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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2020

Open to Public Inspection

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

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

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

A For the 2020 calendar year, or tax year beginning 07-01-2020 , and ending 06-30-2021

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

C Name of organization  
ST CLOUD HOSPITAL  
  
Doing business as  
  
Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
1406 SIXTH AVENUE NORTH  
  
City or town, state or province, country, and ZIP or foreign postal code  
ST CLOUD, MN 563031901

D Employer identification number  
  
41-0695596  
  
E Telephone number  
  
(320) 251-2700  
  
G Gross receipts \$ 1,136,626,024

F Name and address of principal officer:  
JOY PLAMANN  
1406 SIXTH AVENUE NORTH  
ST CLOUD, MN 563031901

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: 1962

M State of legal domicile:  
MN

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:  
WE'RE HERE FOR YOUR WHOLE LIFE - TO LISTEN THEN SERVE, TO GUIDE AND HEAL BECAUSE HEALTH MEANS EVERYTHING.

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 19

4 Number of independent voting members of the governing body (Part VI, line 1b) . . . . . 4 13

5 Total number of individuals employed in calendar year 2020 (Part V, line 2a) . . . . . 5 0

6 Total number of volunteers (estimate if necessary) . . . . . 6 716

7a Total unrelated business revenue from Part VIII, column (C), line 12 . . . . . 7a 40,150

b Net unrelated business taxable income from Form 990-T, line 39 . . . . . 7b 0

Revenue

8 Contributions and grants (Part VIII, line 1h) . . . . . 23,914,090 64,563,940

9 Program service revenue (Part VIII, line 2g) . . . . . 895,296,109 977,780,134

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d ) . . . . . 7,425,317 44,005,514

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) . . . . . 5,312,528 31,632,654

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) . . . . . 931,948,044 1,117,982,242

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) . . . . . 637,892 370,744

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) . . . . . 480,835,563 509,143,016

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) . . . . . 395,208,376 457,116,720

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) . . . . . 876,681,831 966,630,480

19 Revenue less expenses. Subtract line 18 from line 12 . . . . . 55,266,213 151,351,762

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . . 1,486,537,959 1,702,572,092

21 Total liabilities (Part X, line 26) . . . . . 782,733,658 701,913,310

22 Net assets or fund balances. Subtract line 21 from line 20 . . . . . 703,804,301 1,000,658,782

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

\*\*\*\*\*  
Signature of officer  
  
MICHAEL A BLAIR CFO/TREASURER  
Type or print name and title

2022-05-10  
Date

Paid Preparer Use Only

Print/Type preparer's name  
Firm's name ▶ DELOITTE TAX LLP  
Firm's address ▶ 50 SOUTH SIXTH STREET  
MINNEAPOLIS, MN 55402

Preparer's signature  
Date

Check ☐ if self-employed  
Firm's EIN ▶ 86-1065772  
Phone no. (612) 397-4000

PTIN  
P01314196

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

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2020)

**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.

<b>4a</b>	(Code: ) (Expenses \$ 729,012,372 including grants of \$ 370,744 ) (Revenue \$ 941,284,700 )
See Additional Data	





















<b>4b</b>	(Code: ) (Expenses \$ 34,703,565 including grants of \$ ) (Revenue \$ 36,495,434 )
See Additional Data	

<b>4c</b>	(Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )
See Additional Data	

<b>4d</b>	Other program services (Describe in Schedule O.)
(Expenses \$ including grants of \$ ) (Revenue \$ )	

<b>4e</b>	<b>Total program service expenses ▶</b>	763,715,937
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	<b>2</b> Yes	
<b>3</b> 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 	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> 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 	<b>4</b> Yes	
<b>5</b> 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 	<b>5</b>	No
<b>6</b> 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 	<b>6</b>	No
<b>7</b> 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 	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	<b>8</b>	No
<b>9</b> 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 	<b>9</b>	No
<b>10</b> 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	<b>10</b>	No
<b>11</b> 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.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	<b>11a</b> Yes	
<b>b</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 	<b>11b</b>	No
<b>c</b> 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 	<b>11c</b>	No
<b>d</b> 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 	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	<b>11e</b> Yes	
<b>f</b> 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 	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII 	<b>12a</b>	No
<b>b</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 	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</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	<b>14b</b>	No
<b>15</b> 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	<b>15</b>	No
<b>16</b> 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	<b>16</b>	No
<b>17</b> 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)	<b>17</b>	No
<b>18</b> 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	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H 	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	<b>20b</b> Yes	
<b>21</b> 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 	<b>21</b>	No

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

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

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V . . . . . ☒

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

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

<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>2a</b> </div> <div style="border: 1px solid black; padding: 2px; text-align: right;">0</div>			
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<div style="border: 1px solid black; padding: 2px;"> <b>2b</b> </div>			
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . .	<div style="border: 1px solid black; padding: 2px;"> <b>3a</b> Yes       </div>			
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . .	<div style="border: 1px solid black; padding: 2px;"> <b>3b</b> Yes       </div>			
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . <b>b</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).	<div style="border: 1px solid black; padding: 2px;"> <b>4a</b> No       </div>			
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . .	<div style="border: 1px solid black; padding: 2px;"> <b>5a</b> No       </div>			
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<div style="border: 1px solid black; padding: 2px;"> <b>5b</b> No       </div>			
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>5c</b> </div>			
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>6a</b> No       </div>			
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>6b</b> </div>			
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>				
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7a</b> No       </div>			
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7b</b> </div>			
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7c</b> No       </div>			
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7d</b> </div>			
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<div style="border: 1px solid black; padding: 2px;"> <b>7e</b> No       </div>			
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7f</b> No       </div>			
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7g</b> </div>			
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>7h</b> </div>			
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .				
<b>9 Sponsoring organizations maintaining donor advised funds.</b>				
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>9a</b> </div>			
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	<div style="border: 1px solid black; padding: 2px;"> <b>9b</b> </div>			
<b>10 Section 501(c)(7) organizations.</b> Enter:				
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>10a</b> </div>			
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<div style="border: 1px solid black; padding: 2px;"> <b>10b</b> </div>			
<b>11 Section 501(c)(12) organizations.</b> Enter:				
<b>a</b> Gross income from members or shareholders . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>11a</b> </div>			
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>11b</b> </div>			
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?				
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	<div style="border: 1px solid black; padding: 2px;"> <b>12b</b> </div>			
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>				
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? . . . . . <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.	<div style="border: 1px solid black; padding: 2px;"> <b>13a</b> </div>			
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>13b</b> </div>			
<b>c</b> Enter the amount of reserves on hand . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>13c</b> </div>			
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<div style="border: 1px solid black; padding: 2px;"> <b>14a</b> No       </div>			
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . .	<div style="border: 1px solid black; padding: 2px;"> <b>14b</b> </div>			
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.				
<div style="border: 1px solid black; padding: 2px;"> <b>15</b> No       </div>				
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . . If "Yes," complete Form 4720, Schedule O.				
<div style="border: 1px solid black; padding: 2px;"> <b>16</b> No       </div>				

**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
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year	19	
	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>b</b>	Enter the number of voting members included in line 1a, above, who are independent	13	
<b>2</b>	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?	Yes	
<b>3</b>	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?		No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
<b>6</b>	Did the organization have members or stockholders?	Yes	
<b>7a</b>	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?	Yes	
<b>b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body?	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	Yes	
<b>9</b>	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		No

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?		No
<b>b</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?		
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	Yes	
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13	Yes	
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	Yes	
<b>c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	Yes	
<b>13</b>	Did the organization have a written whistleblower policy?	Yes	
<b>14</b>	Did the organization have a written document retention and destruction policy?	Yes	
<b>15</b>	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?		
<b>a</b>	The organization's CEO, Executive Director, or top management official		No
<b>b</b>	Other officers or key employees of the organization		No
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		No
<b>b</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?		

**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 6TH AVENUE NORTH ST CLOUD, MN 563031901 (320) 251-2700**

## 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 ☐

**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.

[illegible]

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
<b>1b Sub-Total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>							0	14,228,226		896,750

**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 **0**

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>		No
<b>4</b> 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? <i>If "Yes," complete Schedule J for such individual</i>	Yes	
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>		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
MCGOUGH CONSTRUCTION CO LLC NW 5970 PO BOX 1450 MINNEAPOLIS, MN 55485	CAPITAL CONSTRUCTION	18,466,782
DELOITTE CONSULTING LLP PO BOX 844717 DALLAS, TX 75284	ERP IMPLEMENTATION CONSULTING SERVICES	4,492,877
MAHOWALD INSURANCE AGENCY 916 WEST SAINT GERMAIN ST STE 100 SAINT CLOUD, MN 56301	INSURANCE	4,104,348
MARCO TECHNOLOGIES INC NW 7128 PO BOX 1450 MINNEAPOLIS, MN 55485	COMPUTER EQUIPMENT MAINTENANCE CONTRACTS	2,358,084
AYA HEALTHCARE INC DEPT 3519 PO BOX 123519 DALLAS, TX 75312	TEMPORARY STAFFING SERVICES	1,701,221

