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

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	Yes	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L,* Part I	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L,* Part I	25b		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part II*	26		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? *If "Yes," complete Schedule L,*Part III	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? *If "Yes," complete Schedule L, Part IV*	28a		No
b	A family member of any individual described in line 28a? *If "Yes," complete Schedule L, Part IV*	28b		No
c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? *If "Yes," complete Schedule L, Part IV*	28c		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	Yes	

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

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

					Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	777			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0			
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c	Yes	

Part V **Statements Regarding Other IRS Filings and Tax Compliance** *(continued)*

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	5,765			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			**3a**	Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*			**3b**	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			**4a**		No
b	If "Yes," enter the name of the foreign country: ▶ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			**5a**		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?			**6a**		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**					
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			**7f**		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**		
9	**Sponsoring organizations maintaining donor advised funds.**					
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?			**9b**		
10	**Section 501(c)(7) organizations.** Enter:					
a	Initiation fees and capital contributions included on Part VIII, line 12	**10a**				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**				
11	**Section 501(c)(12) organizations.** Enter:					
a	Gross income from members or shareholders	**11a**				
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**				
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**				
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**					
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**				
c	Enter the amount of reserves on hand	**13c**				
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			**14b**		
15	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.			**15**	Yes	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.			**16**		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

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year **1a** 20 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent **1b** 14			
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**		No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	**3**		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	**4**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	**5**		No
6	Did the organization have members or stockholders?	**6**		No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		No
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-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.

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶MICHAEL BLAIR 1406 SIXTH AVENUE NORTH ST CLOUD, MN 56303 (320) 251-2700

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

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

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

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

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

See instructions for the order in which to list the persons above.

☐ 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): Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
See Additional Data Table										

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
See Additional Data Table										

	(D)	(E)	(F)
1b Sub-Total ▶			
c Total from continuation sheets to Part VII, Section A ▶			
d Total (add lines 1b and 1c) ▶	9,253,668	6,394,314	1,950,098

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 ▶ 441

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization?*If "Yes," complete Schedule J for such person*	5		No

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
MAYO COLLABORATIVE SERVICES PO BOX 4100 ROCHESTER, MN 559034100	LABORATORY SERVICES	4,584,780
NORTH MEMORIAL 3300 OAKDALE AVE NORTH ROBBINSDALE, MN 55422	PATIENT CARE STAFFING	3,284,436
METRO ANESTHESIA CONSULTANTS 9855 AETNA AVE NE MONTICELLO, MN 55362	ANESTHESIA SERVICES	3,251,000
STELLIS HEALTH PA 1700 HIGHWAY 25 NORTH BUFFALO, MN 55313	PHYSICIAN SERVICES	2,583,961
CENTRAL MN DIAGNOSTICS INC 525 10TH STREET NE MILACA, MN 56353	IMAGING SERVICES	1,711,709

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 ▶ 101

Part VIII Statement of Revenue

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

Contributions, Gifts, Grants and Other Similar Amounts

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
1a Federated campaigns . .	1a					
b Membership dues . .	1b					
c Fundraising events . .	1c					
d Related organizations	1d	2,331,024				
e Government grants (contributions)	1e	21,066,690				
f All other contributions, gifts, grants, and similar amounts not included above	1f	809,928				
g Noncash contributions included in lines 1a - 1f:$	1g					
h **Total.** Add lines 1a-1f . . . . ▶			24,207,642			

Program Service Revenue

	Business Code	(A)	(B)	(C)	(D)
2a PATIENT & SERVICE REVENUE	621110	349,945,598	348,818,932	1,126,666	
b HEALTH INSURANCE PREMIUM CREDIT	621110	36,925,337	36,925,337		
c SHARED/LEGAL SYSTEM REVENUE	621110	31,275,059	24,005,671	7,269,388	
d					
e					
f All other program service revenue.					
g **Total.** Add lines 2a–2f. . . . . ▶		418,145,994			

Other Revenue

			(A)	(B)	(C)	(D)
3 Investment income (including dividends, interest, and other similar amounts) . . . . . . ▶			2,574,700			2,574,700
4 Income from investment of tax-exempt bond proceeds ▶						
5 Royalties . . . . ▶						
	(i) Real	(ii) Personal				
6a Gross rents (6a)	10,619,148					
b Less: rental expenses (6b)	8,852,687					
c Rental income or (loss) (6c)	1,766,461					
d Net rental income or (loss) . . . . ▶			1,766,461			1,766,461
	(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory (7a)	129,399	119,092				
b Less: cost or other basis and sales expenses (7b)	0	0				
c Gain or (loss) (7c)	129,399	119,092				
d Net gain or (loss) . . . . ▶			248,491			248,491
8a Gross income from fundraising events (not including $ ______ of contributions reported on line 1c). See Part IV, line 18	8a					
b Less: direct expenses . . .	8b					
c Net income or (loss) from fundraising events . . ▶						
9a Gross income from gaming activities. See Part IV, line 19 . . .	9a					
b Less: direct expenses . . .	9b					
c Net income or (loss) from gaming activities . . ▶						
10a Gross sales of inventory, less returns and allowances . .	10a	1,818,395				
b Less: cost of goods sold . .	10b	318,728				
c Net income or (loss) from sales of inventory . . ▶			1,499,667			1,499,667

Miscellaneous Revenue	Business Code	(A)	(B)	(C)	(D)
11a ALL OTHER REVENUE	900099	2,262,967		49,095	2,213,872
b REVENUE FROM JOINT VENTURES	900099	-60,222			-60,222
c OTHER SERVICES SOLD	900099	-160,579			-160,579
d All other revenue					
e **Total.** Add lines 11a–11d . . . . ▶		2,042,166			
12 **Total revenue.** See instructions . . . . . ▶		450,485,121	409,749,940	8,445,149	8,082,390

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	278,021	278,021		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	19,704	19,704		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	8,086,873	6,414,675	1,672,198	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	120,682,593	95,727,927	24,954,666	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	13,696,567	10,864,400	2,832,167	
9 Other employee benefits	65,192,222	51,711,818	13,480,404	
10 Payroll taxes	15,094,527	11,973,291	3,121,236	
11 Fees for services (non-employees):				
a Management				
b Legal	1,050,042	832,915	217,127	
c Accounting	315,938	250,609	65,329	
d Lobbying	159,019	159,019		
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	109,643		109,643	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	92,203,048	73,137,363	19,065,685	
12 Advertising and promotion	729,334	578,523	150,811	
13 Office expenses	2,592,374	2,056,325	536,049	
14 Information technology				
15 Royalties				
16 Occupancy	3,730,520	2,959,126	771,394	
17 Travel	645,330	511,889	133,441	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	1,945,318	1,543,066	402,252	
20 Interest	3,850,451	3,054,257	796,194	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	20,466,902	16,234,770	4,232,132	
23 Insurance	2,148,419	1,704,170	444,249	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a DRUGS/MEDICAL SUPPLIES	53,145,684	53,145,684		
b BAD DEBT	6,688,681	6,688,681		
c MEDICAID SURCHARGE/MN C	5,631,666	5,631,666		
d MINOR EQUIPMENT	3,060,797	2,427,887	632,910	
e All other expenses	5,721,673	4,538,549	1,183,124	
25 **Total functional expenses.** Add lines 1 through 24e	427,245,346	352,444,335	74,801,011	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X **Balance Sheet**

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

					(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing			73,547,020	1	60,061,954
	2	Savings and temporary cash investments				2	
	3	Pledges and grants receivable, net				3	
	4	Accounts receivable, net			54,063,342	4	60,079,123
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons				5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)				6	
	7	Notes and loans receivable, net				7	
	8	Inventories for sale or use			6,932,858	8	8,827,149
	9	Prepaid expenses and deferred charges			6,737,591	9	9,450,599
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	430,963,220			
	b	Less: accumulated depreciation	10b	163,612,963	242,716,787	10c	267,350,257
	11	Investments—publicly traded securities				11	
	12	Investments—other securities. See Part IV, line 11			121,743,177	12	99,659,920
	13	Investments—program-related. See Part IV, line 11				13	
	14	Intangible assets				14	
	15	Other assets. See Part IV, line 11			10,347,142	15	32,219,013
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)			516,087,917	16	537,648,015
Liabilities	17	Accounts payable and accrued expenses			51,542,567	17	70,935,370
	18	Grants payable				18	
	19	Deferred revenue			13,865	19	2,358,694
	20	Tax-exempt bond liabilities			65,423,151	20	61,719,752
	21	Escrow or custodial account liability. Complete Part IV of Schedule D				21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons				22	
	23	Secured mortgages and notes payable to unrelated third parties			111,658,569	23	110,270,555
	24	Unsecured notes and loans payable to unrelated third parties				24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D			87,121,942	25	29,666,609
	26	**Total liabilities.** Add lines 17 through 25			315,760,094	26	274,950,980
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**					
	27	Net assets without donor restrictions			180,133,287	27	254,886,558
	28	Net assets with donor restrictions			20,194,536	28	7,810,477
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.					
	29	Capital stock or trust principal, or current funds				29	
	30	Paid-in or capital surplus, or land, building or equipment fund				30	
	31	Retained earnings, endowment, accumulated income, or other funds				31	
	32	Total net assets or fund balances			200,327,823	32	262,697,035
	33	Total liabilities and net assets/fund balances			516,087,917	33	537,648,015

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	450,485,121
2	Total expenses (must equal Part IX, column (A), line 25)	2	427,245,346
3	Revenue less expenses. Subtract line 2 from line 1	3	23,239,775
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	200,327,823
5	Net unrealized gains (losses) on investments	5	-1,898,140
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	41,027,577
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	262,697,035

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☑ Accrual ☐ Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

Additional Data

Software ID:

Software Version:

EIN: 41-1813221

Name: CENTRACARE HEALTH SYSTEM

Form 990 (2019)

Form 990, Part III, Line 4a:

CENTRACARE HEALTH SYSTEM (CCHS) IS AN INTEGRATED HEALTH SYSTEM, INCLUDING COMPRISED OF SIX CRITICAL ACCESS HOSPITALS, TWO ACUTE CARE HOSPITALS, A MULTI-SPECIALITY CLINIC, SURGICAL CENTER, RETAIL PHARMACY NETWORK, NURSING HOME AND A FOUNDATION. CCHS SERVES ITS PATIENTS IN SIX MAIN AREAS.CENTRACARE LABORATORY SERVICES ALL HOSPITALS UNDER ITS UMBRELLA AS WELL AS CENTRACARE CLINIC. IT ALSO PERFORMS TESTS FOR VARIOUS FACILITIES IN THE REGION. CENTRACARE LABORATORY PERFORMED 1,894,576 TESTS IN FISCAL YEAR 2020. IN FISCAL YEAR 2020 CENTRACARE LABORATORY GENERATED $41,192,469 IN PROGRAM REVENUE AND INCURRED $30,459,788 OF EXPENSES.CENTRACARE SURGICAL CENTER PROVIDES ELECTIVE SURGERY PROCEDURES TO PATIENTS IN THE CENTRAL MN REGION. IN FY 2020, THE CENTER PERFORMED 5,453 SURGERIES AND GENERATED $11,056,550 OF PROGRAM REVENUE AND $11,792,306 OF PROGRAM EXPENSE.

Form 990, Part III, Line 4b:

CARRIS HEALTH, LLC IS CONSIDERED A DISREGARDED ENTITY OF CCHS FOR PURPOSES OF 990 REPORTING. CARRIS HEALTH, LLC INCLUDES THE SUBSIDIARY CARRIS HEALTH - RICE MEMORIAL HOSPITAL, WHICH HAS 136 LICENSED BEDS. DURING FISCAL YEAR 2020 RICE MEMORIAL HOSPITAL CARED FOR 3,028 INPATIENT ADMISSIONS WITH 10,263 ASSOCIATED PATIENT DAYS. INPATIENT SERVICES INCLUDE MEDICAL AND SURGICAL CARE, BIRTHING SERVICES, PEDIATRIC SERVICES, BEHAVIORAL HEALTH CARE SERVICES, AND REHABILITATION SERVICES. OUTPATIENT ENCOUNTERS DURING FISCAL YEAR 2020 WERE 95,343 AND INCLUDED EMERGENCY ROOM SERVICES, DIALYSIS, IMAGING, RESPIRATORY THERAPY, A REHABILITATION CENTER, SAME DAY SURGERY AND OTHER AMBULATORY CARE SERVICES. CARRIS HEALTH ALSO OFFERS A CERTIFIED SKILLED NURSING FACILITY LOCATED IN WILLMAR, MN WITH 78 LICENSED BEDS. CARRIS HEALTH HAS REALIZED 17,022 RESIDENT DAYS IN THE LONG TERM CARE PORTION OF THE FACILITY AND 7,632 RESIDENT DAYS IN THE SHORT TERM THERAPY SUITES AREA DURING FISCAL YEAR 2020. CARRIS HEALTH ALSO HAS AN ACCREDITED AMBULATORY SURGICAL CENTER LOCATED IN WILLMAR, MN. CARRIS HEALTH SURGICAL CENTER COMPLETED 4,121 OUTPATIENT (SAME DAY) PRODECURES. IN FISCAL YEAR 2020 CARRIS HEALTH GENERATED $123,229,380 OF PROGRAM REVENUE AND $110,217,850 OF PROGRAM EXPENSE.REDWOOD AREA HOSPITAL JOINED CENTRACARE JANUARY OF 2019 AND IS CONSIDERED A DISREGARDED ENTITY FOR PURPOSES OF 990 REPORTING, THUS IS INCLUDED WITH THIS 990 FILING. CARRIS HEALTH, LLC INCLUDES THE SUBSIDIARY CARRIS HEALTH - REDWOOD AREA HOSPITAL, WHICH IS A 25 BED CRITICAL ACCESS HOSPITAL. DURING FISCAL YEAR 2020 THEY HAD 491 INPATIENT ADMISSIONS WITH 1,554 ASSOCIATED PATIENT DAYS, 21,535 OUTPATIENT VISITS AND 3,717 EMERGENCY ROOM VISITS. IN FISCAL YEAR 2020, REDWOOD GENERATED $34,546,204 OF PROGRAM REVENUE AND $30,288,316 OF PROGRAM EXPENSE.

Form 990, Part III, Line 4c:

MONTICELLO HOSPITAL IS CONSIDERED A DISREGARDED ENTITY FOR PURPOSES OF 990 REPORTING, THUS IT IS INCLUDED WITH THIS 990 FILING. MONTICELLO HOSPITAL IS A 25 BED CRITICAL ACCESS HOSPITAL AND ALSO OPERATES A 10 BED ACUTE GERIATRIC PSYCHIATRIC UNIT. IN FISCAL YEAR 2020, THEY HAD 6,284 PATIENT DAYS, 28,328 OUTPATIENT VISITS AND 11,423 EMERGENCY ROOM VISITS' WHICH GENERATED $73,339,894 OF PROGRAM REVENUE AND $61,219,333 OF PROGRAM EXPENSES.

