

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

# Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047  
**2019**  
Open to Public Inspection

**A For the 2019 calendar year, or tax year beginning 10-01-2019, and ending 09-30-2020**

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

**C** Name of organization  
Southcoast Hospitals Group Inc

% WADE BROUGHMAN  
Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
101 Page Street

City or town, state or province, country, and ZIP or foreign postal code  
New Bedford, MA 02740

**D** Employer identification number  
22-2592333

**E** Telephone number  
(508) 961-5000

**G** Gross receipts \$ 1,114,810,440

**F** Name and address of principal officer:  
KEITH HOVAN  
101 PAGE STREET  
New Bedford, MA 02740

**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.southcoast.org](http://www.southcoast.org)

**K** Form of organization:  Corporation  Trust  Association  Other ▶

**L** Year of formation: 1986 **M** State of legal domicile: MA

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities:  
TO PROMOTE THE OPTIMAL HEALTH AND WELL- BEING OF THE INDIVIDUALS AND FAMILIES IN THE COMMUNITIES SERVED BY SOUTHCOAST HOSPITALS GROUP (SHG).(SEE SCHEDULE O)

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	17
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	13
<b>5</b> Total number of individuals employed in calendar year 2019 (Part V, line 2a)	6,823
<b>6</b> Total number of volunteers (estimate if necessary)	456
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	612,953
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 39	458,903

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	1,840,686	72,972,069
<b>9</b> Program service revenue (Part VIII, line 2g)	879,351,128	843,691,353
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	15,939,874	19,422,490
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	210,473	710,890
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	897,342,161	936,796,802
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	196,750	906,278
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	429,289,873	429,041,200
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	100,000	100,000
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 1,366,710		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	393,109,637	408,932,272
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	822,696,260	838,979,750
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	74,645,901	97,817,052
	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	965,442,251	1,213,595,255
<b>21</b> Total liabilities (Part X, line 26)	390,128,567	550,168,256
<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	575,313,684	663,426,999

**Part II Signature Block**

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

**Sign Here**

Signature of officer: \_\_\_\_\_ Date: 2021-08-16

WADE BROUGHMAN EXEC VP FIN & CFO  
Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: \_\_\_\_\_ Preparer's signature: \_\_\_\_\_ Date: 2021-08-04

Check  if self-employed PTIN: P01441612

Firm's name ▶ PricewaterhouseCoopers LLP Firm's EIN ▶ \_\_\_\_\_

Firm's address ▶ 101 SEAPORT BLVD SUITE 500  
BOSTON, MA 02210 Phone no. (617) 530-5000

**Part III Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission:

TO PROMOTE THE OPTIMAL HEALTH AND WELL-BEING OF THE INDIVIDUALS AND FAMILIES IN THE COMMUNITIES SERVED BY SOUTHCOAST HOSPITALS GROUP (SHG). (SEE SCHEDULE O)

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?  Yes  No

If "Yes," describe these new services on Schedule O.

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services?  Yes  No

If "Yes," describe these changes on Schedule O.

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

**4a** (Code: ) (Expenses \$ 670,607,506 including grants of \$ 906,278 ) (Revenue \$ 843,691,353 )  
See Additional Data

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

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

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

**4e** Total program service expenses ▶ 670,607,506

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response. Rows include questions 1 through 21, covering various organizational requirements and reporting obligations.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

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

Table with 3 columns: Question, Yes, No. Rows 1a-1c regarding Form 1096, Forms W-2G, and backup withholding rules.

**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 . . . . .	<b>2a</b>	6,823		
<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)	<b>2b</b>	Yes		
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	<b>3a</b>	Yes		
<b>b</b> If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O . . . . .</i>	<b>3b</b>	Yes		
<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>4a</b>		No	
<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).				
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	<b>5a</b>		No	
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<b>5b</b>		No	
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .	<b>5c</b>			
<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? . . . . .	<b>6a</b>		No	
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	<b>6b</b>			
<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? . . . . .	<b>7a</b>	Yes		
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<b>7b</b>	Yes		
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	<b>7c</b>		No	
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<b>7d</b>			
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<b>7e</b>		No	
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .	<b>7f</b>		No	
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	<b>7g</b>			
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	<b>7h</b>			
<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>8</b>			
<b>9 Sponsoring organizations maintaining donor advised funds.</b>				
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	<b>9a</b>			
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .	<b>9b</b>			
<b>10 Section 501(c)(7) organizations.</b> Enter:				
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<b>10a</b>			
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<b>10b</b>			
<b>11 Section 501(c)(12) organizations.</b> Enter:				
<b>a</b> Gross income from members or shareholders . . . . .	<b>11a</b>			
<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.) . . . . .	<b>11b</b>			
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?				
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	<b>12b</b>			
<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.	<b>13a</b>			
<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 . . . . .	<b>13b</b>			
<b>c</b> Enter the amount of reserves on hand . . . . .	<b>13c</b>			
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<b>14a</b>		No	
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O . . . . .</i>	<b>14b</b>			
<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.	<b>15</b>	Yes		
<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.	<b>16</b>		No	