**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 **21**

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Part VIII		Statement of Revenue								
Check if Schedule O contains a response or note to any line in this Part VIII . . . . . <input type="checkbox"/>										
			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514				
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . . . .	1a							
	b	Membership dues . . . . .	1b							
	c	Fundraising events . . . . .	1c							
	d	Related organizations . . . . .	1d	2,528,998						
	e	Government grants (contributions) . . . . .	1e	62,010,530						
	f	All other contributions, gifts, grants, and similar amounts not included above . . . . .	1f	24,412						
	g	Noncash contributions included in lines 1a - 1f:\$ . . . . .	1g							
	h	Total. Add lines 1a-1f . . . . . ▶		64,563,940						
Program Service Revenue			Business Code							
	2a	PATIENT & SERVICE REVE . . . . .	621110	969,837,832	969,837,832					
	b	OTHER PROGRAM REVENUE . . . . .	621110	4,398,117	4,357,967	40,150				
	c	FOOD SALES . . . . .	621110	3,544,185	3,544,185					
	d									
	e									
	f	All other program service revenue . . . . .								
g	Total. Add lines 2a-2f. . . . . ▶		977,780,134							
Other Revenue	3		Investment income (including dividends, interest, and other similar amounts) . . . . . ▶	43,933,568		43,933,568				
	4		Income from investment of tax-exempt bond proceeds . . . . . ▶							
	5		Royalties . . . . . ▶							
	6a	Gross rents . . . . .	(i) Real	(ii) Personal						
			6a	3,697,609						
			b	Less: rental expenses . . . . .				6b	3,976,609	
			c	Rental income or (loss) . . . . .				6c	-279,000	
	d		Net rental income or (loss) . . . . . ▶	-279,000		-279,000				
	7a	Gross amount from sales of assets other than inventory . . . . .	(i) Securities	(ii) Other						
			7a					71,946		
			b	Less: cost or other basis and sales expenses . . . . .				7b		0
			c	Gain or (loss) . . . . .				7c		71,946
	d		Net gain or (loss) . . . . . ▶	71,946		71,946				
	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	36,627,514							
		b	Less: cost of goods sold . . . . .				10b	14,667,173		
c		Net income or (loss) from sales of inventory . . . . . ▶	21,960,341		21,960,341					
Miscellaneous Revenue		Business Code								
11a	GAIN ON INTEREST RATE . . . . .	900099	9,951,313		9,951,313					
b										
c										
d	All other revenue . . . . .									
e	Total. Add lines 11a-11d . . . . . ▶		9,951,313							
12	Total revenue. See instructions . . . . . ▶		1,117,982,242	977,739,984	40,150	75,638,168				

Form 990 (2020)

**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 ☐

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	304,151	304,151		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	66,593	66,593		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .				
<b>4</b> Benefits paid to or for members . . . . .				
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .				
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .				
<b>7</b> Other salaries and wages . . . . .	397,517,627	314,038,925	83,478,702	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	17,880,863	14,125,882	3,754,981	
<b>9</b> Other employee benefits . . . . .	71,102,396	56,170,893	14,931,503	
<b>10</b> Payroll taxes . . . . .	22,642,130	17,887,283	4,754,847	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .				
<b>b</b> Legal . . . . .	433,002	342,072	90,930	
<b>c</b> Accounting . . . . .				
<b>d</b> Lobbying . . . . .				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees . . . . .				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	88,275,747	69,737,840	18,537,907	
<b>12</b> Advertising and promotion . . . . .	96,499	76,234	20,265	
<b>13</b> Office expenses . . . . .	393,163	310,599	82,564	
<b>14</b> Information technology . . . . .	38,317,282	30,270,653	8,046,629	
<b>15</b> Royalties . . . . .				
<b>16</b> Occupancy . . . . .	4,630,649	3,658,213	972,436	
<b>17</b> Travel . . . . .	1,889,466	1,492,678	396,788	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .				
<b>19</b> Conferences, conventions, and meetings . . . . .	748,261	591,126	157,135	
<b>20</b> Interest . . . . .	12,537,090	9,904,301	2,632,789	
<b>21</b> Payments to affiliates . . . . .				
<b>22</b> Depreciation, depletion, and amortization . . . . .	56,408,659	44,562,841	11,845,818	
<b>23</b> Insurance . . . . .	2,819,486	2,227,394	592,092	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> DRUGS/MEDICAL SUPPLIES	200,096,748	158,076,431	42,020,317	
<b>b</b> MEDICAID/MNCARE	16,788,643	13,263,028	3,525,615	
<b>c</b> EQUIPMENT RENT & MAINT.	15,957,114	12,606,120	3,350,994	
<b>d</b> IMPLICIT PRICE CONCES.	15,603,368	12,326,660	3,276,708	
<b>e</b> All other expenses	2,121,543	1,676,020	445,523	
<b>25</b> Total functional expenses. Add lines 1 through 24e	966,630,480	763,715,937	202,914,543	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year	
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		165,179,664	<b>1</b>	94,802,236	
	<b>2</b>	Savings and temporary cash investments . . . . .			<b>2</b>		
	<b>3</b>	Pledges and grants receivable, net . . . . .			<b>3</b>		
	<b>4</b>	Accounts receivable, net . . . . .		152,461,603	<b>4</b>	151,010,658	
	<b>5</b>	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 . . . . .			<b>5</b>		
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .			<b>6</b>		
	<b>7</b>	Notes and loans receivable, net . . . . .			<b>7</b>		
	<b>8</b>	Inventories for sale or use . . . . .		25,907,836	<b>8</b>	23,224,366	
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		25,106,900	<b>9</b>	4,518,133	
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b>	1,106,563,423			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b>	619,020,954	514,709,547	<b>10c</b>	487,542,469
	<b>11</b>	Investments—publicly traded securities . . . . .		428,073,358	<b>11</b>	737,259,451	
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		116,380,694	<b>12</b>	32,849,934	
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>		
	<b>14</b>	Intangible assets . . . . .			<b>14</b>		
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		58,718,357	<b>15</b>	171,364,845	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .		1,486,537,959	<b>16</b>	1,702,572,092		
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		102,027,642	<b>17</b>	111,807,783	
	<b>18</b>	Grants payable . . . . .			<b>18</b>		
	<b>19</b>	Deferred revenue . . . . .			<b>19</b>	1,622,868	
	<b>20</b>	Tax-exempt bond liabilities . . . . .			<b>20</b>		
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>		
	<b>22</b>	Loans and other payables to 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 . . . . .			<b>22</b>		
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		405,125,588	<b>23</b>	389,298,431	
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>		
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		275,580,428	<b>25</b>	199,184,228	
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		782,733,658	<b>26</b>	701,913,310	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>						
	<b>27</b>	Net assets without donor restrictions . . . . .		703,804,301	<b>27</b>	1,000,658,782	
	<b>28</b>	Net assets with donor restrictions . . . . .			<b>28</b>		
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>						
	<b>29</b>	Capital stock or trust principal, or current funds . . . . .			<b>29</b>		
	<b>30</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>30</b>		
	<b>31</b>	Retained earnings, endowment, accumulated income, or other funds			<b>31</b>		
	<b>32</b>	<b>Total net assets or fund balances</b> . . . . .		703,804,301	<b>32</b>	1,000,658,782	
<b>33</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		1,486,537,959	<b>33</b>	1,702,572,092		

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☒

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,117,982,242
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	966,630,480
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	151,351,762
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	703,804,301
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	122,160,215
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	23,342,504
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	1,000,658,782

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☒

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</b> Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
<b>c</b> If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	Yes	
<b>3a</b> 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?	Yes	
<b>b</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.		No

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 41-0695596  
**Name:** ST CLOUD HOSPITAL

Form 990 (2020)

**Form 990, Part III, Line 4a:**

CENTRACARE HEALTH IS PRIMARILY ENGAGED IN SUPPORTING AND DIRECTING HEALTHCARE DELIVERY THROUGH ITS AFFILIATED ENTITIES. CENTRACARE OPERATES AS THE PARENT CORPORATION TO THE SAINT CLOUD HOSPITAL WHICH STRIVES TO IMPROVE THE QUALITY AND EXPAND THE CLINICAL SCOPE OF, ENHANCE ACCESS TO, AND ASSURE AFFORDABILITY OF, HEALTH SERVICES FOR RESIDENTS IN THE ST. CLOUD AREA AND CENTRAL MINNESOTA. THESE AIMS ARE SUPPORTED BY CENTRACARE'S COMMITMENT TO ADVANCE MEDICAL EDUCATION, TRAINING AND RESEARCH. AS A HIGH QUALITY REGIONAL MEDICAL CENTER, ST CLOUD HOSPITAL PROVIDES A BROAD RANGE OF ACUTE INPATIENT SERVICES. WITH 489 LICENSED INPATIENT BEDS, ST CLOUD HOSPITAL CARED FOR 24,773 INPATIENT ADMISSIONS WITH 113,159 ASSOCIATED PATIENT DAYS DURING FISCAL 2021. INPATIENT SERVICES INCLUDE MEDICAL AND SURGICAL CARE, BIRTHING SERVICES, CHILDREN'S SERVICES INCLUDING NEONATAL INTENSIVE CARE AND PEDIATRIC INTENSIVE CARE, BEHAVIORAL HEALTH CARE SERVICES FOR ADULTS AND ADOLESCENTS, ALONG WITH SPECIALIZED CARE IN CARDIOLOGY, NEUROSCIENCES, NEUROSURGERY, ORTHOPEDICS AND REHABILITATION SERVICES.

**Form 990, Part III, Line 4b:**

AS PART OF THE ST CLOUD HOSPITAL, ST BENEDICTS SENIOR COMMUNITY PROVIDES RESIDENTIAL HEALTH CARE SERVICES INCLUDING INDEPENDENT LIVING, ASSISTED LIVING AND SHORT AND LONG TERM SKILLED NURSING SERVICES. IN FISCAL 2021 THERE WERE 198 SKILLED STAFFED BEDS AND RESIDENT DAYS OF 51,369. SHORT STAY SKILLED SERVICES INCLUDE AN EXTENSIVE REHABILITATIVE CARE PROGRAM WITH THE GOAL OF ENABLING RESIDENTS TO RETURN TO THEIR HOMES. IN FISCAL 2021 THERE WERE 383 HOUSING UNITS AND TENANT DAYS OF 128,045. ASSISTED LIVING AND INDEPENDENT LIVING COMMUNITIES ARE DESIGNATED AS HOUSING WITH SERVICES. HOMECARE SERVICES ARE PROVIDED TO THESE TENANTS ON A BASE RATE PLUS POINTS SYSTEM.