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KENNETH D HOLMEN MD PRESIDENT/CEO	21.00 19.00	X		X				1,279,307	0	35,898
TOD W SPEER MD PHYSICIAN	40.00 0.00					X		911,775	0	53,203
CINDY FIRKINS SMITH MD CARRIS HEALTH, PRESIDENT/CEO	40.00 0.00				X			0	693,575	89,604
LEAH M SCHAMMEL MD PHYSICIAN	40.00 0.00					X		0	771,775	45,656
NATHANIEL J SLINKARD MD PHYSICIAN	40.00 0.00					X		0	718,560	43,044
JULIE C SCHULTZ MD PHYSICIAN	40.00 0.00					X		0	702,628	46,502
DONALD JURGENS MD DIRECTOR/PHYSICIAN	2.00 38.00	X						0	724,692	33,726
GREGORY R KLUGHERZ TREASURER/CFO, CCH(UNTIL 7/1/2019)	25.00 15.00			X				0	709,157	39,650
PAUL R HARRIS ESQ CORPORATE SECRETARY(UNTIL 3/1/2020)	25.00 15.00			X				505,355	0	131,200
MARK S MATTHIAS MD VICE PRESIDENT	20.00 20.00				X			581,059	0	52,551

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
THOMAS SCHRUP MD VICE PRESIDENT	20.00 20.00				X			498,952	0	81,057
AMY M PORWOLL VICE PRESIDENT	20.00 20.00				X			447,532	0	106,082
THOMAS H LANGE MD PHYSICIAN	40.00 0.00					X		0	565,070	46,540
JOSEPH M BLONSKI MD VICE PRESIDENT	20.00 20.00				X			444,405	0	93,861
GEORGE A MORRIS MD VICE PRESIDENT	20.00 20.00				X			421,201	0	85,928
CHRISTOPHER BOELTER MD VICE PRESIDENT	20.00 20.00				X			537,390	0	20,472
JOSEPH H KALKMAN VICE PRESIDENT	20.00 20.00				X			388,072	0	82,567
CHRISTIAN SCHMIDT MD DIRECTOR/SURGEON	2.00 38.00	X						0	454,815	44,850
KURT OTTO MD VICE PRESIDENT	20.00 20.00				X			351,097	0	92,620
BRYAN ROLPH DIRECTOR/PHYSICIAN	40.00 0.00	X						0	424,650	43,652

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
MICHAEL W SCHRAMM CARRIS HEALTH, PRESIDENT/CEO	40.00 0.00				X			345,454	0	81,906
JOSEPH D HELLIE VICE PRESIDENT	20.00 20.00				X			326,825	0	88,924
JOY PLAMANN VICE PRESIDENT	20.00 20.00				X			302,031	0	90,271
RICHARD WEHLSER MD DIRECTOR/PHYSICIAN	2.00 38.00	X						0	387,087	48,010
ANTHONY V GARDENER VICE PRESIDENT	20.00 20.00				X			317,219	0	65,647
BRADLEY J KONKLER VICE PRESIDENT	20.00 20.00				X			290,397	0	76,667
KATHLEEN M PARSONS VICE PRESIDENT	20.00 20.00				X			273,548	0	56,015
DIANE R BUSCHENA-BRENNA VICE PRESIDENT	20.00 20.00				X			276,565	0	40,509
DAVID A LARSON VICE PRESIDENT	20.00 20.00				X			231,779	0	60,183
SANTO CRUZ CORPORATE SECRETARY(AS OF 6/28/2020)	25.00 15.00			X				262,606	0	22,337

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
SHARON RUGGIERO MD DIRECTOR/PHYSICIAN	2.00 38.00	X						0	242,305	28,503
BETH A HONKOMP VICE PRESIDENT	20.00 20.00				X			163,142	0	21,706
MICHAEL BLAIR TREASURER/CFO(AS OF 9/30/2019)	25.00 15.00			X				97,957	0	757
MIKE BENUSA DIRECTOR/CHAIR	2.00 0.00	X		X				0	0	0
STEVE LARAWAY DIRECTOR/VICE CHAIR	2.00 0.00	X		X				0	0	0
DAVID ANFINSON DIRECTOR	2.00 0.00	X						0	0	0
TERESA BOHNEN DIRECTOR	2.00 0.00	X						0	0	0
CHRISTOPHER COBORN DIRECTOR	2.00 0.00	X						0	0	0
JEFF GAU DIRECTOR	2.00 0.00	X						0	0	0
TIM HEBL MD DIRECTOR	2.00 0.00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position: Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former	(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
MARY DANA HINTON DIRECTOR	2.00 1.00	X						0	0	0
DONALD KETTLER JCL DIRECTOR	2.00 0.00	X						0	0	0
DENISE ROSIN DIRECTOR	2.00 0.00	X						0	0	0
TOHOW SIYAD DIRECTOR	2.00 0.00	X						0	0	0
ROBERT STOCKER MD DIRECTOR/OBGYN	2.00 0.00	X						0	0	0
JOSEPH UPHUS DIRECTOR	2.00 0.00	X						0	0	0
TIMOTHY WENSMAN DIRECTOR	2.00 0.00	X						0	0	0

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f Enter the number of supported organizations . . . .

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf.						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4.						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources.						
9 Net income from unrelated business activities, whether or not the business is regularly carried on.						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.).						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . **15**

16a **33 1/3% support test—2019.** 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—2018.** 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—2019.** 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—2018.** 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 **Total support.** (Add lines 9, 10c, 11, and 12.). .						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2019** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2018** Schedule A, Part III, line 17	18	

19a **331/3% support tests—2019.** 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—2018.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV **Supporting Organizations** (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

a ☐ The organization satisfied the Activities Test. Complete **line 2** below.

b ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.

c ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (a) and (b) below.**

			Yes	No
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

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

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

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

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

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**). See instructions	
7 **Total annual distributions.** Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i)** **Excess Distributions**	**(ii)** **Underdistributions Pre-2019**	**(iii)** **Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions.			
7 **Excess distributions carryover to 2020.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

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

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

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493133052271

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

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

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

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

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

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

	(a)	(b)
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-.		
i Subtract line 1f from line 1c. If zero or less, enter -0-.		

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		63,457
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		95,562
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i			159,019
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
PART II-B, LINE 1:	CENTRACARE HEALTH SYSTEM PAID $159,019 TO STATE AND NATIONAL ASSOCIATIONS TO CONDUCT LOBBYING ACTIVITIES ON ITS BEHALF, AS A MEMBER OF THE ASSOCIATIONS.

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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* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

			Held at the End of the Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $ ________

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other ....

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?. . . ☐ **Yes** ☐ **No**

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? . . . ☐ **Yes** ☐ **No**

			Amount
b	If "Yes," explain the arrangement in Part XIII and complete the following table:		
c	Beginning balance . . .	1c	
d	Additions during the year . . .	1d	
e	Distributions during the year . . .	1e	
f	Ending balance . . .	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ **Yes** ☐ **No**

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII . . . . ☐

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

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

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

a Board designated or quasi-endowment ▶ ....

b Permanent endowment ▶ ....

c Temporarily restricted endowment ▶ ....

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

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

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

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

Part VI **Land, Buildings, and Equipment.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	**(a)** Cost or other basis (investment)	**(b)** Cost or other basis (other)	**(c)** Accumulated depreciation	**(d)** Book value
1a Land		19,872,611		19,872,611
b Buildings		286,390,874	106,559,047	179,831,827
c Leasehold improvements		1,231,805	325,162	906,643
d Equipment		84,421,189	56,700,912	27,720,277
e Other		39,046,741	27,842	39,018,899
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* . . ▶				267,350,257

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) FUNDS HELD BY TRUSTEE UNDER TRUST AND ESCROW AGREEMENT	4,188,451	F
(B) FUNDS HELD BY TRUSTEE UNDER BOND INDENTURES	38,576,914	F
(C) FUNDS HELD BY BOARD FOR FUTURE PROPERTY & EQUIP REPLACEMENT/EXPANSION	46,878,030	F
(D) INVESTMENT IN JOINT VENTURES	8,106,136	C
(E) INVESTMENT IN MUTUAL SERVICE CORP	1,910,389	F
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	99,659,920	

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

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

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

(a) Description	(b) Book value
(1)OTHER ASSETS	10,347,142
(2)DUE FROM AFFILIATES	14,759,012
(3)OPERATING LEASE ASSET	7,112,859
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	32,219,013

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	
(2) PENSION ACCRUAL	-10,055
(3) ASSET RETIREMENT OBLIGATION	612,373
(4) CONTINGENET CONSIDERATIONS	1,356,526
(5) THIRD PARTY SETTLEMENTS	4,691,398
(6) INTERST PAYABLE	15,785,931
(7) LEASE LIABILITY	7,230,436
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	29,666,609

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

Additional Data

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

Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	CENTRACARE, THE CORPORATION, THE CLINIC, CCH-MELROSE, CCH-LONG PRAIRIE, CCH-SAUK CENTRE, THE FOUNDATION AND CARRIS HEALTH FOUNDATION HAVE BEEN DETERMINED TO QUALIFY AS TAX-EXEMPT ORGANIZATIONS UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. CCH-MONTICELLO, CCH-PAYNESVILLE AND CARRIS HEALTH, AS DISREGARDED LIMITED LIABILITY COMPANIES (LLCS) UNDER INTERNAL REVENUE SERVICE REGULATIONS, ACHIEVE TAX-EXEMPT TREATMENT BASED ON THE EXEMPT STATUS OF THEIR PARENT, CENTRACARE HEALTH SYSTEM. AT JUNE 30, 2020 AND 2019, THERE WERE NO UNCERTAIN TAX POSITIONS.

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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* for instructions and the latest information.

OMB No. 1545-0047
2019
Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	Yes	
	☐ 100% ☐ 150% ☐ 200% ☑ Other 17500.0000000000 %			
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	Yes	
	☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other ______ %			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			670,568		670,568	0.160 %
b Medicaid (from Worksheet 3, column a)			52,018,674	40,151,763	11,866,911	2.820 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			52,689,242	40,151,763	12,537,479	2.980 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,497,612		1,497,612	0.360 %
f Health professions education (from Worksheet 5)			88,900		88,900	0.020 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			9,351		9,351	0 %
j **Total.** Other Benefits			1,595,863		1,595,863	0.380 %
k **Total.** Add lines 7d and 7j			54,285,105	40,151,763	14,133,342	3.360 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other			100		100	0 %
10 Total			100		100	0 %

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

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	6,688,681		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	63,452,305
6	Enter Medicare allowable costs of care relating to payments on line 5	6	70,467,528
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-7,015,223

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☐ Cost to charge ratio ☑ Other

Section C. Collection Practices

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes	

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

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
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? **4** Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - MONTICELLO

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

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): SEE SECTION C SUPPLEMENTAL INFORMATION FOR PART V, SECTION B			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): SEE SECTION C SUPPLEMENTAL INFORMATION FOR PART V, SECTION B			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - MONTICELLO

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 175.000000000000 % and FPG family income limit for eligibility for discounted care of 250.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☐ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - MONTICELLO

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - MONTICELLO

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - PAYNESVILLE

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

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?.	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
	a ☑ A definition of the community served by the hospital facility			
	b ☑ Demographics of the community			
	c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
	d ☑ How data was obtained			
	e ☑ The significant health needs of the community			
	f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
	g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
	h ☑ The process for consulting with persons representing the community's interests			
	i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
	j ☑ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
	a ☑ Hospital facility's website (list url): WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/			
	b ☐ Other website (list url): WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/			
	c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
	d ☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): SEE SECTION C SUPPLEMENTAL INFORMATION FOR PART V, SECTION B			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - PAYNESVILLE

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
	a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 175.000000000000 % and FPG family income limit for eligibility for discounted care of 250.000000000000 %			
	b ☐ Income level other than FPG (describe in Section C)			
	c ☐ Asset level			
	d ☐ Medical indigency			
	e ☑ Insurance status			
	f ☐ Underinsurance discount			
	g ☐ Residency			
	h ☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
	a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
	b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
	c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
	d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
	e ☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
	a ☑ The FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
	b ☑ The FAP application form was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
	c ☑ A plain language summary of the FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
	d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
	e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
	f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
	g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
	h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
	i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
	j ☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - PAYNESVILLE

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group CENTRACARE HEALTH - PAYNESVILLE

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - RICE MEMORIAL HOSPITAL

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

		Line	Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?.	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): WWW.CARRISHEALTH.COM/DOCUMENTS/COMMUNITYHEALTHNEEDSASSESSMENT.PDF			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☑ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): WWW.CARRISHEALTH.COM/DOCUMENTS/COMMUNITYHEALTHNEEDSASSESSMENT.PDF			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - RICE MEMORIAL HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 175.000000000000 % and FPG family income limit for eligibility for discounted care of 250.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☐ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - RICE MEMORIAL HOSPITAL

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

CARRIS HEALTH - RICE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - REDWOOD AREA HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?.	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	Yes	
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3		No
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 ___			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5		
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b		
7	Did the hospital facility make its CHNA report widely available to the public?	7		
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☐ Hospital facility's website (list url): ______			
b	☐ Other website (list url): ______			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8		
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 ___			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		
a	If "Yes" (list url): ______			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ ______			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - REDWOOD AREA HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 175.000000000000 % and FPG family income limit for eligibility for discounted care of 250.000000000000 %			
b ☐ Income level other than FPG (describe in Section C)			
c ☐ Asset level			
d ☐ Medical indigency			
e ☑ Insurance status			
f ☐ Underinsurance discount			
g ☐ Residency			
h ☑ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a ☑ The FAP was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
b ☑ The FAP application form was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
c ☑ A plain language summary of the FAP was widely available on a website (list url): WWW.CARRISHEALTH.COM/PATIENT-RESOURCES/PRICING-FINANCIAL-ASSISTANCE			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - REDWOOD AREA HOSPITAL

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group CARRIS HEALTH - REDWOOD AREA HOSPITAL

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

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 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? **13**

	Name and address	Type of Facility (describe)
1	See Additional Data Table	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Part VI **Supplemental Information**