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**Form 990, Part III, Line 4c:**

AS A HIGH QUALITY REGIONAL MEDICAL CENTER, ST CLOUD HOSPITAL PROVIDES A BROAD RANGE OF OUTPATIENT SERVICES. OUTPATIENT ENCOUNTERS DURING FISCAL YEAR 2021 WERE 339,804 AND INCLUDED EMERGENCY ROOM SERVICES, BEHAVIORAL HEALTH CARE, CANCER TREATMENT, DIALYSIS, IMAGING PROCEDURES, DIAGNOSTIC HEART PROCEDURES, REHABILITATION THERAPY, SAME DAY SURGERY AND OTHER AMBULATORY CARE SERVICES.

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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	7.00 ..... 33.00	X		X				0	1,423,120	42,559
CRAIG BROMAN ..... CHIEF OPERATING OFFICER/EVP	7.00 ..... 33.00	X		X				0	1,387,560	51,923
RICHARD E JOLKOVSKY MD ..... DIRECTOR	35.00 ..... 5.00	X						0	586,117	26,612
TODD M SEVERNAK MD ..... DIRECTOR	35.00 ..... 5.00	X						0	437,482	21,641
ALBERT J MERCURI MD ..... DIRECTOR	35.00 ..... 5.00	X						0	417,033	36,613
NATHAN D LEE MD ..... DIRECTOR	35.00 ..... 5.00	X						0	338,670	41,788
BOB THUERINGER ..... CHAIR	0.20 ..... 1.80	X		X				0	0	0
RENEE FRAUENDIENST ..... VICE CHAIR	2.00 ..... 0.00	X		X				0	0	0
ANNESA CHEEK ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
BOB KOVELL ..... 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 (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			
CHIP MARTIN-CHAFFEE ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
COLLEEN QUINLIVAN ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
EILEEN DAUER ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
JIM RUDOLPH ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
MELINDA GAU ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
PATRICIA SNIEZEK ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
RYAN DANIEL ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
SHONDA CRAFT ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
WILLIE JETT ..... DIRECTOR	2.00 ..... 0.00	X						0	0	0
MICHAEL BLAIR ..... CHIEF FINANCIAL OFFICER/SR VP/TREASURER	18.00 ..... 22.00			X				0	544,396	73,619

**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			
SANTO CRUZ ..... CHIEF LEGAL OFFICER/SR VP/SECRETARY	18.00 ..... 22.00			X				0	363,379	45,019
THOMAS G SCHRUP MD ..... CHIEF PHYSICIAN OFFICER/EVP	20.00 ..... 20.00				X			0	654,378	49,047
MARK S MATTHIAS ..... VICE PRESIDENT	18.00 ..... 22.00				X			0	584,022	52,952
KURT T OTTO ..... VICE PRESIDENT	20.00 ..... 20.00				X			0	430,766	71,127
DIANE R BUSCHENA-BRENNA ..... VICE PRESIDENT	2.00 ..... 38.00				X			0	344,361	71,044
JOY M PLAMANN RN ..... VICE PRESIDENT	20.00 ..... 20.00				X			0	387,287	22,350
CATHERINE M GREENLEE ..... VICE PRESIDENT	20.00 ..... 20.00				X			0	261,980	36,669
JEFFREY S GERDES ..... NEUROSURGEON	40.00 ..... 0.00					X		0	1,866,321	48,630
UZMA SAMADANI ..... NEUROSURGEON	40.00 ..... 0.00					X		0	1,226,162	39,519
JERONE D KENNEDY ..... NEUROSURGEON	40.00 ..... 0.00					X		0	1,048,754	67,066

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			
JESSICA P SWARTOUT ..... PHYSICIAN	40.00 ..... 0.00					X		0	948,590	71,200
JENA J SWANSON ..... PHYSICIAN	40.00 ..... 0.00					X		0	977,848	27,372

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization  
ST CLOUD HOSPITAL

Employer identification number  
41-0695596

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

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

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations . . . . .
- g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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	<b>Total.</b> 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	<b>Public support.</b> Subtract line 5 from line 4.						

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
13	<b>First 5 years.</b> 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 <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
<b>14</b>	Public support percentage for 2020 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>
<b>15</b>	Public support percentage for 2019 Schedule A, Part II, line 14 . . . . .	<b>15</b>
<b>16a</b>	<b>33 1/3% support test—2020.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
<b>b</b>	<b>33 1/3% support test—2019.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
<b>17a</b>	<b>10%-facts-and-circumstances test—2020.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
<b>b</b>	<b>10%-facts-and-circumstances test—2019.</b> 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 <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
<b>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . <input type="checkbox"/>	

**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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
<b>c</b> Add lines 7a and 7b. .						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>9</b> Amounts from line 6. . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b> Add lines 10a and 10b.						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) . .						
<b>14 First 5 years.</b> 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 <b>stop here.</b> . . . . . ► <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

<b>15</b> Public support percentage for 2020 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

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

<b>17</b> Investment income percentage for <b>2020</b> (line 10c, column (f) divided by line 13, column (f)) . . . . .	<b>17</b>	
<b>18</b> Investment income percentage from <b>2019</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	

**19a 33 1/3% support tests—2020.** 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—2019.** 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 box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

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

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 lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described in 11a above?		
c A 35% controlled entity of a person described in line 11a or 11b above? If "Yes" to 11a, 11b, or 11c, provide detail in Part VI.		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the officers, 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.		
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.		

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).		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer lines 2a and 2b below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.		
b Did the activities described in line 2a 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.		
3 Parent of Supported Organizations. Answer lines 3a and 3b below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No" provide details in Part VI.		
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.		

<b>Part V</b> <b>Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations</b>			
<b>1</b> <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 ( <i>explain in Part VI</i> ). <b>See instructions.</b> All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

**Part V**

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

Section D - Distributions		Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>	
<b>4</b> Amounts paid to acquire exempt-use assets	<b>4</b>	
<b>5</b> Qualified set-aside amounts ( <i>prior IRS approval required - provide details in <b>Part VI</b></i> )	<b>5</b>	
<b>6</b> Other distributions ( <i>describe in <b>Part VI</b></i> ). See instructions	<b>6</b>	
<b>7 Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in <b>Part VI</b></i> ). See instructions	<b>8</b>	
<b>9</b> Distributable amount for 2020 from Section C, line 6	<b>9</b>	
<b>10</b> Line 8 amount divided by Line 9 amount	<b>10</b>	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
<b>1</b> Distributable amount for 2020 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2020 (reasonable cause required-- <i>explain in <b>Part VI</b></i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2020:			
<b>a</b> From 2015. . . . .			
<b>b</b> From 2016. . . . .			
<b>c</b> From 2017. . . . .			
<b>d</b> From 2018. . . . .			
<b>e</b> From 2019. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2020 distributable amount			
<b>i</b> Carryover from 2015 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2020 from Section D, line 7:			
\$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2020 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, <i>explain in <b>Part VI</b></i> . See instructions.			
<b>6</b> Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, <i>explain in <b>Part VI</b></i> . See instructions.			
<b>7 Excess distributions carryover to 2021.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2016. . . . .			
<b>b</b> Excess from 2017. . . . .			
<b>c</b> Excess from 2018. . . . .			
<b>d</b> Excess from 2019. . . . .			
<b>e</b> Excess from 2020. . . . .			

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

Facts And Circumstances Test

**SCHEDULE 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](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

**2020**

**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 ST CLOUD HOSPITAL	<b>Employer identification number</b> 41-0695596
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**Part I-A**

**Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

<b>1</b>	Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")	
<b>2</b>	Political campaign activity expenditures (see instructions)	▶ \$
<b>3</b>	Volunteer hours for political campaign activities (see instructions)	

**Part I-B**

**Complete if the organization is exempt under section 501(c)(3).**

<b>1</b>	Enter the amount of any excise tax incurred by the organization under section 4955	▶ \$
<b>2</b>	Enter the amount of any excise tax incurred by organization managers under section 4955	▶ \$
<b>3</b>	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>4a</b>	Was a correction made?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>b</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).**

<b>1</b>	Enter the amount directly expended by the filing organization for section 527 exempt function activities	▶ \$
<b>2</b>	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	▶ \$
<b>3</b>	Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b	▶ \$
<b>4</b>	Did the filing organization file <b>Form 1120-POL</b> for this year?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>5</b>	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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....		
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....		
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....		
<b>d</b> Other exempt purpose expenditures .....		
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....		
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>	
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.	
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....		
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....		
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....		
<b>j</b> 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? .....	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	

**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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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)		(b)
		Yes	No	Amount
<b>1</b>	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:			
<b>a</b>	Volunteers? .....		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? .....	Yes		
<b>c</b>	Media advertisements? .....		No	
<b>d</b>	Mailings to members, legislators, or the public? .....		No	
<b>e</b>	Publications, or published or broadcast statements? .....		No	
<b>f</b>	Grants to other organizations for lobbying purposes? .....	Yes		45,347
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body? .....		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		No	
<b>i</b>	Other activities? .....		No	
<b>j</b>	Total. Add lines 1c through 1i .....			45,347
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b>	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
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members? .....	<b>1</b>	
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less? .....	<b>2</b>	
<b>3</b> Did the organization agree to carry over lobbying and political expenditures from the prior year? .....	<b>3</b>	

**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."**

<b>1</b> Dues, assessments and similar amounts from members .....	<b>1</b>	
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	<b>2a</b>	
<b>a</b> Current year .....	<b>2b</b>	
<b>b</b> Carryover from last year .....	<b>2c</b>	
<b>c</b> Total .....	<b>3</b>	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .		
<b>4</b> 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? .....	<b>4</b>	
<b>5</b> Taxable amount of lobbying and political expenditures (see instructions) .....	<b>5</b>	

**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:	ST. CLOUD HOSPITAL AND ST. BENEDICTS SENIOR COMMUNITY PAID \$45,347 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](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization  
ST CLOUD HOSPITAL

Employer identification number  
41-0695596

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 FASB 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 FASB 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 FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 . . . . . ► \$

b Assets included in Form 990, Part X . . . . . ► \$

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Cat. No. 52283D Schedule D (Form 990) 2020

Part III

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

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

a☐ Public exhibition

b☐ Scholarly research

c☐ Preservation for future generations

d☐ Loan or exchange programs

e☐ Other .....

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

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

Part IV

Escrow and Custodial Arrangements.

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

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

b If "Yes," explain the arrangement in Part XIII and complete the following table:

c Beginning balance . . . . .

d Additions during the year . . . . .

e Distributions during the year . . . . .

f Ending balance . . . . .

	Amount
1c	
1d	
1e	
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 Term endowment ▶ .....

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

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

(i) Unrelated organizations . . . . .

(ii) Related organizations . . . . .

b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . .

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

	Yes	No
3a(i)		
3a(ii)		
3b		

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 . . . . .		17,172,374		17,172,374
b Buildings . . . . .		700,936,824	330,240,872	370,695,952
c Leasehold improvements				
d Equipment . . . . .		388,060,616	288,756,542	99,304,074
e Other . . . . .		393,609	23,540	370,069
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				487,542,469

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 _____		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII

Investments—Program Related.

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
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)DUE FROM AFFILIATES	148,987,620
(2)OPERATING LEASED ASSETS	21,134,179
(3)OTHER ASSETS	1,243,046
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) . . . . . ▶	171,364,845

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	
See Additional Data Table	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	199,184,228

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

☒

Schedule D (Form 990) 2020

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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 41-0695596  
**Name:** ST CLOUD HOSPITAL

**Form 990, Schedule D, Part X, - Other Liabilities**

1. (a) Description of Liability	(b) Book Value
THIRD PARTY PAYOR SETTLEMENTS	6,987,793
INTEREST RATE SWAP AGREEMENTS	22,865,880
ACCRUED PENSION LIABILITY	36,189,261
EXECUTIVE BENEFIT ACCRUAL	552,394
ASSET RETIREMENT OBLIGATION	1,215,900
SETTLEMENTS RESERVE	1,464,505
OPERATING LEASE LIABILITY	21,134,271
ACCELERATED ADVANCED PAYMENTS	100,403,822
INTEREST PAYABLE	2,440,323
FICA PAYROLL TAX DEFERRAL	5,930,079

## Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	CENTRACARE, THE CORPORATION, THE CLINIC, CCH - MELROSE, CCH - LONG PRAIRIE, CCH - SAUK CENTRE AND THE 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, 2021 AND 2020, THERE WERE NO UNCERTAIN TAX POSITIONS .

**Form 990, Schedule D, Part X, - Other Liabilities**

1. (a) Description of Liability	(b) Book Value
THIRD PARTY PAYOR SETTLEMENTS	6,987,793
INTEREST RATE SWAP AGREEMENTS	22,865,880
ACCRUED PENSION LIABILITY	36,189,261
EXECUTIVE BENEFIT ACCRUAL	552,394
ASSET RETIREMENT OBLIGATION	1,215,900
SETTLEMENTS RESERVE	1,464,505
OPERATING LEASE LIABILITY	21,134,271
ACCELERATED ADVANCED PAYMENTS	100,403,822
INTEREST PAYABLE	2,440,323
FICA PAYROLL TAX DEFERRAL	5,930,079

SCHEDULE H  
(Form 990)

Hospitals

OMB No. 1545-0047

2020

Open to Public Inspection

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

Department of the Treasury

Internal Revenue Service

Name of the organization

ST CLOUD HOSPITAL

Employer identification number

41-0695596

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1) . . . . .			2,530,271		2,530,271	0.270 %
b Medicaid (from Worksheet 3, column a) . . . . .			149,040,850	115,847,569	33,193,281	3.490 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d Total Financial Assistance and Means-Tested Government Programs . . . . .			151,571,121	115,847,569	35,723,552	3.760 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			391,461		391,461	0.040 %
f Health professions education (from Worksheet 5) . . . . .			4,365,000	2,806,220	1,558,780	0.160 %
g Subsidized health services (from Worksheet 6) . . . . .			8,715	8,715		
h Research (from Worksheet 7) . . . . .			310,012		310,012	0.030 %
i Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			153,933		153,933	0.020 %
j Total. Other Benefits . . . . .			5,229,121	2,814,935	2,414,186	0.250 %
k Total. Add lines 7d and 7j . . . . .			156,800,242	118,662,504	38,137,738	4.010 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support			16,588		16,588	0 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development			26,148		26,148	0 %
<b>9</b> Other						
<b>10 Total</b>			42,736		42,736	0 %

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. . . . .	<b>2</b>	15,603,368	
<b>3</b> 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. . . . .	<b>3</b>		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME) . . . . .	<b>5</b>	253,165,267	
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	<b>6</b>	237,814,718	
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	<b>7</b>	15,350,549	
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:			
<input type="checkbox"/> Cost accounting system			
<input type="checkbox"/> Cost to charge ratio			
<input checked="" type="checkbox"/> Other			

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year? . . . . .	<b>9a</b>	Yes	
<b>b</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 . . . . .	<b>9b</b>	Yes	

**Part IV Management Companies and Joint Ventures**

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

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

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

How many hospital facilities did the organization operate during the tax year?  
**1**

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
ST CLOUD HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

ST CLOUD HOSPITAL			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 175.000000000000 % and FPG family income limit for eligibility for discounted care of 250.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input checked="" type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.CENTRACARE.COM/PRICING-FINANCIAL-ASSISTANCE			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input checked="" type="checkbox"/> Other (describe in Section C)			

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

ST CLOUD HOSPITAL

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

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

**Policy Relating to Emergency Medical Care**

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

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

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

ST CLOUD HOSPITAL

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

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

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

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

If "Yes," explain in Section C.

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C.

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No



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

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

How many non-hospital health care facilities did the organization operate during the tax year? 28

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, LN 7 COL(F):	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$15,603,368

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	THE ACTIVITIES INCLUDED IN COMMUNITY BUILDING ACTIVITIES INCLUDE COMMUNITY SUPPORT WHICH CONSISTS OF SEVERAL ST. CLOUD HOSPITAL DIRECTORS PARTICIPATING IN A VARIETY OF COMMITTEES SUCH AS THE BOARD OF BIG BROTHERS/BIG SISTERS, REHAB BOARD ETC. UNDER COMMUNITY HEALTH IMPROVEMENTS ADVOCACY, EMPLOYEES PARTICIPATED WITH CREATE COMMUNITY, WHICH IS A COLLABORATION TO BUILD INCLUSION AMONGST DIVERSE POPULATION AND SEVERAL COUNTY TASK FORCES TO ADVOCATE FOR MENTAL AND CHEMICAL HEALTH. FINALLY UNDER WORKFORCE DEVELOPMENT, AN EMPLOYEE IS A BOARD MEMBER OF THE STEARNS BENTON WORKFORCE COUNCIL AND STUDENTS WERE GIVEN TOURS OF THE HOSPITAL AND ATTENDED PRESENTATIONS ON CAREERS IN HEALTHCARE. THE HEALTH SYSTEM PROVIDED DRIVE THROUGH TEST SITES, FREE VACCINATION CLINICS, MANDATED EMPLOYEE VACCINATION, TRAINING, SCREENING, PRODUCTS TO ENSURE SAFE ENVIRONMENTS, AND OTHER VARIOUS SERVICES/PRODUCTS.
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 ON PAGE 11 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 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 ST. CLOUD HOSPITAL 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 REPORTING AGENCIES.
PART VI, LINE 2:	ST. CLOUD HOSPITAL FOUNDATION HAS IN PLACE A COMMUNITY COLLABORATION COMMITTEE WHICH HAS A MEMBERSHIP OF OVER 30 MEMBERS. THIS COMMITTEE IS MADE UP OF COMMUNITY LEADERS FROM BOTH THE HEALTHCARE AND BUSINESS WORLD. THESE MEMBERS MEET MONTHLY TO ADDRESS COMMUNITY HEALTH ISSUES (SEE PROMOTION OF COMMUNITY HEALTH FOR MORE DETAIL). THESE IDENTIFIED HEALTH NEEDS ARE THEN COMMUNICATED TO ST. CLOUD HOSPITAL.