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A:	CENTRACARE HEALTH SYSTEM PREPARES AN ANNUAL COMMUNITY BENEFIT REPORT THAT INCLUDES ALL RELATED ORGANIZATIONS.
PART I, LINE 7:	THE HOSPITALS' TOTAL EXPENSES (NET OF BAD DEBT) WERE REDUCED BY OTHER OPERATING REVENUE (NET OF EHR INCENTIVE REVENUE) AND ALSO BY MEDICAID SURCHARGE AND TAXES, AND THEN DIVIDED BY TOTAL PATIENT REVENUE TO DETERMINE COST TO CHARGE RATIO.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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 $ 6,688,681.
PART III, LINE 2:	THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	THE FOLLOWING IS FROM THE "ACCOUNTS RECEIVABLE" PARAGRAPH INCLUDED IN NOTE 2 OF THE ORGANIZATION'S AUDITED FINANCIALS."CENTRACARE REPORTS PATIENT AND RESIDENT SERVICE REVENUE AT THE AMOUNT THAT REFLECTS THE CONSIDERATION TO WHICH CENTRACARE EXPECTS TO BE ENTITLED TO IN EXCHANGE FOR PROVIDING PATIENT CARE. THESE AMOUNTS ARE DUE FROM PATIENTS AND THIRD-PARTY PAYORS (INCLUDING MEDICARE, MEDICAID, BLUE CROSS AND OTHER THIRD-PARTY PAYORS). CERTAIN REIMBURSEMENT ARRANGEMENTS INCLUDE VARIABLE CONSIDERATION FOR AMOUNTS SUBJECT TO RETROACTIVE AUDIT AND ADJUSTMENT. DIFFERENCES BETWEEN AMOUNTS ORIGINALLY RECORDED AND FINALLY SETTLED ARE INCLUDED IN OPERATIONS IN THE YEAR IN WHICH THE DIFFERENCES ARE KNOWN. REVENUE IS RECOGNIZED AS PERFORMANCE OBLIGATIONS ARE SATISFIED."
PART III, LINE 8:	THE SHORTFALL OF $7,015,223 IN TREATING MEDICARE PATIENTS SHOULD BE CONSIDERED A COMMUNITY BENEFIT IN ITS ENTIRETY. THE HOSPITALS PROVIDE AN EXCELLENT LEVEL OF CARE TO THE PEOPLE IN THE COMMUNITY. DESPITE THE SHORTFALL IN REIMBURSEMENT FORM MEDICARE, THE HOSPITALS CONTINUE TO PROVIDE ESSENTIAL HEALTHCARE SERVICES TO THE POPULATION. THE AMOUNT ON LINE 6 OF PART III WAS DETERMINED BY UTILIZING THE MEDICARE COST REPORT UTILIZING KEY SECTIONS OF THAT REPORT, PRIMARILY THE D SERIES AND E SERIES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B:	THE COLLECTION POLICIES AT THE HOSPITALS REQUIRE COLLECTION STAFF TO OFFER CHARITY TO PATIENTS WHO INDICATE THAT PAYMENT MAY BE AN ISSUE. IF A PATIENT DOES QUALIFY FOR FULL CHARITY, ALL OTHER COLLECTION EFFORTS MUST CEASE, IF A PATIENT QUALIFIES FOR PARTIAL CHARITY, COLLECTION EFFORTS WILL CONTINUE ON THE BALANCE OF THE ACCOUNT. THESE PROVISIONS APPLY TO BOTH HOSPITAL EMPLOYED COLLECTION STAFF AND COLLECTION AGENCY STAFF. NO PATIENTS, WHETHER THEY QUALIFY FOR CHARITY OR NOT, ARE REPORTED TO CREDIT RATING AGENCIES.
PART VI, LINE 2:	THE ORGANIZATIONS' STRATEGIC PLANNING ASSESSES THE NEEDS OF THE COMMUNITY AND PATIENTS THROUGH PATIENT SATISFACTION SURVEYS, COMMENT CARDS, COMMUNITY ASSESSMENTS AND A DIVERSE OPERATING COMMITTEE THAT REPRESENTS THE COMMUNITY AND BRINGS TO THE TABLE ISSUES, CONCERNS AND RECOMMENDATIONS FOR HEALTH CARE SERVICES.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3:	INPATIENTS WHO ARE SELF PAY ARE IDENTIFIED, AND A REPRESENTATIVE OF THE ORGANIZATION'S BILLING DEPARTMENT EXPLAINS THE CHARITY CARE POLICY TO PATIENTS. THEY ALSO EXPLAIN THE SELF PAY DISCOUNT AND SCREENS THE PATIENT FOR ELIGIBILITY FOR ANY STATE OR FEDERAL PROGRAMS. THEY ALSO ASSIST THE PATIENT WITH ANY PAPERWORK REQUIRED TO APPLY FOR SUCH PROGRAMS. OUTPATIENTS WHO ARE SELF PAY RECEIVE AN AUTOMATIC SELF PAY DISCOUNT. IF THE PATIENT DOES NOT REMIT PAYMENT, COLLECTION STAFF ATTEMPT TO REACH THE PATIENT BY PHONE. PATIENTS ARE TOLD ABOUT THE CHARITY PROGRAM. FOR BOTH INPATIENTS AND OUTPATIENTS, ALL STATEMENTS CONTAIN A LETTER REGARDING THE AVAILABILITY OF CHARITY CARE. ALSO ALL PRECOLLECTION LETTERS HAVE THIS SAME LANGUAGE INDICATING THE AVAILABILITY AND PROCESS OF OBTAINING CHARITY CARE.
PART VI, LINE 4:	CENTRACARE HEALTH - MONTICELLO IS LOCATED IN CENTRAL MINNESOTA IN WRIGHT COUNTY. THE ESTIMATED 2020 CENSUS SHOWS A POPULATION OF 20,213, WITH A PROJECTED 2025 GROWTH PERCENTAGE OF 5.19% TO 21,262 POPULATION LEVEL. THIS AREA OF THE STATE IS SHOWING A SIGNIFICANT INCREASE IN POPULATION AND IS EXPECTED TO CONTINUE INTO THE FUTURE. THE PROJECTED GROWTH BY AGE BRACKET FROM 2020 TO 2025 IS AS FOLLOWS: 0-17: 1.15%, 18-44: 2.12%, 45-64: 6.20%, 65+: 20.67%. THE ESTIMATED 2020 ETHNIC MIX IS AS FOLLOWS: CAUCASIAN: 88.70%, AFRICAN AMERICAN: 1.67%, ASIAN: 1.09%, HISPANIC: 5.98%, OTHER: 2.56%. CENTRACARE HEALTH - PAYNESVILLE IS LOCATED IN CENTRAL MINNESOTA IN STEARNS COUNTY. THE ESTIMATED 2020 CENSUS SHOWS A POPULATION OF 6,318 AND IS PROJECTED TO INCREASE SLIGHTLY TO 6,475 BY 2025 WHICH REPRESENTS A 2.48% INCREASE. THE PROJECTED GROWTH BY AGE BRACKET FROM 2020 TO 2025 IS AS FOLLOWS: 0-17: 3.65%, 18-44: 4.79%, 45-64: -6.98%, 65+: 8.02%. THE ESTIMATED 2020 ETHNIC MIX IS AS FOLLOWS: CAUCASIAN: 95.41%, AFRICAN AMERICAN: .55%, ASIAN: .46%, HISPANIC: 2.48%, OTHER: 1.09%. CENTRACARE HEALTH - RICE MEMORIAL HOSPITAL IS LOCATED IN CENTRAL MINNESOTA IN KANDIYOHI COUNTY. THE ESTIMATED 2020 CENSUS SHOWS A POPULATION OF 23,727 AND IS PROJECTED TO INCREASE SLIGHTLY TO 24,188 BY 2025 WHICH REPRESENTS A 1.94% INCREASE. THE PROJECTED GROWTH BY AGE BRACKET FROM 2020 TO 2025 IS AS FOLLOWS: 0-17: 2.00%, 18-44: 1.83%, 45-64: -5.48%, 65+: 11.36%. THE ESTIMATED 2020 ETHNIC MIX IS AS FOLLOWS: CAUCASIAN: 65.63%, AFRICAN AMERICAN: 10.79%, ASIAN: 1.34%, HISPANIC: 20.63%, OTHER: 1.60%. CENTRACARE HEALTH - REDWOOD FALLS HOSPITAL IS LOCATED IN REDWOOD COUNTY, MINNESOTA. THE ESTIMATED 2021 CENSUS SHOWS A POPULATION OF 6,363 AND IS PROJECTED TO DECREASE SLIGHTLY TO 6,314 BY 2026 WHICH REPRESENTS A 0.77% DECREASE. THE PROJECTED GROWTH BY AGE BRACKET FROM 2021 TO 2026 IS AS FOLLOWS: 0-17: -2.16%, 18-44: 1.96%, 45-64: -10.13%, 65+: 6.90%. THE ESTIMATED 2021 ETHNIC MIX IS AS FOLLOWS: CAUCASIAN: 83.78%, AFRICAN AMERICAN: .90%, ASIAN: .42%, HISPANIC: 5.83%, OTHER: 9.07%.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5:	THE ORGANIZATION PROMOTES THE HEALTH OF THE COMMUNITY IN SEVERAL IMPORTANT WAYS. ONE OF THESE WAYS IS THROUGH THE COMMUNITY COLLABORATION COMMITTEE (CCC), A STANDING COMMITTEE OF THE CENTRACARE HEALTH FOUNDATION. THE CCC HAS A MEMBERSHIP OF OVER 30 PERSONS REPRESENTING HEALTHCARE AND COMMUNITY NEEDS ACROSS CENTRAL MINNESOTA. THE CCC MEETS MONTHLY TO DISCUSS WAYS TO ADDRESS TYPICAL HEALTH ISSUES THROUGH AWARENESS BUILDING, EDUCATION AND/OR AN INTERVENTION PROJECT. THERE ARE SEVERAL COMMUNITY HEALTH OUTREACH INITIATIVES THAT THE FOUNDATION IS INVOLVED WITH. THESE INITIATIVES INCLUDE: 1) BLEND CHILDHOOD OBESITY COALITION OF CENTRAL MINNESOTA, 2) SMOKE FREE COMMUNITIES (CONTINUED EFFORTS TO CREATE CLEAN INDOOR AND OUTDOOR AIR FOR ALL), 3) TOBACCO CESSATION SERVICES CLINICS (COLLABORATION WITH CLINIC), 4) CENTRACARE CLINIC TEAM BASED CARE PILOT, 5) ST. CLOUD HOSPITAL - TRANSITION OF CARE PILOT (CREATE MORE SEAMLESS INTEGRATION FROM CARE SETTING TO CARE SETTING, AND 6) CLINIC - DIVERSITY AND CULTURAL COMPETENCY TRAINING.
PART VI, LINE 6:	THE ORGANIZATION IS PART OF CENTRACARE HEALTH SYSTEM (CCHS) WHICH PROVIDES A BROAD RANGE OF HEALTH CARE SERVICES TO THE PATIENTS OF CENTRAL MINNESOTA. CCHS IS DEDICATED TO IMPROVING THE HEALTH OF PEOPLE LIVING AND WORKING IN THE COMMUNITIES IT SERVES. TO ACCOMPLISH ITS GOALS IT WORKS ACTIVELY WITH ITS AFFILIATE HEALTH CARE ORGANIZATIONS. CCHS CONTINUES TO FOCUS ON PROVIDING THE BEST CARE POSSIBLE AND IN REINVESTING INTO THE COMMUNITY. CCHS ALSO PROMOTES WELLNESS BY SPONSORING PROGRAMS AND EVENTS IN LOCAL COMMUNITIES THAT FOCUS ON HEALTHY EATING AND EXERCISE, AND BY CONDUCTING SCREENINGS FOR CONDITIONS SUCH AS HIGH BLOOD PRESSURE.

990 Schedule H, Supplemental Information

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

Additional Data

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

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **4** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	CENTRACARE HEALTH - MONTICELLO 1013 HART BLVD MONTICELLO, MN 55362 WWW.CENTRACARE.COM/LOCATIONS/MONTICELL 399601	X	X			X		X		DISTINCT PSYCH UNIT	
2	CENTRACARE HEALTH - PAYNESVILLE 200 WEST FIRST STREET PAYNESVILLE, MN 56362 WWW.CENTRACARE.COM/LOCATIONS/PAYNESVIL 399803	X	X			X		X		NONE	
3	CARRIS HEALTH - RICE MEMORIAL HOSPITAL 301 BECKER AVE SW WILLMAR, MN 56201 WWW.CARRISHEALTH.COM/LOCATIONS/CARRIS- 399309	X	X					X		NONE	
4	CARRIS HEALTH - REDWOOD AREA HOSPITAL 100 FALLWOOD ROAD REDWOOD FALLS, MN 56283 CARRISHEALTH.COM/LOCATIONS/CARRIS-HEAL 399308	X	X					X		NONE	

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
CARRIS HEALTH - REDWOOD AREA HOSPITAL	PART V, SECTION B, LINE 2: EFFECTIVE JANUARY 1, 2019, CARRIS HEALTH AFFILIATED WITH REDWOOD AREA HOSPITAL, A DIVISION OF THE CITY OF REDWOOD FALLS, MINNESOTA, EXPANDING CARRIS HEALTH TO INCLUDE CARRIS REDWOOD.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 3J: CENTRACARE UTILIZED THE MAPP (MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS) PROCESS TO CONDUCT THE CHNA AND PREPARE THE IMPLEMENTATION STRATEGY WHICH WE CALLED THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP). THE MAPP PROCESS INCLUDES A LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT, STAKEHOLDER INTERVIEWS, COMMUNITY HEALTH SURVEY JOINTLY FUNDED AND MANAGED WITH THREE COUNTY PUBLIC HEALTH DEPARTMENTS, AND SEVERAL COMMUNITY MEETINGS TO GATHER INFORMATION ON FORCES THAT CREATE HEALTH, TRENDS, FACTORS AND EVENTS AFFECTING HEALTH, AND STRATEGIES TO OVERCOME BARRIERS TO HEALTHY LIVING. THE CHNA INCLUDED A HEALTH EQUITY ASSESSMENT AND INFORMATION ON NATIONAL, STATE, AND OTHER LOCAL PLANNING PROCESSES RELATED TO HEALTH. AS A FOLLOW UP TO THE PRIOR CHNA PROCESS WHERE PUBLIC HEALTH DATA WAS A SIGNIFICANT GAP, THIS CHNA AND SUBSEQUENT CHIP WAS A COLLABORATIVE EFFORT EXECUTED WITH BENTON COUNTY PUBLIC HEALTH, SHERBURNE COUNTY PUBLIC HEALTH, AND STEARNS COUNTY PUBLIC HEALTH. THE RESULT WAS A JOINT CHNA AND CHIP.