**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:	ST. CLOUD HOSPITAL'S IMMEDIATE SERVICE AREA CONSISTS OF STEARNS, BENTON AND SHERBURNE COUNTIES. COLLECTIVELY THEIR ESTIMATED POPULATION IN 2022 IS 316,326 AND IS PROJECTED TO GROW BY 4.2% IN 2027.THE PROJECTED POPULATION GROWTH BY AGE BRACKET FOR 2022 TO 2027 IS 0-24, 1.5%; 25-44, 3.7%; 45-64, 0.2% AND 65+ 18.1%.THE OTHER NINE COUNTIES LOCATED IN THE SERVICE AREA ARE CROW WING, DOUGLAS, KANDIYOHI, MEEKER, MILLE LACS, MORRISON, POPE, TODD AND WRIGHT.COLLECTIVELY THEIR POPULATION IN 2022 WAS 419,079 AND IS PROJECTED TO GROW BY 3.4% BY 2027.THAT 9-COUNTY PROJECTED POPULATION GROWTH TO 2025 BY AGE BRACKET ARE AS FOLLOWS: 0-24, 4.3%; 25-44, -1.0%; 45-64, -2.4% AND 65+ 14.7%.THE PROJECTED 2027 ETHNICITY BREAKDOWN FOR THE ENTIRE 12-COUNTY AREA IS AS FOLLOWS: WHITE 86.8%, BLACK 4.8%, ASIAN & PACIFIC ISLANDER 1.5%, HISPANIC 4.4% AND OTHER 2.6%. THE DEMOGRAPHIC INFORMATION IS UPDATED EVERY 2 YEARS BY THE ORGANIZATION.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 5:	THE CENTRACARE FOUNDATION BOARD OF DIRECTORS HAS A MEMBERSHIP OF OVER 20 PERSONS REPRESENTING HEALTHCARE AND COMMUNITY NEEDS ACROSS CENTRAL MINNESOTA. THE BOARD MEETS QUARTERLY TO DISCUSS WAYS TO ADDRESS TYPICAL HEALTH ISSUES THROUGH AWARENESS BUILDING, EDUCATION AND ADVOCACY WITHIN CENTRACARE AS WELL AS THE COMMUNITY. THERE ARE SEVERAL COMMUNITY HEALTHY OUTREACH INITIATIVES THAT THE FOUNDATION HAS DEPLOYED FUNDING TOWARDS INCLUDING: ACES TRAUMA-INFORMED CARE - INCREASE AWARENESS AND INTERVENTIONS SURROUNDING ADVERSE CHILDHOOD EXPERIENCES, STATE-OF-THE-ART \$2.9 MILLION SIMULATION CENTER RENOVATION AVAILABLE FOR COMMUNITY USE, ADULT AND PEDIATRIC BARIATRIC WEIGHT MANAGEMENT COLLABORATIVES, CHILD ADVOCACY CENTER HELPS CHILDREN WHO HAVE BEEN PHYSICALLY, SEXUALLY OR EMOTIONALLY ABUSED. BY WORKING CLOSELY WITH LAW ENFORCEMENT, CHILD PROTECTION, COUNTY ATTORNEYS, ADVOCATES, MENTAL HEALTH AND MEDICAL PROFESSIONALS IN ONE LOCATION, WE CAN ENSURE CHILDREN RECEIVE THE PROPER CARE AND SUPPORT DURING AND AFTER A CHILD ABUSE INVESTIGATION. 408 VICTIMS OF CHILD ABUSE FROM BENTON AND STEANS COUNTIES HAVE RECEIVED CARE IN THE FIRST TWO YEARS AT THE CAC WITH NO COST TO THEIR FAMILIES, CAREER ONE SUMMER INTERNSHIP PROGRAM FOR YOUTH.
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:** 41-0695596

**Name:** ST CLOUD HOSPITAL

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

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	ST CLOUD HOSPITAL 1406 6TH AVENUE NORTH ST CLOUD, MN 563031901 WWW.CENTRACARE.COM/LOCATIONS/CENTRACARE 395453	X	X		X			X		REHAB, PSYCH, HOME HEALTH, HOSPICE, AND RENAL DIALYSIS	

**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
ST. CLOUD HOSPITAL	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
ST. CLOUD HOSPITAL	<p>PART V, SECTION B, LINE 5: CENTRACARE POPULATION HEALTH CONDUCTED SPECIFIC AND COMPREHENSIVE EVALUATION OF ZIP CODE 56304 THAT HAS THE WORST HEALTH OUTCOMES IN THE THREE COUNTIES INCLUDED IN THE CHNA AND CHIP. THIS EVALUATION INCLUDED DATA EVALUATION, KEY INFORMANT INTERVIEWS, 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 REPRESENTING DIFFERENT POPULATIONS IN ORDER TO COMPILE A LIST OF TOP PRIORITIES IN THE REGION: THE COMMUNITY HEALTH STATUS ASSESSMENT (CHSA) WAS DATA COLLECTED FROM THE COMMUNITY HEALTH ASSESSMENT COMPLETED IN 2018, 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, PREVIOUS PLANNING PROCESS PRIORITY LISTS, HEALTH EQUITY DATA ANALYSES (HEDA) FROM EACH COUNTY, TYPES OF DATA REQUESTS OUR AGENCIES WERE GETTING FROM THE PUBLIC, AND THE MN DEPARTMENT OF HEALTH DATA INDICATOR LIST. A "COMMUNITY PRIORITY CATEGORY" WAS ASSIGNED TO EACH DATA POINT TO IDENTIFY A LIST OF COMMUNITY PRIORITIES. THE COMMUNITY THEMES AND STRENGTHS ASSESSMENT (CTSA) WAS CONDUCTED IN THE FORM OF KEY STAKEHOLDER INTERVIEWS VIA PHONE WITH A WIDE VARIETY OF COMMUNITY PARTNERS THROUGHOUT THE THREE COUNTIES. A TOTAL OF 50 STAKEHOLDERS WERE INTERVIEWED FROM 20 DIFFERENT SECTORS INCLUDING YOUTH, PARENT, SMALL BUSINESS OWNER, CORPORATE BUSINESS OWNER, MEDIA, SCHOOL/EDUCATION, YOUTH-SERVING ORGANIZATION, LAW ENFORCEMENT, RELIGIOUS OR FAITH-BASED ORGANIZATION, PRIMARY HEALTHCARE, BEHAVIORAL HEALTH, HOSPITAL-BASED HEALTHCARE, STATE/LOCAL GOVERNMENT- ELECTED, STATE/LOCAL GOVERNMENT- NON-ELECTED, NON-PROFIT, CIVIC/VOLUNTEER GROUP, VETERANS INTEREST GROUP, AGING POPULATION INTEREST GROUP, ENVIRONMENTAL INTEREST GROUP, AND MINORITY INTEREST GROUP. FOR THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA) BENTON, SHERBURNE, AND STEARNS 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 QUESTIONS WERE THEN UTILIZED TO FORMULATE A SURVEY FOR THREE SECTORS OF THE LOCAL PUBLIC HEALTH SYSTEM: EMERGENCY PREPAREDNESS, ENVIRONMENTAL HEALTH, AND HEALTHCARE ACCESS/INFECTIOUS DISEASE. COMMUNITY PARTNERS WERE INVITED TO PARTICIPATE IN THE SURVEY VIA EMAIL. AFTER ANALYZING 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 IMPROVEMENT PLAN. THE FORCES OF CHANGE (FOC) ASSESSMENT WAS COMPLETED IN THE FORM OF A COMMUNITY MEETING IN AUGUST OF 2018 TO IDENTIFY FORCES THAT MAY AFFECT A COMMUNITY AND OPPORTUNITIES AND THREATS ASSOCIATED WITH THOSE FORCES. THE AGENDA INCLUDED A BRAINSTORMING ACTIVITY AND TIME IN SMALL GROUP AND LARGE GROUP DISCUSSION. A Flier ADVERTISING THE</p>

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

Form and Line Reference	Explanation
ST. CLOUD HOSPITAL	MEETING WAS DISTRIBUTED TO COMMUNITY MEMBERS VIA EMAIL. THERE WERE 68 PEOPLE THAT ATTENDE D REPRESENTING 27 ORGANIZATIONS AND TWO THAT IDENTIFIED THEIR AFFILIATION AS 'COMMUNITY ME MBER'. AS A FOLLOW UP TO THE FORCES OF CHANGE COMMUNITY MEETING, A WORLD CAFE WAS HELD IN JANUARY 2019 FOR MEMBERS OF THE COMMUNITY TO COME AND TALK ABOUT THEIR PERCEPTION OF NEEDS IN THE SURROUNDING COMMUNITIES. THERE WERE 94 PEOPLE THAT ATTENDED THE MEETING REPRESENTI NG 32 ORGANIZATIONS AND THREE THAT IDENTIFIED THEIR AFFILIATION AS 'COMMUNITY MEMBER'. ORG ANIZATIONS THAT WERE REPRESENTED AT BOTH COMMUNITY MEETINGS INCLUDED LOCAL GOVERNMENT, HEA LTHCARE, LOCAL NONPROFITS, EDUCATION, UNDERREPRESENTED COMMUNITIES, FAITH COMMUNITY, AND O THERS.IN ORDER TO BETTER ENGAGE INDIVIDUALS OR ORGANIZATIONS WITH A PERSPECTIVE OF AT-RISK POPULATIONS, A HEALTH EQUITY ASSESSMENT WAS ALSO COMPLETED. FOCUS-GROUP MEETINGS WERE HEL D ON THREE SEPARATE OCCASIONS AT THE GREAT RIVER REGIONAL LIBRARY IN ST. CLOUD, AND COMMUN ITY 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, N EGATIVES, AND AREAS-TO-IMPROVE-ON WITHIN THE COMMUNITY. AT THE COUNTY FAIRS, INFORMATION W AS 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
ST. CLOUD HOSPITAL	PART V, SECTION B, LINE 6A: ST. CLOUD HOSPITAL CONDUCTED THE CHNA WITH CENTRACARE PAYNESVILLE, CENTRACARE MELROSE, AND CENTRACARE SAUK CENTRE.

**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
ST. CLOUD HOSPITAL	PART V, SECTION B, LINE 6B: ST. CLOUD HOSPITAL CONDUCTED THE CHNA WITH BENTON COUNTY PUBLIC HEALTH, SHERBURNE COUNTY PUBLIC HEALTH AND STEARNS COUNTY PUBLIC 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
ST. CLOUD HOSPITAL	<p>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 OF 10 COMMUNITY PRIORITIES. AS A REMINDER, THE FOUR ASSESSMENTS INCLUDE: COMMUNITY HEALTH STATUS ASSESSMENT, COMMUNITY THEMES AND STRENGTHS ASSESSMENT, LOCAL PUBLIC HEALTH STATUS ASSESSMENT, AND FORCES OF CHANGE ASSESSMENT. THOSE FOUR LISTS OF 10 ARE INCLUDED IN THE NARRATIVE 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 THEMES OR COMMONALITIES AMONGST THE FOUR LISTS. THE CORE SUPPORT TEAM THEN CAME TOGETHER IN A MEETING AND WENT THROUGH A FACILITATED PROCESS USING THE CENTRAL MN ALLIANCE VISION AS A GUIDE TO COME UP WITH A TOP 10 LIST TO SEND ON TO THE DELEGATED AUTHORITIES. THE DELEGATED AUTHORITIES 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 ADDRESSING 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: ARE THERE OPPORTUNITIES FOR ACTION TO ADDRESS THE CRITICAL ISSUE? IS THERE ROOM TO MAKE MEANINGFUL IMPROVEMENT ON THE ISSUE? RESOURCES: ARE RESOURCES (FUNDS, STAFF, &amp; EXPERTISE) EITHER READILY AVAILABLE OR LIKELY RESOURCES CAN BE OBTAINED TO ADDRESS THE CRITICAL ISSUE? ARE THERE RESOURCES THROUGH THE STATE AND COMMUNITY MEMBERS TO WORK ON THE ISSUE? IF NOT, CAN RESOURCES BE ACQUIRED? COMMUNITY READINESS: IS THIS A CRITICAL ISSUE IDENTIFIED AS IMPORTANT BY THE COMMUNITY? ARE PEOPLE IN THE COMMUNITY INTERESTED IN THE ISSUE? IS THERE COMMUNITY MOMENTUM TO MOVE THIS INITIATIVE FORWARD? INTEGRATION: IS THERE OPPORTUNITY FOR COLLABORATION? IS THERE OPPORTUNITY TO BUILD ON EXISTING INITIATIVES? WILL THIS DUPLICATE EFFORTS? FINALLY, THE PRIORITIES WERE PLACED ON A CONTROL/INFLUENCE GRID. THE PRIORITIES IDENTIFIED WERE AS FOLLOWS IN COMMUNITY INFORMED RANKING: 1) BUILDING FAMILIES, 2) MENTAL HEALTH, 3) ENCOURAGING SOCIAL CONNECTION, 4) ADVERSE CHILDHOOD EXPERIENCES (ACES), 5) TOBACCO/NICOTINE 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 COLLABORATION ON THIS WORK, A DECISION WAS MADE TO FOCUS ON THE TOP TWO PRIORITIES FOR THE COMMUNITY HEALTH IMPROVEMENT PLAN. THE PRIORITIES THREE THROUGH TEN WILL NOT SPECIFICALLY BE ADDRESSED THROUGH ACTION PLANNING OR MEASUREMENT, HOWEVER, THERE ARE WAYS MANY OF THESE PRIORITIES ARE BEING ADDRESSED EITHER WITH</p>

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

Form and Line Reference	Explanation
ST. CLOUD HOSPITAL	<p>ITHIN THE TOP TWO PRIORITIES OR THE COMMUNITY. IN THE FUTURE, THE GROUP WILL ASSESS THE CAPACITY TO EXPAND THE NUMBER OF PRIORITIES BEING ADDRESSED AND MEASURED. ALTHOUGH NOT DIRECTLY ADDRESSED IN THE PLAN, CENTRACARE DOES ACTIVELY SUPPORT OTHER ORGANIZATIONS WITHIN THE COMMUNITY WHO ARE WORKING ON DETERMINANTS OF HEALTH IDENTIFIED DURING THE CHNA PROCESS LIKE ACES, TOBACCO, TRAUMA, EDUCATING POLICYMAKERS, ETC. THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) IS THE ACTION PLAN THAT USES GUIDING PRINCIPLES AND STRATEGIES TO ADDRESS THE 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 PRINCIPLES OF COMMUNITY COLLABORATION, AWARENESS, RESILIENCE, EQUITY, EDUCATION, AND HEALTH ORGANIZATIONS TO DRIVE OUR STRATEGIES. IN THE CURRENT FISCAL YEAR THE ORGANIZATION LOOKED AT GRANTS FOR SCHOOLS TO TEACH IN THEIR CURRICULUM AND LOOKED AT PARTNERING WITH OTHER ORGANIZATIONS TO OFFER CLASSES/RESOURCES FOR THOSE IN NEED OF PARENTING SKILLS AND CAREGIVER RESOURCES. THEY ALSO LOOKED INTO CREATING SUPPORT GROUPS, MEDICATION ASSISTED TREATMENT AND ADDITIONAL AWARENESS WITHIN THE COMMUNITY REGARDING MENTAL HEALTH NEEDS. 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 STRATEGIES OUTLINED IN THE CHIP. THERE WILL BE MEETINGS AS OUTLINED IN THE CHIP UNDER LEADERSHIP SYSTEM &amp; PROCESS FOR MONITORING AND REVISION. TO SEE THE FULL CHIP GO TO THE CENTRACARE WEBSITE AT <a href="https://www.centracare.com/about-us/community-health-needs-assessment/">HTTPS://WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH -NEEDS-ASSESSMENT/</a>.</p>

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

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

Form and Line Reference	Explanation
ST. CLOUD 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.**

**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
ST. CLOUD 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.

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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
ST. CLOUD HOSPITAL	PART V, SECTION B, LINE 20E: OUR CREDIT COLLECTION AGENCIES ARE REQUIRED TO PROVIDE CHARITY CARE INFORMATION AS PART OF THEIR COLLECTION PROCESS PRIOR TO ANY CONSIDERATION OF LEGAL ACTION AGAINST A PATIENT.

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 22B:	THE FOLLOWING DISCLOSURE IS IN ACCORDANCE WITH REV. PROC. 2015-21 SECTION 7 IN REGARDS TO SCHEDULE H, PART V, SECTION B, LINE 22B. DURING THE TAX PERIOD ENDED JUNE 30, 2021, THE FINANCIAL ASSISTANCE POLICY DID NOT INCLUDE THE PERCENTAGE CALCULATED FOR THE "AMOUNTS GENERALLY BILLED" USING THE LOOK BACK METHOD. CENTRACARE IDENTIFIED THIS ERROR IN MARCH 2022 DURING THE PREPARATION OF THE FORM 990 FOR THE TAX PERIOD ENDED JUNE 30, 2021 AND CORRECTED THIS ERROR IN APRIL 2022. THIS ERROR WAS MINOR AND INADVERTENT AND CORRECTIVE ACTIONS WERE TAKEN AFTER THE DISCOVERY OF THE ERROR.

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 7A:	<a href="https://www.centracare.com/about-us/community-health-needs-assessment/">HTTPS://WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/</a>

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 10A:	<a href="https://www.centracare.com/about-us/community-health-needs-assessment/">HTTPS://WWW.CENTRACARE.COM/ABOUT-US/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/</a>

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 - SAINT BENEDICT'S SENIOR COMMUNITY 990 19TH ST SOUTH SARTELL, MN 56377	SKILLED NURSING FACILITY
1 2 - COBORN CANCER CENTER 1900 CENTRACARE CIRCLE ST CLOUD, MN 56303	OUTPATIENT CANCER
2 3 - CENTRACARE FAMILY HEALTH CENTER 1555 NORTHWAY DR STE 200 ST CLOUD, MN 56303	CLINIC SERVICES
3 4 - ST CLOUD HOSPITAL BEHAVIOR HEALTH 166 19TH ST S STE 201 ST CLOUD, MN 56303	OUTPATIENT CLINIC
4 5 - RECOVERY PLUS 713 ANDERSON AVE ST CLOUD, MN 56303	OUTPATIENT SERVICES
5 6 - DIAGNOSTIC CENTER 1900 CENTRACARE CIRCLE ST CLOUD, MN 56303	OUTPATIENT RADIOLOGY
6 7 - ST CLOUD SLEEP CENTER 1586 COUNTY RD 134 ST CLOUD, MN 56303	OUTPATIENT SERVICES
7 8 - ST CLOUD PHYSICAL THERAPY 12800 ROLLING ROCK RIDGE RD BECKER, MN 55308	PHYSICAL THERAPY
8 9 - SARTELL PSYCHOLOGY 166 19TH ST S SARTELL, MN 56377	BEHAVIORAL HEALTH
9 10 - PASSAGE HOME 121 PARK AVE SO ST CLOUD, MN 56301	SUBSTANCE ABUSE
10 11 - JOURNEY HOME 1485 10TH AVE NE SAUK RAPIDS, MN 56379	SUBSTANCE ABUSE
11 12 - CLARA'S HOUSE 1564 COUNTY ROAD 134 ST CLOUD, MN 56303	ADOLESCENT MENTAL HEALTH
12 13 - ST CLOUD HOSPITAL WOUND CARE CENTER 2035 15TH ST NORTH SUITE 130 ST CLOUD, MN 56303	WOUND CARE
13 14 - ST CLOUD HOSPITAL PHYSICAL THERAPY 320 3RD AVE ALBANY, MN 56307	PHYSICAL THERAPY
14 15 - RECOVERY PLUS RESIDENTIAL - ADOLESCENT 1572 CO RD 134 ST CLOUD, MN 563030346	BEHAVIORAL HEALTH