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 5: TO BETTER UNDERSTAND HEALTH ISSUES FACING THE COMMUNITIES OF WR IGHT COUNTY, BUFFALO HOSPITAL, PART OF ALLINA HEALTH, CENTRACARE MONTICELLO, WRIGHT COUNTY PUBLIC HEALTH AND WRIGHT COUNTY COMMUNITY ACTION PARTNERED TO DEVELOP AND CONDUCT A COMMU NITY HEALTH NEEDS ASSESSMENT (CHNA). IN EARLY 2017, THE ORGANIZATIONS FORMED WRIGHT COUNTY COMMUNITY HEALTH COLLABORATIVE IN AN EFFORT TO COLLECT AND PRIORITIZE DATA FROM VARIOUS S OURCES, AND DEVELOP A JOINT COMMUNITY HEALTH IMPLEMENTATION PLAN. THE PURPOSE OF THE COLLA BORATIVE GROUP IS TO SYSTEMATICALLY IDENTIFY AND ANALYZE HEALTH ISSUES IN THE COMMUNITY AN D CREATE A PLAN FOR HOW TO ADDRESS THEM. THE GROUP INCLUDES ALL WRIGHT COUNTY ORGANIZATION S WHO ARE ENCOURAGED OR REQUIRED TO COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). T HE COLLABORATIVE EMPLOYED THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP) FRAMEWORK WHICH EMPHASIZES COLLABORATION OF HEALTH CARE ENTITIES, PUBLIC HEALTH AND COMM UNITY ORGANIZATIONS AND IS CENTERED UPON COMMUNITY ENGAGEMENT.THE CHNA UTILIZED A VARIETY OF INFORMATION SOURCES AND COMMUNITY INPUT TO ANALYZE AND PRIORITIZE COMMUNITY HEALTH ISSU ES. THIS INFORMATION WAS USED TO DEVELOP THE HEALTH IMPROVEMENT ACTION PLAN TO ADDRESS THE IDENTIFIED ISSUES. IMPORTANT ACTIVITIES IN THE CHNA PROCESS ARE OUTLINED IN THE CHNA, AS WELL AS ROLES AND RESPONSIBILITIES AMONG THE PARTNERS IN THE COLLABORATIVE. THE CHNA PROCE SS WAS BASED ON THE PARTNERSHIP BETWEEN FOUR ORGANIZATIONS: BUFFALO HOSPITAL, PART OF ALLI NA HEALTH, CENTRACARE MONTICELLO, WRIGHT COUNTY PUBLIC HEALTH AND WRIGHT COUNTY COMMUNITY ACTION. MAJOR CHNA DECISIONS WERE BASED ON CONSENSUS AND OPEN DIALOGUE BETWEEN THE PARTNER S, AS WELL AS COMMUNITY INPUT. THE COLLABORATIVE AGREED THAT THE DEFINITION OF HEALTH ENCO MPASSES A BROAD RANGE OF CONDITIONS, NOT JUST HEALTH IN TERMS OF HEALTHCARE. IMPROVING HEA LTH IS NO LONGER ABOUT TREATING AND PREVENTING MEDICAL CONDITIONS; IT IS THE IMPROVEMENT O F COMPLETE PHYSICAL, MENTAL, SPIRITUAL AND SOCIAL WELL-BEING. REPRESENTATIVES FROM PARTNER ING ORGANIZATIONS MET REGULARLY FROM SEPTEMBER 2017 TO JULY 2019 FOR PROGRESS UPDATES, DIS CUSSION ON UPCOMING CHNA ACTIVITIES AND EVENT PLANNING. ALL CORE PARTNERS IN THE COLLABORA TIVE CONTRIBUTED TO THE COMPLETION OF THE PROCESS TO THE BEST OF THEIR ABILITY AND UTILIZE D THE STRENGTHS AND CAPACITY OF VARIOUS GROUP MEMBERS.THE PARTNERSHIP ADOPTED THE MAPP MOD EL FOR ASSESSMENT AND PLANNING. MAPP IS A COMMUNITY DRIVEN STRATEGIC PLANNING PROCESS FOR IMPROVING COMMUNITY HEALTH. FACILITATED BY PUBLIC HEALTH LEADERS, THIS FRAMEWORK HELPS COM MUNITIES APPLY STRATEGIC THINKING TO PRIORITIZE PUBLIC HEALTH ISSUES AND IDENTIFY RESOURCE S TO ADDRESS THEM. MAPP IS NOT AN AGENCY-FOCUSED ASSESSMENT PROCESS; RATHER, IT IS AN INTE RACTIVE PROCESS THAT CAN IMPROVE THE EFFICIENCY, EFFECTIVENESS, AND ULTIMATELY THE PERFORM ANCE OF LOCAL PUBLIC HEALTH SYSTEMS. COMMUNITY OWNERSHIP IS A KEY COMPONENT OF MAPP. PARTI CIPATION FROM THE BROADER COMM

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	UNITY LEADS TO COLLECTIVE THINKING AND SUSTAINABLE SOLUTIONS TO COMPLEX PROBLEMS.THIS EFFO RT INCLUDED: (1) COMPLETION OF A CHNA TO SYSTEMATICALLY IDENTIFY AND ANALYZE HEALTH PRIORI TIES IN THE COMMUNITY, AND (2) DEVELOPMENT OF A PLAN TO ADDRESS THESE PRIORITIES AS A COLL ABORATIVE AND IN PARTNERSHIP WITH OTHERS. THROUGH THIS PROCESS, THE COLLABORATIVE ENGAGED WITH COMMUNITY STAKEHOLDERS TO BETTER UNDERSTAND THE HEALTH NEEDS OF THE COMMUNITIES IT SE RVES, IDENTIFIED INTERNAL AND EXTERNAL RESOURCES FOR HEALTH PROMOTION AND CREATED AN IMPLE MENTATION PLAN THAT LEVERAGES THOSE RESOURCES TO IMPROVE COMMUNITY HEALTH.

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 5: CENTRACARE POPULATION HEALTH CONDUCTED SPECIFIC AND COMPREHENSI VE EVALUATION OF ZIP CODE 56304 THAT HAS THE WORST HEALTH OUTCOMES IN THE THREE COUNTIES I NCLUDED IN THE CHNA AND CHIP. THIS EVALUATION INCLUDED DATA EVALUATION, KEY INFORMANT INTE RVIEWS, AND HEALTH INDICATORS FOR MINORITY GROUPS. THE CENTRAL MN ALLIANCE ALSO COMPLETED SEVERAL SURVEYS AND ASSESSMENTS TO GET INPUT FROM MULTIPLE SECTORS OF EACH COMMUNITY REPRE SENTING DIFFERENT POPULATIONS IN ORDER TO COMPILE A LIST OF TOP PRIORITIES IN THE REGION:T HE COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) WAS DATA COLLECTED FROM THE COMMUNITY HEALTH ASSESSMENT COMPLETED IN 2016, CENTRACARE PATIENT DATA, MINNESOTA STUDENT SURVEY DATA, AND MINNESOTA PUBLIC HEALTH VITAL STATISTICS. THIS DATA WAS COMPARED TO DOCUMENTS AND DATASETS FROM THE MN STATEWIDE HEALTH ASSESSMENT (SHA), CENTRAL MN COMMUNITY HEALTH SURVEY DATA, P REVIOUS PLANNING PROCESS PRIORITY LISTS, HEALTH EQUITY DATA ANALYSES (HEDA) FROM EACH COUN TY, TYPES OF DATA REQUESTS OUR AGENCIES WERE GETTING FROM THE PUBLIC, AND THE MN DEPARTMEN T OF HEALTH DATA INDICATOR LIST. A "COMMUNITY PIRORITY CATEGORY" WAS ASSIGNED TO EACH DATA POINT TO IDENTIFY A LIST OF COMMUNITY PRIORITIES. THE COMMUNITY THEMES AND STRENGTHS ASSE SSMENT (CTSA) WAS CONDUCTED IN THE FORM OF KEY STAKEHOLDER INTERVIEWS VIA PHONE WITH A WID E VARIETY OF COMMUNITY PARTNERS THROUGHOUT THE THREE COUNTIES. A TOTAL OF 54 STAKEHOLDERS WERE INTERVIEWED FROM 10 DIFFERENT SECTORS INCLUDING: HEALTHCARE PROFESSIONALS, STATE, LOC AL OR TRIBAL GOV'T AGENCIES WITH EXPERTISE IN SUBSTANCE ABUSE, BUSINESSES, SCHOOLS, CIVIC GROUPS, LAW ENFORCEMENT, YOUTH, MEDIA, RELIGIOUS/FRATERNAL GROUPS AND YOUTH-SERVING ORGANI ZATIONS. FOR THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) BENTON, SHERBURNE, AND STEA RNS COUNTY LPH AGENCIES PARTICIPATED IN A CAPACITY ASSESSMENT TO HELP DETERMINE THE EXTENT TO WHICH REQUIRED LOCAL PUBLIC HEALTH ACTIVITIES ARE IN PLACE STATEWIDE. THE ASSESSMENT Q UESTIONS WERE THEN UTILIZED TO FORMULATE A SURVEY FOR THREE SECTORS OF THE LOCAL PUBLIC HE ALTH SYSTEM: EMERGENCY PREPAREDNESS, ENVIRONMENTAL HEALTH, AND HEALTHCARE ACCESS/INFECTIOU S DISEASE. COMMUNITY PARTNERS WERE INVITED TO PARTICIPATE IN THE SURVEY VIA EMAIL. AFTER A NALYZING THE RESULTS, THE LPHSA SUBGROUP DEVELOPED A LIST OF THEIR TOP 10 RECOMMENDATIONS FROM ALL 3 SECTORS TO SUPPORT THE DEVELOPMENT OF THE COMMUNITY COMMUNITY HEALTH IMPROVEMEN T PLAN. THE FORCES OF CHANGE (FOC) ASSESSMENT WAS COMPLETED IN THE FORM OF A COMUNITY MEET ING TO IDENTIFY FORCES THAT MAY AFFECT A COMMUNITY AND OPPORTUNITIES AND THREATS ASSOCIATE D WITH THOSE FORCES. THE AGENDA INCLUDED A BRAINSTORMING ACTIVITY AND TIME IN SMALL GROUP AND LARGE GROUP DISCUSSION. A FLIER ADVERTISING THE MEETING WAS DISTRIBUTED TO COMMUNITY M EMBERS VIA EMAIL. THERE WERE 68 PEOPLE THAT ATTENDED REPRESENTING 27 ORGANIZATIONS AND TWO THAT IDENTIFIED THEIR AFFILIATION AS 'COMMUNITY MEMBER'. AS A FOLLOW UP TO THE FORCES OF CHANGE COMMUNITY MEETING, A WO

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	RLD CAFE WAS HELD IN JANUARY 2019 FOR MEMBERS OF THE COMMUNITY TO COME AND TALK ABOUT THEI R PERCEPTION OF NEEDS IN THE SURROUNDING COMMUNITIES. THERE WERE 94 PEOPLE THAT ATTENDED T HE MEETING REPRESENTING 32 ORGANIZATIONS AND THREE THAT IDENTIFIED THEIR AFFILIATION AS 'C OMMUNITY MEMBER'. ORGANIZATIONS THAT WERE REPRESENTED AT BOTH COMMUNITY MEETINGS INCLUDED LOCAL GOVERNMENT, HEALTHCARE, LOCAL NONPROFITS, EDUCATION, UNDERREPRESENTED COMMUNITIES, F AITH COMMUNITY, AND OTHERS. IN ORDER TO BETTER ENGAGE INDIVIDUALS OR ORGANIZATIONS WITH A PERSPECTIVE OF AT-RISK POPULATIONS, A HEALTH EQUITY ASSESSMENT WAS ALSO COMPLETED. FOCUS-G ROUP MEETINGS WERE HELD ON THREE SEPARATE OCCASIONS AT THE GREAT RIVER REGIONAL LIBRARY IN ST. CLOUD, AND COMMUNITY INPUT WAS GATHERED AT THE BENTON, SHERBURNE, AND STEARNS COUNTY FAIRS TO REACH OUT TO A VARIETY OF COMMUNITIES. IN TOTAL, THERE WERE 30 SOMALI ADULTS WHO DISCUSSED POSITIVES, NEGATIVES, AND AREAS-TO-IMPROVE-ON WITHIN THE COMMUNITY. AT THE COUNT Y FAIRS, INFORMATION WAS GATHERED FROM RESPONDENTS FROM THE 56304-ZIP CODE.