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)
<b>16</b> 16 - RECOVERY PLUS WOMEN'S OUTPATIENT SERV 1428 2ND ST N SAUK RAPIDS, MN 563792533	BEHAVIORAL HEALTH
<b>1</b> 17 - DIALYSIS - LITCHFIELD 520 HWY 12 E SUITE 6 LITCHFIELD, MN 55355	DIALYSIS
<b>2</b> 18 - DIALYSIS - STAPLES 403 PRAIRIE AVE NE STAPLES, MN 56479	DIALYSIS
<b>3</b> 19 - DIALYSIS - BRAINERD 2024 6TH STREET BRAINERD, MN 56401	DIALYSIS
<b>4</b> 20 - DIALYSIS - ALEXANDRIA 111 17TH AVE E ALEXANDRIA, MN 56308	DIALYSIS
<b>5</b> 21 - DIALYSIS - PRINCETON 112 S RUM RIVER DR SUITE 10 PRINCETON, MN 55371	DIALYSIS
<b>6</b> 22 - DIALYSIS - BIG LAKE 16830 198TH AVE NW BIG LAKE, MN 55309	DIALYSIS
<b>7</b> 23 - DIALYSIS - LITTLE FALLS 808 3RD ST SSE LITTLE FALLS, MN 56345	DIALYSIS
<b>8</b> 24 - DIALYSIS - CAMBRIDGE 520 11TH AVE SW SOUTH BLD CAMBRIDGE, MN 55008	DIALYSIS
<b>9</b> 25 - DIALYSIS - OLIVIA 600 EAST PARK AVE SUITE 1 OLIVIA, MN 56277	DIALYSIS
<b>10</b> 26 - CENTRACARE PLAZA REHAB 1900 CENTRACARE CIRCLE ST CLOUD, MN 56303	PHYSICIAL, OCCUPATIONAL, SPEECH THERAPY
<b>11</b> 27 - CENTRACARE SOUTHWAY REHAB 1301 33RD ST S ST CLOUD, MN 56301	PHYSICIAL, OCCUPATIONAL, SPEECH THERAPY
<b>12</b> 28 - DIALYSIS - AITKIN 200 BUNKER HILLS DR AITKIN, MN 56431	DIALYSIS

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

Schedule I  
(Form 990)

Grants and Other Assistance to Organizations,  
Governments and Individuals in the United States  
Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

2020

Open to Public  
Inspection

Department of the  
Treasury  
Internal Revenue Service  
Name of the organization  
ST CLOUD HOSPITAL

Employer identification number  
41-0695596

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

**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) HOME DELIVERED MEALS	128		66,593 FMV		PROVIDED 18,192 MEALS TO THE NEEDY.
(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 COMMUNICATION/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. OTHER CENTRACARE ENTITIES INCLUDING CENTRACARE HEALTH - LONG PRAIRIE, MELROSE, MONTICELLO, PAYNESVILLE, AND SAUK CENTRE, MAY DEVELOP A BUDGET FOR APPROVAL AND IMPLEMENT THEIR OWN CONTRIBUTION 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 FROM 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.

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2020
		Open to Public Inspection
Department of the Treasury Internal Revenue Service	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 <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for instructions and the latest information.	
Name of the organization ST CLOUD HOSPITAL		Employer identification number 41-0695596

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

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.

[illegible]

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 3	THE COMPENSATION PAID TO THE PRESIDENT AND VICE PRESIDENTS (NON-MEDICAL PROVIDERS) IS DETERMINED BY CENTRACARE HEALTH SYSTEM, A RELATED ORGANIZATION. CENTRACARE HEALTH SYSTEM USES THE FOLLOWING METHODS TO DETERMINE COMPENSATION: - COMPENSATION COMMITTEE - INDEPENDENT COMPENSATION CONSULTANT - FORM 990 OF OTHER ORGANIZATIONS - COMPENSATION SURVEY OR STUDY - APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE
PART I, LINE 4B	THE CORPORATIONS' EXECUTIVES ARE ELIGIBLE TO PARTICIPATE IN BENEFIT PLANS WHICH INCLUDE TAX DEFERRED 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 FORM 990, THE AMOUNTS LISTED IN PART VII AND SCHEDULE J, PART II, COLUMN C, REFLECT TAX DEFERRED COMPENSATION. THIS COMPENSATION IS POTENTIALLY REPORTED TWICE ON FORM 990 - ONCE WHEN THE COMPENSATION IS DEFERRED OR ACCRUED AND AGAIN IF AND WHEN IT IS PAID TO THE EXECUTIVE. THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE NON-QUALIFIED PLAN: THOMAS SCHRUP - PAID \$39,658 KURT OTTO - PAID \$51,669 JOY PLAMANN - PAID \$41,727 CRAIG BROMAN - PAID \$199,215
PART I, LINE 7	THE ORGANIZATION PROVIDES INCENTIVE COMPENSATION TO DESIGNATED INDIVIDUALS BASED ON FOUR DISCRETE AREAS: STEWARDSHIP, THROUGH A COMPARISON BETWEEN BUDGETED AND ACTUAL NET OPERATING INCOME FOR SAINT CLOUD HOSPITAL AND/OR CENTRACARE HEALTH SYSTEM AS WELL THROUGH ACHIEVING METRICS FOR AN IDENTIFIED COST REDUCTION PROGRAM; QUALITY, THROUGH ACHIEVING SAINT CLOUD HOSPITAL AND SYSTEM QUALITY METRICS; PATIENT EXPERIENCE, THROUGH ACHIEVEMENT OF PATIENT SATISFACTION GOALS AS COMPARED TO NATIONAL AND BASELINE RANKINGS; AND PEOPLE/EMPLOYEES, THROUGH ACHIEVEMENT OF SPECIFIED EMPLOYMENT SATISFACTION GOALS AND HIRING AND/OR RETENTION GOALS. THE INCENTIVE COMPENSATION PAID OUT IS NOT A PORTION OR PERCENTAGE OF ACTUAL NET EARNINGS OF ANY CENTRACARE HEALTH SYSTEM AFFILIATE, HOWEVER NET EARNINGS GOALS ARE REQUIRED TO BE MET BEFORE THE INCENTIVE COMPENSATION IS PAID.

Additional Data

Software ID:  
Software Version:  
EIN: 41-0695596  
Name: ST CLOUD HOSPITAL

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1JEFFREY S GERDES NEUROSURGEON	(i)	0	0	0	0	0	0	0
	(ii)	1,851,088	9,692	5,541	26,000	22,630	1,914,951	0
1KENNETH D HOLMEN MD PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	1,025,380	0	397,740	14,981	27,578	1,465,679	0
2CRAIG BROMAN CHIEF OPERATING OFFICER/EVP	(i)	0	0	0	0	0	0	0
	(ii)	956,517	250,000	181,043	27,625	24,298	1,439,483	199,215
3UZMA SAMADANI NEUROSURGEON	(i)	0	0	0	0	0	0	0
	(ii)	865,308	360,293	561	38,156	1,363	1,265,681	0
4JERONE D KENNEDY NEUROSURGEON	(i)	0	0	0	0	0	0	0
	(ii)	988,506	54,650	5,598	44,155	22,911	1,115,820	0
5JESSICA P SWARTOUT PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	939,329	4,650	4,611	39,000	32,200	1,019,790	0
6JENA J SWANSON PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	968,605	4,650	4,593	0	27,372	1,005,220	0
7THOMAS G SCHRUP MD CHIEF PHYSICIAN OFFICER/EVP	(i)	0	0	0	0	0	0	0
	(ii)	550,409	0	103,969	26,000	23,047	703,425	39,658
8MARK S MATTHIAS VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	456,401	0	127,621	26,000	26,952	636,974	0
9MICHAEL BLAIR CHIEF FINANCIAL OFFICER/SR VP/TREASU	(i)	0	0	0	0	0	0	0
	(ii)	524,778	0	19,618	45,500	28,119	618,015	0
10 RICHARD E JOLKOVSKY MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	506,162	75,160	4,795	25,572	1,040	612,729	0
11KURT T OTTO VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	373,663	0	57,103	45,500	25,627	501,893	51,669
12TODD M SEVERNAK MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	425,415	4,650	7,417	0	21,641	459,123	0
13ALBERT J MERCURI MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	405,626	4,650	6,757	8,717	27,896	453,646	0
14 DIANE R BUSCHENA- BRENNA VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	280,047	0	64,314	45,500	25,544	415,405	0
15JOY M PLAMANN RN VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	336,411	0	50,876	0	22,350	409,637	41,727
16SANTO CRUZ CHIEF LEGAL OFFICER/SR VP/SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	336,391	0	26,988	19,500	25,519	408,398	0
17NATHAN D LEE MD DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	324,398	4,650	9,622	14,972	26,816	380,458	0
18CATHERINE M GREENLEE VICE PRESIDENT	(i)	0	0	0	0	0	0	0
	(ii)	215,405	0	46,575	21,021	15,648	298,649	0

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

Department of the Treasury

Name of the organization  
ST CLOUD HOSPITAL

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

**Employer identification number**

41-0695596

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART V, LINE 15	ST. CLOUD HOSPITAL HAS PERFORMED THE CALCULATION TO DETERMINE THAT IT IS SUBJECT TO AN EXCISE TAX UNDER IRC SECTION 4960 FOR REMUNERATION PAID IN EXCESS OF \$1,000,000. THE FORM 4720 WILL BE FILED WITH THE IRS BY CENTRACARE HEALTH ON BEHALF OF ST. CLOUD HEALTH TO REPORT THE EXCISE TAX.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	MERRYN JOLKOVSKY & RICHARD JOLKOVSKY - FAMILY RELATIONSHIP (MARRIED)

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE CORPORATE MEMBERS OF ST. CLOUD HOSPITAL ARE TWO REPRESENTATIVES OF THE SISTERS OF THE ORDER OF SAINT BENEDICT, TWO REPRESENTATIVES OF THE DIOCESE OF ST. CLOUD, AND FOUR OTHER CORPORATE MEMBERS APPOINTED BY THE FOUR REPRESENTATIVES. THE CORPORATE MEMBERS SERVE AS REPRESENTATIVES OF THE LOCAL CATHOLIC CHURCH OF SAINT CLOUD.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE CENTRACARE HEALTH SYSTEM (CCHS) BOARD APPOINTS THE ST. CLOUD HOSPITAL (SCH) BOARD BASED ON RECOMMENDATION OF THE SCH JOINT NOMINATION COMMITTEE.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	IN ADDITION TO APPOINTING THE ST. CLOUD HOSPITAL BOARD, THE MEMBERS APPROVE AMENDMENTS TO THE ARTICLES OF INCORPORATION, APPROVE DISSOLUTION OF THE HOSPITAL, AND SUPPORT AND ASSESS THE HOSPITAL'S ROMAN CATHOLIC IDENTITY AND MISSIONS.

## 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 COMMITTEE. ANNUALLY, AT THE AUDIT COMMITTEE MEETING, PRIOR TO FILING WITH THE IRS, THE AUDIT COMMITTEE REVIEWS AND APPROVES FORM 990. A COPY OF FORM 990 IS THEN PROVIDED FOR THE FULL 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	<p>THE BOARD MEMBERS ARE REQUIRED TO REVIEW AND SIGN A CONFLICT OF INTEREST QUESTIONNAIRE TWICE A YEAR. ALL STAFF SIGN CONFLICTS OF INTEREST FORMS ON AN ANNUAL BASIS. THE QUESTIONNAIRES ARE REVIEWED BY THE CORPORATE COMPLIANCE OFFICER AS WELL AS THE CORPORATE COMPLIANCE GROUP (A COMPLIANCE COMMITTEE WHICH INCLUDES INTERNAL MEMBERS AND OUTSIDE COUNSEL). THE RESPONSES TO THE QUESTIONNAIRES ARE THEN REVIEWED WITH THE EXECUTIVE COMMITTEE OF THE BOARD. THE CORPORATE COMPLIANCE OFFICER IS RESPONSIBLE FOR MONITORING CONFLICTS OF INTERESTS RELATED 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 MAKING PROCESS. THE CORPORATE COMPLIANCE OFFICER ATTENDS BOARD MEETINGS AND SPECIFIED BOARD COMMITTEE MEETINGS WHERE CONFLICT ISSUES MAY ARISE.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	<p>THE COMPENSATION AND BENEFITS OF THE PRESIDENTS (NON-MEDICAL PROVIDERS) ARE SUBJECT TO FULL COMPENSATION AND BENEFITS COMPARABILITY STUDIES CONDUCTED BIENNIALLY BY A THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT. HOWEVER, THE COMPENSATION PORTION OF THE STUDY IS REVIEWED ANNUALLY BY THE CONSULTANT AND UPDATED FOR COMPENSATION COMMITTEE AND BOARD OF DIRECTORS REVIEW AND APPROVAL. THE MOST RECENT FULL REVIEW WAS DONE IN JUNE 2021. THE THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT IS RETAINED BY ST. CLOUD HOSPITAL TO PERFORM SERVICES . THE COMPENSATION AND BENEFITS OF THE VICE PRESIDENTS (NON-MEDICAL PROVIDERS) ARE ALSO PAID BY A RELATED ORGANIZATION AND SUBJECT TO FULL COMPENSATION AND BENEFITS COMPARABILITY STUDIES CONDUCTED BIENNIALLY BY A THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT. HOWEVER, THE COMPENSATION PORTION OF THE STUDY IS REVIEWED ANNUALLY BY THE CONSULTANT AND UPDATED FOR COMPENSATION COMMITTEE AND BOARD OF DIRECTORS REVIEW AND APPROVAL. THE MOST RECENT FULL REVIEW WAS DONE IN JUNE 2021. THE THIRD PARTY INDEPENDENT COMPENSATION CONSULTANT IS RETAINED BY ST. CLOUD HOSPITAL TO PERFORM THESE SERVICES.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE HOSPITAL/CENTRACARE HEALTH SYSTEM DOES NOT GENERALLY MAKE ITS GOVERNING DOCUMENTS OR CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC. THE HOSPITAL/CENTRACARE HEALTH SYSTEM DOES RELEASE AN ANNUAL REPORT TO THE COMMUNITY IN WHICH FINANCIAL RESULTS ARE REPORTED TO AND DISCUSSED WITH THE PUBLIC. THIS REPORT IS AVAILABLE TO THE PUBLIC ON THE ORGANIZATION'S WEBSITE.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	ADJUSTMENTS TO FUNDED STATUS OF PENSION PLAN 30,285,536. NET EQUITY TRANSFERS TO AFFILIATED ORGANIZATIONS -7,261,054. OTHER CHANGES IN NET ASSETS 318,022.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XII, LINE 3B:	DUE TO COVID-19 THE OFFICE OF MANAGEMENT AND BUDGET EXTENDED THE SINGLE AUDIT DUE DATE. DUE TO THIS THE SINGLE AUDIT REQUIRED TO BE COMPLETED IS IN PROCESS, HOWEVER THE JUNE 30, 2020 SINGLE AUDIT HAS BEEN COMPLETED.

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization  
ST CLOUD HOSPITAL

Employer identification number  
41-0695596

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ST BENEDICTS SENIOR COMMUNITY 1810 MINNESOTA BOULEVARD SE ST CLOUD, MN 56304 41-1321978	ACUTE/LT CARE	MN	38,702,600	13,520,030	ST CLOUD HOSPITAL

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) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> MONTICELLO CANCER CENTER 1001 HART BOULEVARD SUITE 50 MONTICELLO, MN 55362 26-1909519	RADIATION & ONCOLOGY SERVICES	MN	N/A					No			No	
<b>(2)</b> BENSON MEDICAL LLC 1228 ATLANTIC AVENUE BENSON, MN 56215 20-3149203	HEALTHCARE	MN	N/A					No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
<b>(1)</b> CENTRACARE HOLDINGS INC 1406 6TH AVENUE NORTH SAINT CLOUD, MN 56303 47-2688595	INVESTMENT/PHARMACY	MN	N/A	C					No
<b>(2)</b> AFFILIATED COMMUNITY MEDICAL CENTERS PA 301 BECKER AVENUE SOUTHWEST WILLMAR, MN 56201 41-0850702	HEALTHCARE SYSTEM	MN	N/A	C					No
<b>(3)</b> AFFILIATED COMMUNITY HEALTH NETWORK INC 101 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 41-1765606	HEALTH NETWORK	MN	N/A	C					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.**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)CENTRACARE HEALTH SYSTEM	P	733,216,730	FMV
(2)CENTRACARE HEALTH SYSTEM	O	86,114,929	FMV
(3)CENTRACARE HEALTH SYSTEM	K	205,468	FMV
(4)CENTRACARE HEALTH SYSTEM	N	55,118,622	FMV
(5)CENTRACARE HEALTH FOUNDATION	C	1,440,825	FMV
(6)CENTRACARE HEALTH SYSTEM	C	1,088,173	FMV

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.

[illegible]

**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: 41-0695596  
Name: ST CLOUD HOSPITAL

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 AVENUE NORTH SAINT CLOUD, MN 56303 41-1813221	INTEGRATED HEALTHCARE SYSTEM	MN	501(C)(3)	3	N/A		No
11 NORTH 5TH AVENUE WEST MELROSE, MN 56352 41-1865315	ACUTE/LT CARE	MN	501(C)(3)	3	CENTRACARE HEALTH SYSTEM		No
50 CENTRACARE DRIVE LONG PRAIRIE, MN 56347 41-1924645	ACUTE/LT CARE	MN	501(C)(3)	3	CENTRACARE HEALTH SYSTEM		No
425 ELM STREET NORTH SAUK CENTRE, MN 56378 45-2438973	ACUTE/LT CARE	MN	501(C)(3)	3	CENTRACARE HEALTH SYSTEM		No
1200 6TH AVENUE NORTH SAINT CLOUD, MN 56303 41-1806657	MULTI-SPECIALTY	MN	501(C)(3)	3	CENTRACARE HEALTH SYSTEM		No
1406 6TH AVENUE NORTH SAINT CLOUD, MN 56303 41-1855173	FUNDRAISING	MN	501(C)(3)	7	CENTRACARE HEALTH SYSTEM		No
1100 WEST ST GERMAIN STREET SAINT CLOUD, MN 56303 41-6019335	SUPPORT FOR CARRIS HEALTH	MN	501(C)(3)	12A, I	CARRIS HEALTH		No
301 BECKER AVENUE SOUTHWEST WILLMAR, MN 56201 41-1611555	SUPPORT FOR CARRIS HEALTH	MN	501(C)(3)	7	CENTRACARE HEALTH FOUNDATION		No

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

<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
CENTRACARE HEALTH SYSTEM	P	733,216,730	FMV
CENTRACARE HEALTH SYSTEM	O	86,114,929	FMV
CENTRACARE HEALTH SYSTEM	K	205,468	FMV
CENTRACARE HEALTH SYSTEM	N	55,118,622	FMV
CENTRACARE HEALTH FOUNDATION	C	1,440,825	FMV
CENTRACARE HEALTH SYSTEM	C	1,088,173	FMV