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
CARRIS HEALTH - RICE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5: CONDUCTING A HEALTH NEEDS ASSESSMENT IS A MULTIFACETED PROCESS THAT REQUIRES AMPLE PREPARATION, EFFECTIVE USE OFRESOURCES, SOUND METHODOLOGY, AND COLLABORATION ON BEHALF OF ALL STAKEHOLDERS. WITH THAT IN MIND, THE ASSESSMENTPROCESS WAS ORGANIZED INTO FIVE MAIN PHASES, WHICH WERE FURTHER BROKEN DOWN INTO A SERIES OF INTERCONNECTEDCOMPONENTS:1. FORMATION OF SYSTEM-WIDE WORKING GROUP AND DEFINITION OF SERVICE AREAS2. DATA COLLECTION AND ANALYSIS (APRIL-JUNE 2018)3. INITIAL PRIORITIZATION (JULY-AUGUST 2018)4. EVALUATION AND ASSESSMENT OF COMMUNITY MEMBERS (SEPTEMBER-OCTOBER 2018)5. FINAL PRIORITIZATION (NOVEMBER-DECEMBER 2018)ALTHOUGH THE PROCESS MOVED IN THIS CHRONOLOGICAL ORDER, THE COMPLEXITY OF THE ASSESSMENT PROCESS NECESSITATED AFLUID MOVEMENT BETWEEN EACH PHASE. INDEED, KEY TO A THOROUGH AND COMPREHENSIVE ASSESSMENT IS THE ABILITY TOEXAMINE AND REEXAMINE EACH COMPONENT OF THE PROCESS IN LIGHT OF WHAT IS LEARNED IN LATER PHASES OF ASSESSMENT.CARRIS HEALTH TAKES PRIDE IN ITS LEVEL OF INVOLVEMENT IN THE COMMUNITY AND ITS RECEPTIVENESS TO THE COMMUNITY'S HEALTH CARE NEEDS. THEREFORE, SYSTEM ADMINISTRATION CONSIDERED IT BOTH REASONABLE AND APPROPRIATE THAT STAFF AND LEADERS WITHIN CARRIS HEALTH BE CHARGED WITH THE TASK OF CONDUCTING THE ASSESSMENT, RATHER THAN CONTRACT WITH A THIRD PARTY REMOVED FROM THE COMMUNITY ITSELF. AN INTERNAL TEAM CALLED THE CHNA WORKING GROUP WAS ASSEMBLED, COMPRISED OF INDIVIDUALS WITH DIVERSE KNOWLEDGE AND EXPERTISE IN HEALTH CARE DELIVERY, ADMINISTRATION, PLANNING AND DEVELOPMENT, MARKETING, COMMUNITY AND GOVERNMENT RELATIONS, AMONG OTHER DEPARTMENTS. THIS GROUP, WHICH CONSISTS OF INDIVIDUALS FROM ACROSS THE CARRIS HEALTH SYSTEM, IS INDICATIVE OF THE COLLABORATIVE NATURE OF THE CHNA PROCESS AND A TESTAMENT, MORE GENERALLY, OF THE MUTUAL SUPPORT THROUGHOUT THE SYSTEM. ADDITIONALLY, HOSPITAL BOARD MEMBERS AND EXECUTIVES WERE ENGAGED IN THE ASSESSMENT PROCESS AT AN EARLY STAGE. IN THE INITIAL STAGES OF DATA ANALYSIS AND PRIORITIZATION, ALL WORKING GROUP MEMBERS WERE PRESENTED WITH DATA BROKEN DOWN BY COUNTY IN ORDER TO INDICATE MOST CLEARLY THOSE ISSUES THAT WERE PREVALENT THROUGHOUT THE CARRIS HEALTH SERVICE AREA AND THOSE ISSUES UNIQUE TO EACH CARRIS LOCATION. FURTHERMORE, EACH MEMBER OF THE WORKING GROUP PARTICIPATED IN THE PRIORITIZATION PROCESS SO THAT THE FINAL SET OF COMMUNITY HEALTH NEEDS MIGHT ACCURATELY REFLECT GENUINE ISSUES THAT ARE PREVALENT WITHIN THE BROADER CARRIS HEALTH SERVICE AREA. AN IMPLEMENTATION STRATEGY, SPECIFIC TO THE NEEDS OF THE CORRESPONDING SERVICE AREA WAS DEVELOPED IN RESPONSE TO THE FINDINGS OF THE COLLABORATIVE.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 6A: WRIGHT COUNTY COMMUNITY HEALTH COLLABORATIVE INCLUDES CENTRACARE MONTICELLO ALONG WITH ALLINA HEALTH BUFFALO HOSPITAL, WRIGHT COUNTY COMMUNITY ACTION, AND WRIGHT COUNTY 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
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 6A: CENTRACARE CONDUCTED THREE DIFFERENT CHNA GROUPS. THE CENTRAL MN ALLIANCE INCLUDES ST. CLOUD HOSPITAL, CENTRACARE- MELROSE, CENTRACARE-SAUK CENTRE, AND CENTRACARE- PAYNESVILLE, ALONG WITH BENTON, SHERBURNE, AND STEARNS COUNTY PUBLIC HEALTH DEPARTMENTS.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 6B: WRIGHT COUNTY COMMUNITY HEALTH COLLABORATIVE INCLUDES CENTRACARE MONTICELLO ALONG WITH ALLINA HEALTH BUFFALO HOSPITAL, WRIGHT COUNTY COMMUNITY ACTION, AND WRIGHT COUNTY 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
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 6B: CENTRACARE CONDUCTED THREE DIFFERENT CHNA GROUPS. THE CENTRAL MN ALLIANCE INCLUDES ST. CLOUD HOSPITAL, CENTRACARE- MELROSE, CENTRACARE-SAUK CENTRE, AND CENTRACARE- PAYNESVILLE, ALONG WITH BENTON, SHERBURNE, AND STEARNS COUNTY PUBLIC HEALTH DEPARTMENTS.

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
CARRIS HEALTH - RICE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B: CARRIS HEALTH'S CHNA WAS CONDUCTED WITH THE KANDIYOHI/RENVILLE PUBLIC HEALTH DEPARTMENT.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 11: COMMUNITY MEMBERS, COMMUNITY ORGANIZATIONS, PUBLIC HEALTH AND HOSPITAL/HEALTH SYSTEM STAFF PARTICIPATED IN A PROCESS THAT IDENTIFIED THE FOLLOWING PRIOR ITY AREAS FOR COMMUNITY HEALTH IN THE COMMUNITIES SERVED BY THE COLLABORATIVE:1) MENTAL HE ALTH AND WELLNESS2) DENTAL CARE3) SUBSTANCE USE AND ABUSEIN 2018-19, STAFF SOLICITED COMMU NITY INPUT, ASSESSED EXISTING RESOURCES AND DEVELOPED A COMMUNITY HEALTH IMPROVEMENT PLAN FOR 2020-2022 IN ORDER TO ADDRESS THESE PRIORITIES. THIS IMPLEMENTATION PLAN INCLUDES THE FOLLOWING GOALS, EACH OF WHICH IS SUPPORTED BY MULTIPLE STRATEGIES AND WILL BE IMPLEMENTED THROUGH A VARIETY OF ACTIVITIES MONITORED FOR PROGRESS AND OUTCOMES OVER TIME.MENTAL HEAL TH AND WELLNESS GOAL: REDUCE THE RATE OF MENTAL HEALTH CARE DELAY AND THE NUMBER OF NOT GO OD" MENTAL HEALTH DAYS IN WRIGHT COUNTY.DENTAL CARE GOAL: REDUCE THE RATE OF DENTAL CARE D ELAY IN WRIGHT COUNTY.SUBSTANCE USE AND ABUSE GOAL: SUPPORT LOCAL PREVENTION EFFORTS AND A DVOCATE FOR POLICY CHANGES TO ADDRESS SUBSTANCE ABUSE IN WRIGHT COUNTY.DATA REVIEW AND ISS UE PRIORITIZATIONAPPROXIMATELY 150 STAKEHOLDERS REPRESENTING BROAD INTERESTS OF THE COMMUN ITY AND 40 COMMUNITY ORGANIZATIONS PARTICIPATED IN KEY INFORMANT INTERVIEWS AND/OR ATTENDE D AT LEAST ONE OF SEVERAL MEETINGS TO REVIEW AND DISCUSS THE CHNA DATA GATHERED AND HELP I DENTIFY THREE PRIORITY HEALTH ISSUES. THE REVIEW PROCESS INCLUDED A FORMAL PRIORITIZATION TOOL KNOWN AS THE HANLON METHOD, WHICH INCLUDES RANKING HEALTH PRIORITIES BASED ON THREE P RIMARY CRITERIA: THE SIZE OF THE PROBLEM, INCLUDING PROJECTION OF FUTURE TRENDS; THE SERIO USNESS OF THE PROBLEM, INCLUDING DISPARATE HEALTH BURDENS WITHIN THE POPULATION; AND THE E FFECTIVENESS AND FEASIBILITY OF INTERVENTIONS ON THE PART OF HEALTH CARE. AS A RESULT OF T HE PRIORITIZATION SESSION, THE COLLABORATIVE ARRIVED AT 10 TOP HEALTH PRIORITIES FACING TH E POPULATION OF WRIGHT COUNTY.AFTER COLLECTING EXTENSIVE FEEDBACK AND CONDUCTING COMMUNITY CONVERSATIONS AND DIALOGUES, THE COLLABORATIVE ARRIVED AT TOP 10 PRIORITIES, WHICH WERE T HEN REVIEWED BY EACH ORGANIZATIONS' STAKEHOLDER GROUPS. EACH GROUP CONSISTED OF KEY STAKEH OLDERS, INCLUDING SENIOR LEADERS AND MANAGERS. ALL FOUR GROUPS FOCUSED ON DEFINING WHAT HE ALTH PRIORITIES ARE THE MOST RELEVANT TO THE POPULATION EACH ORGANIZATION SERVES, AND HOW THE POPULATION IS AFFECTED BY THE GAPS IDENTIFIED IN THE CHNA PROCESS.EACH GROUP ARRIVED A T THEIR OWN PRIORITIZED LIST OF HEALTH ISSUES FACING WRIGHT COUNTY. THE LISTS WERE THEN CO MBINED BY THE CORE GROUP AND ISSUES WERE AGAIN PRIORITIZED BASED ON THE RANKINGS FROM INDI VIDUAL ORGANIZATIONS. THE CORE GROUP FOCUSED ON THE ISSUES FACING THE MAJORITY OF THE POPU LATION SERVED AND THE SEVERITY AND MAGNITUDE OF THE HEALTH CONCERNS. THE COLLABORATIVE CHO SE THE TOP THREE PRIORITIES BASED ON TRUE COMMUNITY NEED, VERSUS JUST THE ABILITY TO PROVI DE INTERVENTIONS. THE COLLABORATIVE BELIEVES THAT PART OF THE SOLUTION IS STARTING THE CON VERSATION AROUND THE TOPICS TH

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	AT HAVE NOT YET BEEN ADDRESSED, AND ENGAGING COMMUNITY PARTNERS AND OTHER ORGANIZATIONS TO ASSIST IN IMPLEMENTATION PLANNING AND DEVELOPMENT OF TACTICS/ACTIVITIES TO ADDRESS THOSE PRIORITIES.NEEDS IDENTIFIED BUT NOT INCLUDED IN THE CHNA:GOING INTO THE HANLON PRIORITIZAT ION, THE CORE GROUP HAD A LIST OF 20 IDENTIFIED HEALTH ISSUES THAT NEEDED TO BE DISCUSSED AND ARRANGED ACCORDING TO THE WEIGHT OF ITS SIZE, SERIOUSNESS AND EFFECTIVENESS. AFTER ALL THE HEALTH ISSUES WERE RANKED, THE CORE GROUP REALIZED THERE WERE SEVERAL IDENTIFIED ISSU ES THAT COULD BE COMBINED WITH TOP PRIORITIES. FOR EXAMPLE, SUICIDE AWARENESS AND PREVENTI ON CAN BE COMBINED WITH ONE OF THE TOP PRIORITIES OF MENTAL HEALTH AND WELLNESS. OTHER ISS UES THAT WERE IDENTIFIED INCLUDED STRESS, LACK OF PHYSICAL ACTIVITY AND SOCIAL CONNECTEDNE SS/ISOLATION. WHILE THE CORE GROUP UNDERSTANDS THAT ALL OF THESE ISSUES ARE IMPORTANT AND NEED CONCENTRATED EFFORTS IN ORDER TO RESOLVE, THEY WILL BE CONSCIOUSLY DISCUSSED AND NATU RALLY ADDRESSED IN THE STRATEGIES AND TACTICS EACH ORGANIZATION CREATES.WHILE TOPICS SUCH AS DISTRACTED DRIVING RANKED AS A HIGH NEED IN WRIGHT COUNTY, THERE ARE CURRENTLY MANY GRO UPS ALREADY WORKING ON THIS ISSUE AND ACTIVELY PURSUING INTERVENTIONS AROUND THIS CONCERN (SAFE COMMUNITIES OF WRIGHT COUNTY, HIGHWAY 55 COALITION, HIGHWAY 12 COALITION AND I94 WES T CHAMBER OF COMMERCE). SOME OF THE PRIORITIES IDENTIFIED IN 20172019 IMPLEMENTATION PLAN ARE STILL RELEVANT TO THE WORK OF THE COLLABORATIVE (FOOD INSECURITY, OBESITY, PHYSICAL AC TIVITY, ACCESS TO CARE). THE COLLABORATIVE MADE SIGNIFICANT STRIDES IN ADDRESSING THOSE PR IORITIES AND WILL CONTINUE TO SUPPORT THE EFFORTS AROUND THESE INITIATIVES THROUGH CURRENT WORKFLOWS AND SERVICE MODELS.

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 11: THE PRIORITIZATION PROCESS TOOK PLACE WHILE UTILIZING THE MAPP PROCESS. THE WORK OF EACH OF THE FOUR MAPP ASSESSMENT SUB-GROUPS RESULTED IN FOUR LISTS O F 10 COMMUNITY PRIORITIES. AS A REMINDER, THE FOUR ASSESSMENTS INCLUDE: COMMUNITY HEALTH S TATUS ASSESSMENT, COMMUNITY THEMES AND STRENGTHS ASSESSMENT, LOCAL PUBLIC HEALTH STATUS AS SESSMENT, AND FORCES OF CHANGE ASSESSMENT. THOSE FOUR LISTS OF 10 ARE INCLUDED IN THE NARR ATIVE EARLIER IN THIS DOCUMENT.THE CORE SUPPORT TEAM WAS PROVIDED THOSE FOUR LISTS OF TEN PRIORITIES. THEY TOOK THOSE LISTS AND TALKED WITH THEIR AGENCY STAFF TO IDENTIFY ANY THEME S OR COMMONALITIES AMONGST THE FOUR LISTS. THE CORE SUPPORT TEAM THEN CAME TOGETHER IN A M EETING AND WENT THROUGH A FACILITATED PROCESS USING THE CENTRAL MN ALLIANCE VISION AS A GU IDE TO COME UP WITH A TOP 10 LIST TO SEND ON TO THE DELEGATED AUTHORITIES.THE DELEGATED AU THORITIES MET AND CONTINUED THE DISCUSSION ABOUT THE PRIORITY LIST. THE PRIORITIES PASSED ON BY THE CORE SUPPORT TEAM WERE RUN THROUGH TWO PRIORITIZATION EXERCISES. THE FIRST WAS A RANKING DISCUSSION WITH POINTS ASSIGNED FOR CERTAIN CRITERIA. RANKS INCLUDED 3 FOR HIGH, 2 FOR MEDIUM, AND 1 FOR LOW. THE CRITERIA INCLUDED: URGENCY: IS THIS A PRIORITY ISSUE THAT NEEDS TO BE ADDRESSED IN THE NEXT 1-3 YEARS? POTENTIAL IMPACT: IS IT LIKELY THAT ADDRESSI NG THIS CRITICAL ISSUE WILL HAVE A SIGNIFICANT IMPACT ON ONE OR MORE SPECIFIC POPULATIONS? DO YOU HAVE REASON TO BELIEVE YOU CAN BE SUCCESSFUL ON THIS ISSUE? ACTIONABLE/FEASIBLE: A RE THERE OPPORTUNITIES FOR ACTION TO ADDRESS THE CRITICAL ISSUE? IS THERE ROOM TO MAKE MEA NINGFUL IMPROVEMENT ON THE ISSUE? RESOURCES: ARE RESOURCES (FUNDS, STAFF, & EXPERTISE) EIT HER READILY AVAILABLE OR LIKELY RESOURCES CAN BE OBTAINED TO ADDRESS THE CRITICAL ISSUE? A RE THERE RESOURCES THROUGH THE STATE AND COMMUNITY MEMBERS TO WORK ON THE ISSUE? IF NOT, C AN RESOURCES BE ACQUIRED? COMMUNITY READINESS: IS THIS A CRITICAL ISSUE IDENTIFIED AS IMPO RTANT BY THE COMMUNITY? ARE PEOPLE IN THE COMMUNITY INTERESTED IN THE ISSUE? IS THERE COMM UNITY MOMENTUM TO MOVE THIS INITIATIVE FORWARD? INTEGRATION: IS THERE OPPORTUNITY FOR COLL ABORATION? IS THERE OPPORTUNITY TO BUILD ON EXISTING INITIATIVES? WILL THIS DUPLICATE EFFO RTS? FINALLY, THE PRIORITIES WERE PLACED ON A CONTROL/INFLUENCE GRID.THE PRIORITIES IDETIF IED WERE AS FOLLOWS IN COMMUNITY INFORMED RANKING: 1) BUILDING FAMILIES, 2) MENTAL HEALTH, 3) ENCOURAGING SOCIAL CONNECTION, 4) ADVERSE CHILDHOOD EXPERIENCES (ACES), 5) TOBACCO/NIC OTINE USE, 6) HEALTH CARE, 7) RISKY YOUTH BEHAVIOR, 8) FINANCIAL STRESS, 9) TRAUMA, AND 10) EDUCATING POLICY MAKERS AND KEY COMMUNITY STAKEHOLDERS. DUE TO THE NEWNESS OF THE COLLAB ORATION ON THIS WORK, A DECISION WAS MADE TO FOCUS ON THE TOP TWO PRIORITIES FOR THE COMMU NITY HEALTH IMPROVEMENT PLAN. THE PRIORITIES THREE THROUGH TEN WILL NOT SPECIFICALLY BE AD DRESSED THROUGH ACTION PLANNING OR MEASUREMENT, HOWEVER, THERE ARE WAYS MANY OF THESE PRIO RITIES ARE BEING ADDRESSED EIT

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	HER WITHIN THE TOP TWO PRIORITIES OR THE COMMUNITY. IN THE FUTURE, THE GROUP WILL ASSESS T HE CAPACITY TO EXPAND THE NUMBER OF PRIORITIES BEING ADDRESSED AND MEASURED. ALTHOUGH NOT DIRECTLY ADDRESSED IN THE PLAN, CENTRACARE DOES ACTIVELY SUPPORT OTHER ORGANIZATIONS WITHI N THE COMMUNITY WHO ARE WORKING ON DETERMINANTS OF HEALTH IDENTIFIED DURING THE CHNA PROCE SS LIKE ACES, TOBACCO, TRAUMA, EDUCATING POLICYMAKERS, ETC. THE COMMUNITY HEALTH IMPROVEME NT PLAN (CHIP) IS THE ACTION PLAN THAT USES GUIDING PRINCIPLES AND STRATEGIES TO ADDRESS T HE COMMUNITY PRIORITIES IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS . THE TOP PRIORITIES ARE BUILDING FAMILIES AND MENTAL HEALTH. WE WILL USE THE GUIDING PRIN CIPLES OF COMMUNITY COLLABORATION, AWARENESS, RESILIENCE, EQUITY, EDUCATION, AND HEALTH OR GANIZATIONS TO DRIVE OUR STRATEGIES. THE ST. CLOUD HOSPITAL, CENTRACARE- MELROSE HOSPITAL, CENTRACARE- SAUK CENTRE, AND CENTRACARE-PAYNESVILLE WILL MAINTAIN THEIR ENGAGEMENTS WITH THE CENTRAL MN ALLIANCE AND FOLLOW THE MAPP LEADERSHIP STRUCTURE TO CARRY OUT THE STRATEG IES OUTLINED IN THE CHIP. THERE WILL BE MEETINGS AS OUTLINED IN THE CHIP UNDER LEADERSHIP SYSTEM & PROCESS FOR MONITORING AND REVISION. TO SEE THE FULL CHIP GO TO THE CENTRACARE WE BSITE AT HTTPS://WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/.

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
CARRIS HEALTH - RICE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 11: IN ORDER TO PRIORITIZE THE HEALTH INDICATORS THAT WERE IDENTIFIED, THE CHNA WORKING GROUP EVALUATED A SET OF FOUR RANKING CRITERIA TO ALIGN PRIORITIES WITH COMMUNITY HEALTH OBJECTIVES. THE CRITERIA THAT WERE USED, AND THEIR CORRESPONDING DESCRIPTION ARE LISTED BELOW:1. MISSION RELEVANCY: THE HEALTH ISSUE FALLS WITHIN THE HOSPITAL'S OVERALL MISSION AND CORE COMPETENCIES2. COMMUNITY IMPACT: THE PREVALENCE AND SEVERITY OF THE HEALTH ISSUE3. RESOURCE AVAILABILITY: THE AVAILABILITY OF CARRIS HEALTH'S TIME, HUMAN, AND STRATEGIC RESOURCES NECESSARY TO ADDRESS THE ISSUE4. ESTIMATED EXPENSE: THE EXPENSE (BOTH INTERNAL AND EXTERNAL) OF ADDRESSING THE ISSUETHE PRIORITIZATION PROCESS ITSELF WAS DIVIDED INTO THE TWO STAGES. THE FIRST STAGE CONSISTED IN RATING EACH HEALTH INDICATOR ACCORDING TO MISSION RELEVANCY ALONE. EACH CHNA WORKING GROUP MEMBER WAS ASKED TO RESPOND, "IS EACH RESPECTIVE COURSE OF ACTION RELEVANT TO CARRIS HEALTH'S MISSION AND CORE COMPETENCIES?" AFTER A REVIEW OF THE RESPONSES TO THE SURVEY, 6 PRIORITY AREAS WERE SELECTED. THE SECOND STAGE OF THE PROCESS CONSISTED IN THE PRIORITIZATION OF THE 6 HIGH PRIORITY AREAS ACCORDING TO COMMUNITY IMPACT, RESOURCE AVAILABILITY, AND ESTIMATED EXPENSES. THESE TOP SIX PRIORITY AREAS WERE REVIEWED IN COMPARISON TO DATA GATHERED BY CARRIS HEALTH'S ONGOING, COLLABORATIVE EFFORT WITH KANDIYOHI PUBLIC HEALTH TO COMPLETE THEIR HEALTH NEEDS ASSESSMENT. NO DATA FROM THE COUNTY HEALTH ASSESSMENT CONTRADICTED THE CHOICE OF THE PRIORITIES FROM THE CARRIS HEALTH COMMUNITY HEALTH NEEDS ASSESSMENTS. THE COLLABORATION BETWEEN CARRIS HEALTH AND KANDIYOHI PUBLIC HEALTH STRENGTHENED THE COLLECTIVE IMPACT THAT THIS GROUP OF HEALTH PROFESSIONALS RECOGNIZE IS NEEDED IN ORDER TO HAVE SUSTAINABLE IMPACT ON POPULATION HEALTH IMPROVEMENT. FINALLY, THE RANKED ISSUES WERE PRESENTED TO CARRIS HEALTH'S OPERATING COMMITTEES, BOARDS, MEDICAL STAFFS AND LEADERSHIP GROUP FOR FEEDBACK AND CLARIFICATION. AN ACTION PLAN WAS DEVELOPED TO ADDRESS THE TOP PRIORITY HEALTH CONCERNS THAT WERE IDENTIFIED BY THE CHNA WORKING COMMITTEE. AN INTERNAL REVIEW OF PERFORMANCE AND OUTCOME DATA USING VARIOUS REPORTING AND DATA COLLECTION TOOLS, IN ADDITION TO THE INCORPORATION OF COMMUNITY CONVERSATIONS LED BY THE LOCAL HEALTH DEPARTMENT SUPPORTED THE IDENTIFICATION OF THE TOP HEALTH PRIORITIES THAT WERE DETERMINED TO HAVE THE LARGEST IMPACT AND POTENTIAL FOR IMPROVEMENT ON POPULATION HEALTH. THESE PRIORITY AREAS ARE AS FOLLOWS: OBESITY, DEPRESSION, TOBACCO, DIABETES, OPIOID USE, AND CANCER.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 13H: A NON-CITIZEN CAN BE DENIED CARE IF THEY CAME TO THE US SPECIFICALLY TO RECEIVE FREE CARE. PRESUMPTIVE ELIGIBILITY - IF PATIENTS FAIL TO SUPPLY SUFFICIENT INFORMATION TO SUPPORT FINANCIAL ASSISTANCE ELIGIBILITY, CENTRACARE HEALTH MAY REFER TO OR RELY ON EXTERNAL SOURCES AND/OR OTHER PROGRAM ENROLLMENT RESOURCES TO DETERMINE ELIGIBILITY WHEN:(A) PATIENT IS HOMELESS(B) PATIENT IS ELIGIBLE FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS(C) PATIENT IS ELIGIBLE FOR FOOD STAMPS OR SUBSIDIZED SCHOOL LUNCH PROGRAM(D) PATIENT IS ELIGIBLE FOR A STATE-FUNDED PRESCRIPTION MEDICATION PROGRAM(E) PATIENT'S VALID ADDRESS IS CONSIDERED LOW-INCOME OR SUBSIDIZED HOUSING(F) PATIENT RECEIVES FREE CARE FROM A COMMUNITY CLINIC AND IS REFERRED TO HOSPITAL FOR FURTHER TREATMENT

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 13H: A NON-CITIZEN CAN BE DENIED CARE IF THEY CAME TO THE US SPECIFICALLY TO RECEIVE FREE CARE. PRESUMPTIVE ELIGIBILITY - IF PATIENTS FAIL TO SUPPLY SUFFICIENT INFORMATION TO SUPPORT FINANCIAL ASSISTANCE ELIGIBILITY, CENTRACARE HEALTH MAY REFER TO OR RELY ON EXTERNAL SOURCES AND/OR OTHER PROGRAM ENROLLMENT RESOURCES TO DETERMINE ELIGIBILITY WHEN:(A) PATIENT IS HOMELESS(B) PATIENT IS ELIGIBLE FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS(C) PATIENT IS ELIGIBLE FOR FOOD STAMPS OR SUBSIDIZED SCHOOL LUNCH PROGRAM(D) PATIENT IS ELIGIBLE FOR A STATE-FUNDED PRESCRIPTION MEDICATION PROGRAM(E) PATIENT'S VALID ADDRESS IS CONSIDERED LOW-INCOME OR SUBSIDIZED HOUSING(F) PATIENT RECEIVES FREE CARE FROM A COMMUNITY CLINIC AND IS REFERRED TO HOSPITAL FOR FURTHER TREATMENT

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Form and Line Reference	Explanation
CARRIS HEALTH - RICE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 13H: A NON-CITIZEN CAN BE DENIED CARE IF THEY CAME TO THE US SPECIFICALLY TO RECEIVE FREE CARE. PRESUMPTIVE ELIGIBILITY - IF PATIENTS FAIL TO SUPPLY SUFFICIENT INFORMATION TO SUPPORT FINANCIAL ASSISTANCE ELIGIBILITY, CENTRACARE HEALTH MAY REFER TO OR RELY ON EXTERNAL SOURCES AND/OR OTHER PROGRAM ENROLLMENT RESOURCES TO DETERMINE ELIGIBILITY WHEN:(A) PATIENT IS HOMELESS(B) PATIENT IS ELIGIBLE FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS(C) PATIENT IS ELIGIBLE FOR FOOD STAMPS OR SUBSIDIZED SCHOOL LUNCH PROGRAM(D) PATIENT IS ELIGIBLE FOR A STATE-FUNDED PRESCRIPTION MEDICATION PROGRAM(E) PATIENT'S VALID ADDRESS IS CONSIDERED LOW-INCOME OR SUBSIDIZED HOUSING(F) PATIENT RECEIVES FREE CARE FROM A COMMUNITY CLINIC AND IS REFERRED TO HOSPITAL FOR FURTHER TREATMENT

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

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Form and Line Reference	Explanation
CARRIS HEALTH - REDWOOD AREA HOSPITAL	PART V, SECTION B, LINE 13H: A NON-CITIZEN CAN BE DENIED CARE IF THEY CAME TO THE US SPECIFICALLY TO RECEIVE FREE CARE. PRESUMPTIVE ELIGIBILITY - IF PATIENTS FAIL TO SUPPLY SUFFICIENT INFORMATION TO SUPPORT FINANCIAL ASSISTANCE ELIGIBILITY, CENTRACARE HEALTH MAY REFER TO OR RELY ON EXTERNAL SOURCES AND/OR OTHER PROGRAM ENROLLMENT RESOURCES TO DETERMINE ELIGIBILITY WHEN:(A) PATIENT IS HOMELESS(B) PATIENT IS ELIGIBLE FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS(C) PATIENT IS ELIGIBLE FOR FOOD STAMPS OR SUBSIDIZED SCHOOL LUNCH PROGRAM(D) PATIENT IS ELIGIBLE FOR A STATE-FUNDED PRESCRIPTION MEDICATION PROGRAM(E) PATIENT'S VALID ADDRESS IS CONSIDERED LOW-INCOME OR SUBSIDIZED HOUSING(F) PATIENT RECEIVES FREE CARE FROM A COMMUNITY CLINIC AND IS REFERRED TO HOSPITAL FOR FURTHER TREATMENT

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

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Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO	PART V, SECTION B, LINE 16J: PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE FINANCIAL ASSISTANCE INFORMATION EITHER VIA A TELEPHONE CALL OR ON BILLING STATEMENTS.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE	PART V, SECTION B, LINE 16J: PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE FINANCIAL ASSISTANCE INFORMATION EITHER VIA A TELEPHONE CALL OR ON BILLING STATEMENTS.

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

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Form and Line Reference	Explanation
CARRIS HEALTH - RICE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 16J: PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE FINANCIAL ASSISTANCE INFORMATION EITHER VIA A TELEPHONE CALL OR ON BILLING STATEMENTS.

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

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Form and Line Reference	Explanation
CARRIS HEALTH - REDWOOD AREA HOSPITAL	PART V, SECTION B, LINE 16J: PATIENTS WHO ARE AT A SELF PAY STATUS RECEIVE FINANCIAL ASSISTANCE INFORMATION EITHER VIA A TELEPHONE CALL OR ON BILLING STATEMENTS.

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

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Form and Line Reference	Explanation
CENTRACARE HEALTH - MONTICELLO:	PART V, SECTION B, LINES 7A AND 10A: THE HOSPITAL'S CHNA CAN BE FOUND ON ITS WEBSITE AT WWW.CENTRACARE.COM/DOCUMENTS/ABOUT/WRIGHT-COUNTY-COMMUNITY-HEALTH-COLLABORATIVE-CHNA-2019-2022-VERSION-1-UPDATED-10.19.PDF.THE HOSPITAL'S IMPLEMENTATION PLAN CAN BE FOUND ON ITS WEBSITE AT WWW.CENTRACARE.COM/DOCUMENTS/ABOUT/CENTRACARE-MONTICELLO-IMPLEMENTATION-PLAN-2019-2022-VERSION-1-UPDATED-10.19.PDF.

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

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

Form and Line Reference	Explanation
CENTRACARE HEALTH - PAYNESVILLE:	PART V, SECTION B, LINES 7A AND 10A: THE HOSPITAL'S CHNA AND IMPLEMENTATION PLAN CAN BE FOUND ON ITS WEBSITE AT WWW.CENTRACARE.COM/DOCUMENTS/ABOUT/CENTRAL-MN-ALLIANCE-CHIP_CHNA-2019-2022-VERSION-2-UPDATED-02.20.PDF.

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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?________________________

	Name and address	Type of Facility (describe)
1	1 - MONTICELLO CARE CENTER 1104 EAST RIVER STREET MONTICELLO, MN 55362	SKILLED NURSING FACILITY
1	2 - CENTRACARE - MONTICELLO SPECIALTY CLINIC 1107 HART BLVD MONTICELLO, MN 55362	CLINIC
2	3 - KORONIS MANOR CARE CENTER 200 WEST FIRST STREET PAYNESVILLE, MN 56362	SKILLED NURSING FACILITY
3	4 - CCH PAYNESVILLE - EDEN VALLEY CLINIC 405 MEEKER AVENUE EDEN VALLEY, MN 56362	CLINIC
4	5 - CCH PAYNESVILLE - PAYNESVILLE CLINIC 200 WEST FIRST STREET PAYNESVILLE, MN 56362	CLINIC
5	6 - CCH PAYNESVILLE - RICHMOND CLINIC 130 FIRST STREET NE RICHMOND, MN 56368	CLINIC
6	7 - RICE CARE CENTER 1801 WILLMAR AVE SW WILLMAR, MN 56201	SKILLED NURSING FACILITY
7	8 - RICE HOME MEDICAL 1033 19TH AVE SW WILLMAR, MN 56201	DURABLE MEDICAL EQUIPMENT PROVIDER
8	9 - CARRIS HEALTH SURGERY CENTER WILLMAR 1310 1ST STREET S WILLMAR, MN 56201	AMBULATORY SURGICAL CENTER
9	10 - CARRIS HEALTH-REDWOOD HEALTH PAVILION 1110 E BRIDGE ST REDWOOD FALLS, MN 56283	HOME CARE, HOSPICE AND ADULT DAY SERVICES
10	11 - CARRIS HEALTH - REDWOOD SEASONS HOUSE 400 VEDA DR REDWOOD FALLS, MN 56283	ADULT FOSTER CARE WITH SERVICES (END OF LIFE CARE)
11	12 - RICE REHABILITATION CENTER 311 SW 3RD ST WILLMAR, MN 56201	PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY
12	13 - MARSHALL SURGERY CENTER 1521 CARLSON ST 200 MARSHALL, MN 56258	OUTPATIENT SURGERY

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . ▶ 5

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

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) SCHOLARSHIPS	0	19,704			
(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:	CONTRIBUTIONS MUST BE IN KEEPING WITH THE MISSION OF CENTRACARE HEALTH, WHICH IS TO WORK TO IMPROVE THE HEALTH OF EVERY PATIENT, EVERY DAY. CONTRIBUTIONS WILL BE MADE TO ORGANIZATIONS RATHER THAN TO INDIVIDUALS WITHIN THE CENTRAL MINNESOTA REGION. CENTRACARE'S CHARITABLE FUNDS MAY NOT BE USED TO SUPPORT ANY ORGANIZATION OR EVENT THAT WOULD RESULT IN BENEFITS OF ANY KIND TO AN EMPLOYEE OF THE HEALTH SYSTEM OR A MEMBER OF THE VARIOUS BOARDS OF DIRECTORS, EITHER DIRECTLY OR INDIRECTLY. ONE EXCEPTION EXISTS TO THE GUIDELINE REGARDING BENEFIT TO EMPLOYEES: WE WILL SUPPORT, VIA SCHOLARSHIPS AND THE PURCHASE OF SUPPLIES, THE MEDICAL MISSION WORK OF OUR STAFF AND PHYSICIANS. THE CENTRACARE HEALTH CONTRIBUTIONS COMMITTEE IS MADE UP OF: ONE REPRESENTATIVE FROM CENTRACARE HEALTH FOUNDATION; ONE REPRESENTATIVE FROM ST. CLOUD HOSPITAL HUMAN RESOURCES/DIVERSITY COMMITTEE; THE DIRECTOR OF CENTRACARE HEALTH'S COMMUNICATION DEPARTMENT AND THE COMMUNICATIONS/MARKETING FOR ST. BENEDICT'S SENIOR COMMUNITY; THE DIRECTOR OF CENTRACARE HEALTH'S MARKETING DEPARTMENT; THE DIRECTOR OF ST. CLOUD HOSPITAL VOLUNTEER SERVICES; AND ST. CLOUD HOSPITAL'S DIRECTOR OF MISSION & SPIRITUAL CARE. THE COMMITTEE MEETS MONTHLY TO ENSURE A STREAMLINED, COORDINATED PROCESS OF REVIEWING REQUESTS AND DETERMINING FUNDING. THE COMMITTEE MAINTAINS A DATABASE TO TRACK ALL CONTRIBUTIONS. OTHER CENTRACARE ENTITIES, INCLUDING CENTRACARE HEALTH - LONG PRAIRIE, MELROSE, MONTICELLO, PAYNESVILLE AND SAUK CENTRE, MAY DEVELOP A BUDGET FOR APPROVAL AND IMPLEMENT THEIR OWN CONTRIBUTIONS DECISIONS WITHIN THE GUIDELINES OF THIS DOCUMENT. CONTRIBUTIONS MAY NOT EXCEED THE STATED BUDGET AND NO MULTI-YEAR COMMITMENTS TO ORGANIZATIONS MAY BE MADE WITHOUT APPROVAL FORM THE CENTRACARE HEALTH EXECUTIVE COUNCIL. INDIVIDUALS AND DEPARTMENTS FORM THROUGHOUT ST. CLOUD HOSPITAL AND CENTRACARE CLINIC SHOULD FORWARD ALL OUTSIDE FUNDING REQUESTS TO A MEMBER OF THE COMMITTEE FOR THE FULL GROUP'S CONSIDERATION. THOSE REQUESTING FUNDS SHOULD BE ASKED TO SUBMIT REQUESTS IN WRITING.

Additional Data

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

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ST CLOUD STATE UNIVERSITY 720 FOURTH AVE SOUTH ST CLOUD, MN 56301	41-1687554	STATE GOVERNMENT	150,000				HELP FUND THE GRADUATE NURSING EDUCATION AND THE CENTER FOR HEALTH OUTCOMES AND POLICY RESEARCH
UNITED WAY 921 1ST ST N STE 200 ST CLOUD, MN 56303	41-0915124	501(C)(3)	23,125				TO HELP THE COMMUNITIES MOST CRITICAL HUMAN SERVICES ISSUES.

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITYGIVING 101 7TH AVE SOUTH ST CLOUD, MN 56302	36-3412544	501(C)(3)	21,000				SPONSOR AT COMMUNITY GIVING DAY, SOCIAL CAPITAL SURVEY SPONSORSHIP/PLEDGE CONTRIBUTION - STAFF PARTICIPATING IN LEADERSHIP PROGRAM
JUNIOR ACHEIVEMENT OF THE UPPER MIDWEST INC 3515 3RD STREET N ST CLOUD, MN 56303	41-1424988	501(C)(3)	5,000				LEARNING PROGRAM FOR STUDENTS K-12

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
REGIONS HOSPITAL FOUNDATION PO BOX 1309 MINNEAPOLIS, MN 55440	41-0956618	501(C)(3)	25,000				LITTLE MOMENTS COUNT FUND - TO ADVANCE EARLY BRAIN DEVELOPMENT WORK.
ST CLOUD DOWNTOWN COUNCIL PO BOX 535 ST CLOUD, MN 56302	41-1384835	501(C)(4)	25,000				EARTH DAY EVENT FOR COMMUNITY

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☑ Compensation committee ☑ Written employment contract ☑ Independent compensation consultant ☑ Compensation survey or study ☑ Form 990 of other organizations ☑ Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**	Yes	
b	Any related organization?	**6b**	Yes	
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 4B	THE CORPORATIONS' EXECUTIVES ARE ELIGIBLE TO PARTICIPATE IN BENEFIT PLANS WHICH INCLUDE TAX DEFERRRED NON-QUALIFIED INVESTMENT ACCOUNTS. THESE PLANS MAY PROVIDE, BUT ARE NOT CERTAIN TO PROVIDE, FOR PAYMENT OF TAX DEFERRED COMPENSATION TO THESE EXECUTIVES AT SOME TIME IN THE FUTURE. THE EXECUTIVE HAS NO LEGAL RIGHT TO THESE DOLLARS UNTIL, AND UNLESS, CERTAIN FUTURE EVENTS OCCUR. IN ACCORDANCE WITH THE INSTRUCTIONS TO THE FORM 990, THE AMOUNTS LISTED IN SECTION VII AND IN SCHEDULE J REFLECT THIS TAX DEFERRED COMPENSATION. THIS COMPENSATION IS POTENTIALLY REPORTED TWICE ON THE FORM 990. ONCE WHEN THE COMPENSATION IS DEFERRED OR ACCRUED AND AGAIN IF IT IS PAID TO THE EXECUTIVE. THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE NON-QUALIFIED PLAN: PAUL R HARRIS - PAID $68,871; ACCRUED $88,628 CINDY FIRKINS SMITH, MD - PAID $0; ACCRUED $43,281 AMY M PORWOLL - PAID $49,269; ACCRUED $66,313 THOMAS SCHRUP - PAID $36,642; ACCRUED $42,705 KURT OTTO - PAID $38,983; ACCRUED $54,854 JOY PLAMANN - PAID $18,710; ACCRUED $47,972 MARK S MATTHIAS, MD - PAID $63,822; ACCRUED $16,122 GEORGE A MORRIS, MD - PAID $25,249; ACCRUED $47,483 JOSEPH M BLONSKI, MD - PAID $43,757; ACCRUED $54,527 JOSEPH H KALKMAN - PAID $0; ACCRUED $50,875 ANTHONY V GARDENER - PAID $35,817; ACCRUED $44,496 BRADLEY J KONKLER - PAID $32,032; ACCRUED $42,372 DAVID A LARSON - PAID $0; ACCRUED $22,065 JOSEPH D HELLIE - PAID $37,072; ACCRUED $51,408 KATHLEEN M PARSONS - PAID $0; ACCRUED $18,629 MICHAEL SCHRAMM - PAID $0; ACCRUED $34,398

Additional Data

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
1KENNETH D HOLMEN MD PRESIDENT/CEO	(i)	1,256,282	0	23,025	14,000	22,738	1,316,045	0
	(ii)	0	0	0	0	0	0	0
1TOD W SPEER MD PHYSICIAN	(i)	645,185	186,776	79,814	25,505	28,207	965,487	0
	(ii)	0	0	0	0	0	0	0
2CINDY FIRKINS SMITH MD CARRIS HEALTH, PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	423,748	268,738	1,089	65,259	25,150	783,984	0
3LEAH M SCHAMMEL MD PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	189,471	543,280	39,024	17,562	28,504	817,841	0
4 NATHANIEL J SLINKARD MD PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	345,786	187,500	185,274	15,951	27,504	762,015	0
5JULIE C SCHULTZ MD PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	162,399	520,143	20,086	15,992	30,909	749,529	0
6DONALD JURGENS MD DIRECTOR/PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	698,954	0	25,738	21,000	14,872	760,564	0
7GREGORY R KLUGHERZ TREASURER/CFO, CCH (UNTIL 7/1/2019)	(i)	0	0	0	0	0	0	0
	(ii)	636,563	0	72,594	18,403	22,088	749,648	0
8PAUL R HARRIS ESQ CORPORATE SECRETARY (UNTIL 3/1/2020)	(i)	414,352	0	91,003	106,487	25,591	637,433	68,871
	(ii)	0	0	0	0	0	0	0
9MARK S MATTHIAS MD VICE PRESIDENT	(i)	497,049	0	84,010	30,603	22,825	634,487	16,122
	(ii)	0	0	0	0	0	0	0
10THOMAS SCHRUP MD VICE PRESIDENT	(i)	460,466	0	38,486	61,343	22,422	582,717	36,642
	(ii)	0	0	0	0	0	0	0
11AMY M PORWOLL VICE PRESIDENT	(i)	364,101	0	83,431	83,745	23,215	554,492	49,269
	(ii)	0	0	0	0	0	0	0
12THOMAS H LANGE MD PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	250,999	274,695	39,376	16,796	30,133	611,999	0
13JOSEPH M BLONSKI MD VICE PRESIDENT	(i)	398,774	0	45,631	71,523	25,135	541,063	43,757
	(ii)	0	0	0	0	0	0	0
14GEORGE A MORRIS MD VICE PRESIDENT	(i)	361,969	0	59,232	63,590	23,215	508,006	25,249
	(ii)	0	0	0	0	0	0	0
15 CHRISTOPHER BOELTER MD VICE PRESIDENT	(i)	390,936	0	146,454	20,472	3,077	560,939	0
	(ii)	0	0	0	0	0	0	0
16JOSEPH H KALKMAN VICE PRESIDENT	(i)	355,018	0	33,054	57,854	25,591	471,517	0
	(ii)	0	0	0	0	0	0	0
17CHRISTIAN SCHMIDT MD DIRECTOR/SURGEON	(i)	0	0	0	0	0	0	0
	(ii)	437,978	0	16,837	20,137	27,542	502,494	0
18KURT OTTO MD VICE PRESIDENT	(i)	292,370	0	58,727	69,283	24,215	444,595	38,983
	(ii)	0	0	0	0	0	0	0
19BRYAN ROLPH DIRECTOR/PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	400,537	0	24,113	18,665	26,528	469,843	0

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

(A) Name and Title		(B)(i) Base Compensation	(B)(ii) Bonus & incentive compensation	(B)(iii) Other reportable compensation	(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
21MICHAEL W SCHRAMM CARRIS HEALTH, PRESIDENT/CEO	(i)	345,131	0	323	59,570	23,214	428,238	0
	(ii)	0	0	0	0	0	0	0
1JOSEPH D HELLIE VICE PRESIDENT	(i)	289,339	0	37,486	68,763	37,072	432,660	0
	(ii)	0	0	0	0	0	0	0
2JOY PLAMANN VICE PRESIDENT	(i)	283,051	0	18,980	66,475	24,673	393,179	18,710
	(ii)	0	0	0	0	0	0	0
3RICHARD WEHLSER MD DIRECTOR/PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	86,974	146,418	153,695	18,266	29,786	435,139	0
4ANTHONY V GARDENER VICE PRESIDENT	(i)	259,060	0	58,159	56,989	9,535	383,743	35,817
	(ii)	0	0	0	0	0	0	0
5BRADLEY J KONKLER VICE PRESIDENT	(i)	248,613	0	41,784	54,329	23,215	367,941	32,032
	(ii)	0	0	0	0	0	0	0
6KATHLEEN M PARSONS VICE PRESIDENT	(i)	272,774	0	774	36,768	20,125	330,441	0
	(ii)	0	0	0	0	0	0	0
7 DIANE R BUSCHENA-BRENNA VICE PRESIDENT	(i)	235,216	0	41,349	19,461	21,782	317,808	0
	(ii)	0	0	0	0	0	0	0
8DAVID A LARSON VICE PRESIDENT	(i)	223,081	0	8,698	37,846	23,215	292,840	0
	(ii)	0	0	0	0	0	0	0
9SANTO CRUZ CORPORATE SECRETARY(AS OF 6/28/2020)	(i)	262,444	0	162	0	23,330	285,936	0
	(ii)	0	0	0	0	0	0	0
10SHARON RUGGIERO MD DIRECTOR/PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	215,588	1,076	25,641	17,687	12,124	272,116	0
11BETH A HONKOMP VICE PRESIDENT	(i)	152,317	0	10,825	10,025	12,187	185,354	0
	(ii)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047
2019
Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pool financing Yes	(i) Pool financing No
A	THE CITY OF ST CLOUD	41-6005515		12-28-2011	31,445,000	HEALTH CARE REVENUE BONDS 2011B		X		X		X
B	THE CITY OF ST CLOUD	41-6005515	78916VCZ1	11-19-2014	48,876,925	HEALTH CARE REVENUE BONDS 2014B		X		X		X
C	THE CITY OF ST CLOUD	41-6005515		08-01-2014	128,310,000	HEALTH CARE REVENUE BONDS 2014		X		X		X
D	THE CITY OF ST CLOUD	41-6005515	78916VDR8	05-12-2016	216,598,436	HEALTH CARE REVENUE BONDS 2016A		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	31,445,000	48,876,925	128,310,000	216,598,436
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				161,480,506
7	Issuance costs from proceeds		550,981		1,760,260
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds			15,000,000	53,357,670
11	Other spent proceeds	31,445,000	48,325,944	113,310,000	
12	Other unspent proceeds				
13	Year of substantial completion	2012	2010	2016	2017

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X			X	X			X
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X	X			X	X	
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?		X	X			X	X	
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?			X				X	
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		0.870 %		2.370 %		0.630 %		1.890 %
6	Total of lines 4 and 5		0.870 %		2.370 %		0.630 %		1.890 %
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of.								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X		X		X	X	
b	Exception to rebate?	X			X		X		X
c	No rebate due?	X		X		X			X
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X	X			X
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X		X	

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

Return Reference	Explanation
DATE REBATE COMPUTATION PERFORMED	ISSUER NAME: THE CITY OF ST CLOUD DATE THE REBATE COMPUTATION WAS PERFORMED: 02/23/2017 ISSUER NAME: THE CITY OF ST CLOUD DATE THE REBATE COMPUTATION WAS PERFORMED: 07/23/2019 ISSUER NAME: THE CITY OF ST CLOUD DATE THE REBATE COMPUTATION WAS PERFORMED: 07/09/2019

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

Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047
2019
Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pool financing Yes	(i) Pool financing No
A	THE CITY OF ST CLOUD	41-6005515	78916VDW7	03-28-2019	143,227,442	HEALTH CARE REVENUE BONDS 2019		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	14,322,744			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	1,512,827			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	77,343,447			
11	Other spent proceeds	8,156,941			
12	Other unspent proceeds	56,214,227			
13	Year of substantial completion				

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X							
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X						
16	Has the final allocation of proceeds been made?		X						
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c	Are there any research agreements that may result in private business use of bond-financed property?	X							
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X							
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	1.010 %							
6	Total of lines 4 and 5	1.010 %							
7	Does the bond issue meet the private security or payment test?		X						
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of.								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X							

Part IV Arbitrage

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X							
b	Exception to rebate?		X						
c	No rebate due?		X						
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X						
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X						
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X							

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X							

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

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE BOARD OF DIRECTORS HAS DELEGATED THE APPROVAL AUTHORITY OF THE FORM 990 TO THE AUDIT C OMMITTEE. ANNUALLY, AT THE AUDIT COMMITTEE MEETING, PRIOR TO FILING WITH THE IRS, THE AUDI T COMMITTEE REVIEWS AND APPROVES FORM 990. A COPY OF FORM 990 IS THEN PROVIDED FOR THE FUL L BOARD TO REVIEW PRIOR TO FILING WITH THE IRS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	THE BOARD MEMBERS ARE REQUIRED TO REVIEW AND SIGN A CONFLICT OF INTEREST QUESTIONNAIRE TWI CE A YEAR. ALL STAFF SIGN CONFLICTS OF INTEREST FORMS ON AN ANNUAL BASIS. THE QUESTIONNAIR ES ARE REVIEWED BY THE CORPORATE COMPLIANCE OFFICER AS WELL AS THE CORPORATE COMPLIANCE GR OUP (A COMPLIANCE COMMITTEE WHICH INCLUDES INTERNAL MEMBERS AND OUTSIDE COUNSEL). THE RESP ONSES TO THE QUESTIONNAIRES ARE THEN REVIEWED WITH THE EXECUTIVE COMMITTEE OF THE BOARD. T HE CORPORATE COMPLIANCE OFFICER IS RESPONSIBLE FOR MONITORING CONFLICTS OF INTERESTS RELAT ED TO BOARD AND STAFF AND TO ALERT AFFECTED PARTIES WHEN A CONFLICT ARISES. WHEN AN ACTUAL CONFLICT ARISES, THE AFFECTED PARTY IS ASKED TO RECUSE HIM/HER SELF FROM THE DECISION MAK ING PROCESS. THE CORPORATE COMPLIANCE OFFICER ATTENDS BOARD MEETINGS AND SPECIFIED BOARD C OMMITTEE MEETINGS WHERE CONFLICT ISSUES MAY ARISE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE COMPENSATION AND BENEFITS OF THE PRESIDENT AND THE VICE PRESIDENTS (NON-MEDICAL PROVID ERS) ARE SUBJECT TO FULL COMPENSATION AND BENEFITS COMPARABILITY STUDIES CONDUCTED BIENNIA LLY BY A THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT. HOWEVER, THE COMPENSATION PORTIO N OF THE STUDY IS REVIEWED ANNUALLY BY THE CONSULTANT AND UPDATED FOR COMPENSATION COMMITT EE AND BOARD OF DIRECTORS REVIEW AND APPROVAL.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE NOT REQUIRE D BY LAW TO BE MADE AVAILABLE TO THE PUBLIC AND CENTRACARE HEALTH SYSTEM DOES NOT MAKE THE M AVAILABLE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	MEDICAL/OTHER FEES: PROGRAM SERVICE EXPENSES 15,385,196. MANAGEMENT AND GENERAL EXPENSES 4 ,010,663. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 19,395,859. CONTRACTED SERVICES/PURCH SVC S: PROGRAM SERVICE EXPENSES 57,752,167. MANAGEMENT AND GENERAL EXPENSES 15,055,022. FUNDRA ISING EXPENSES 0. TOTAL EXPENSES 72,807,189.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	PENSION PLAN ADJUSTMENT 327,122. NET EQUITY TRANSFERS TO RELATED ORGS 41,817,290. CONTRIBU TED NA OF AFFILIATIONS 15,555. OTHER CHANGES IN NET ASSETS -1,132,390.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CENTRACARE HEALTH SYSTEM

Employer identification number
41-1813221

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

See Additional Data Table

(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.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) MONTICELLO CANCER CENTER 1001 HART BLVD STE 50 MONTICELLO, MN 55362 26-1909519	RADIATION & ONCOLOGY SERVICES	MN	CENTRACARE HEALTH SYSTEM - MONTICELLO	RELATED	3,588,013	6,545,459		No		Yes		60.000 %
(2) MONTICELLO SURGERY CENTER 1013 HART BLVD STE 50 MONTICELLO, MN 55362 81-3593057	AMBULATORY SURGERY CENTER	MN	CENTRACARE HEALTH SYSTEM	RELATED	-123,602	-2,153,201		No		Yes		

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity? Yes	(i) No
(1)CENTRACARE HOLDINGS INC 1406 6TH AVE N ST CLOUD, MN 56303 47-2688595	INVESTMENTS/PHARMACY	MN	CENTRACARE HEALTH SYSTEM	C	-453,899	1,276,465	100.000 %	Yes	
(2)AFFILIATED COMMUNITY MEDICAL CENTERS PA 301 BECKER AVE SW WILLMAR, MN 56201	HEALTH CARE SYSTEM	MN	CARRIS HEALTH LLC	C	-18,696,123	118,390,416	100.000 %		No

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

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

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

See Additional Data Table

(a) Name of related organization	**(b)** Transaction type (a-s)	**(c)** Amount involved	**(d)** Method of determining amount involved

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

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

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

Part VII **Supplemental Information**

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

Return Reference	Explanation

Additional Data

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

Form 990, Schedule R, Part I - Identification of Disregarded Entities

(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
CENTRACARE SURGERY CENTER LLC 1406 6TH AVE N ST CLOUD, MN 56303 61-1514974	SURGICAL CENTER	MN	11,101,942	5,196,616	CENTRACARE HEALTH SYSTEM
CENTRACARE HEALTH - MONTICELLO 1013 HART BLVD MONTICELLO, MN 55362 46-1584944	HEALTHCARE	MN	77,620,929	69,924,097	CENTRACARE HEALTH SYSTEM
CENTRACARE HEALTH - PAYNESVILLE 200 W200 WEST FIRST STREET PAYNESVILLE, MN 56362 43-3298651	HEALTHCARE	MN	46,661,890	35,254,292	CENTRACARE HEALTH SYSTEM
CENTRAL MINNESOTA HEALTH NETWORK LLC (FKA CIN LLC) 1406 6TH AVE N ST CLOUD, MN 56303 47-3924684	CLINICAL INEGRATED NETWORK	MN	0	-1,431,177	CENTRACARE HEALTH SYSTEM
CENTRAL MINNESOTA ACO LLC 1406 6TH AVE N ST CLOUD, MN 56303 47-4591476	ACCREDITED CARE ORGANIZATION	MN	8,075	-784,029	CENTRACARE HEALTH SYSTEM
CARRIS HEALTH LLC 301 BECKER AVE SW WILLMAR, MN 56201 82-3166379	HEALTH CARE SYSTEM	MN	259,446,086	250,040,552	CENTRACARE HEALTH SYSTEM
CENTRAL MINNESOTA IHP LLC 1406 6TH AVE N ST CLOUD, MN 56303	HEALTHCARE	MN	0	0	CENTRACARE HEALTH SYSTEM
ALBANY CLINIC PROPERTY LLC 1406 6TH AVE N ST CLOUD, MN 56303	HEALTHCARE	MN	0	0	CENTRACARE HEALTH SYSTEM
CENTRACARE PROVIDER SERVICES LLC 1406 6TH AVE N ST CLOUD, MN 56303	HEALTHCARE	MN	0	0	CENTRACARE HEALTH SYSTEM

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
1406 6TH AVE N ST CLOUD, MN 56303 41-0695596	ACUTE/LT CARE	MN	501(C)(3)	LINE 3	CENTRACARE HEALTH SYSTEM	Yes	
11 NORTH 5TH AVE WEST MELROSE, MN 56352 41-1865315	ACUTE/LT CARE	MN	501(C)(3)	LINE 3	CENTRACARE HEALTH SYSTEM	Yes	
50 CENTRACARE DRIVE LONG PRAIRIE, MN 56347 41-1924645	ACUTE/LT CARE	MN	501(C)(3)	LINE 3	CENTRACARE HEALTH SYSTEM	Yes	
425 ELM STREET NORTH SAUK CENTRE, MN 56378 45-2438973	ACUTE/LT CARE	MN	501(C)(3)	LINE 3	CENTRACARE HEALTH SYSTEM	Yes	
1200 6TH AVE NORTH ST CLOUD, MN 56303 41-1806657	MULTI-SPECIALTY	MN	501(C)(3)	LINE 3	CENTRACARE HEALTH SYSTEM	Yes	
1406 6TH AVE N ST CLOUD, MN 56303 41-1855173	FUNDRAISING	MN	501(C)(3)	LINE 7	CENTRACARE HEALTH SYSTEM	Yes	
1100 WEST ST GERMAIN STREET ST CLOUD, MN 56303 41-6019335	SUPPORT FOR CARRIS HEALTH	MN	501(C)(3)	LINE 12A, I	CARRIS HEALTH		No
301 BECKER AVE SW WILLMAR, MN 56303 41-1611555	SUPPORT FOR CARRIS HEALTH	MN	501(C)(3)	LINE 12A, I	CENTRACARE HEALTH FOUNDATION	Yes	

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
CENTRACARE PHARMACY SERVICES	A	83,568	ARMS LENGTH
CENTRACARE CLINIC	A	7,286,762	ARMS LENGTH
ST CLOUD HOSPITAL	A	149,520	ARMS LENGTH
CENTRACARE HEALTH - LONG PRAIRIE	D	1,707,973	ARMS LENGTH
ST CLOUD HOSPITAL	K	1,940,969	ARMS LENGTH
CENTRACARE CLINIC	P	623,777	ARMS LENGTH
CENTRACARE HEALTH - LONG PRAIRIE	Q	3,717,096	ARMS LENGTH
CENTRACARE HEALTH - MELROSE	Q	3,758,964	ARMS LENGTH
CENTRACARE HEALTH - SAUK CENTRE	Q	3,219,468	ARMS LENGTH
CENTRACARE PHARMACY SERVICES	Q	345,156	ARMS LENGTH
CENTRACARE CLINIC	Q	30,520,067	ARMS LENGTH
ST CLOUD HOSPITAL	Q	81,449,052	ARMS LENGTH
CENTRACARE CLINIC	R	43,531,914	ARMS LENGTH
CENTRACARE PHARMACY SERVICES	R	2,818,821	ARMS LENGTH
CENTRACARE HEALTH - LONG PRAIRIE	S	634,935	ARMS LENGTH
CENTRACARE HEALTH - SAUK CENTRE	S	3,734,950	ARMS LENGTH
CENTRACARE HEALTH - MELROSE	S	6,222,232	ARMS LENGTH
ST CLOUD HOSPITAL	S	90,214,274	ARMS LENGTH