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



Section A. Governing Body and Management

Table with 5 columns: Question ID, Question Text, Answer, Yes, No. Rows include 1a (17), 1b (13), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 5 columns: Question ID, Question Text, Answer, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MA
18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records: WADE BROUGHMAN 101 PAGE STREET New Bedford, MA 02740 (508) 973-2905

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

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

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

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

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

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

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(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										

**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>1c Total from continuation sheets to Part VII, Section A</b>										
<b>1d Total (add lines 1b and 1c)</b>							7,651,348	1,788,657	1,224,255	

**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 ▶ 694

	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>	3 Yes	
<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>	4 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>	5	No

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
EPIC SYSTEMS CORPORATION, 1979 MILKY WAY VERONA, WI 53593	IT SYSTEM CONSULTANT	4,768,260
NORTH AMERICAN PARTNERS IN ANESTHESIA, 68 SOUTH SERVICE ROAD MELVILLE, NY 11747	ANESTHESIA SERVICES	10,748,321
SHAWMUT WOODWORKING AND SUPPLY INC, 560 HARRISON AVENUE BOSTON, MA 02118	CONSTRUCTION	3,972,914
QUEST DIAGNOSTICS, PO BOX 740709 ATLANTA, GA 30374	LAB SERVICES	2,938,320
ROBINSON COLE LLP, 280 TRUMBULL STREET HARTFORD, CT 06103	LEGAL SERVICES	3,277,491

**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 ▶ 184



**Part VIII Statement of Revenue**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b>	721		
	<b>d</b> Related organizations . . . . .	<b>1d</b>	114,981		
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>	70,062,588		
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	2,793,779		
	<b>g</b> Noncash contributions included in lines 1a - 1f:\$ . . . . .	<b>1g</b>	272,635		
	<b>h Total.</b> Add lines 1a-1f . . . . .		72,972,069		

<b>Program Service Revenue</b>			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
		Business Code				
<b>2a</b> PATIENT SVC REVENUE		621500	777,872,627	777,772,716	99,911	
<b>b</b> HEALTHCARE SVC REVENUE		446110	58,714,597	58,709,950	4,647	
<b>c</b> PARTNERSHIP INCOME		525990	1,901,871		508,395	1,393,476
<b>d</b> GIFT SHOP INCOME		621400	215,309			215,309
<b>e</b> CAFETERIA		722210	3,261,277	3,261,277		
<b>f</b> All other program service revenue.			1,725,672			1,725,672
<b>g Total.</b> Add lines 2a-2f. . . . .			843,691,353			

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			6,016,412			6,016,412	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0				
	<b>5</b> Royalties . . . . .			0				
	<b>6a</b> Gross rents	<b>6a</b>	(i) Real					
			(ii) Personal					
				904,662				
	<b>b</b> Less: rental expenses . . . . .	<b>6b</b>		215,075				
	<b>c</b> Rental income or (loss) . . . . .	<b>6c</b>		689,587	0			
	<b>d</b> Net rental income or (loss) . . . . .			689,587			689,587	
	<b>7a</b> Gross amount from sales of assets other than inventory	<b>7a</b>	(i) Securities					
			(ii) Other		26,488			
				191,166,457				
	<b>b</b> Less: cost or other basis and sales expenses . . . . .	<b>7b</b>		176,528,214	1,258,652			
	<b>c</b> Gain or (loss) . . . . .	<b>7c</b>		14,638,243	-1,232,164			
	<b>d</b> Net gain or (loss) . . . . .			13,406,078			13,406,078	
	<b>8a</b> Gross income from fundraising events (not including \$ 721 of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>8a</b>			33,000			
			<b>b</b> Less: direct expenses . . . . .	<b>8b</b>		11,697		
			<b>c</b> Net income or (loss) from fundraising events . . . . .			21,303		21,303
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>9a</b>			0				
		<b>b</b> Less: direct expenses . . . . .	<b>9b</b>		0			
		<b>c</b> Net income or (loss) from gaming activities . . . . .			0		0	
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>10a</b>			0				
		<b>b</b> Less: cost of goods sold . . . . .	<b>10b</b>		0			
		<b>c</b> Net income or (loss) from sales of inventory . . . . .			0		0	
<b>11a</b> Miscellaneous Revenue		Business Code						
<b>b</b>								
<b>c</b>								
<b>d</b> All other revenue . . . . .								
<b>e Total.</b> Add lines 11a-11d . . . . .				0				
<b>12 Total revenue.</b> See instructions . . . . .				936,796,802	839,743,943	612,953	23,467,837	

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	906,278	906,278		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .	0			
<b>4</b> Benefits paid to or for members . . . . .	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	5,198,199	4,117,932	1,070,418	9,849
<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) . . . . .	182,564	144,899	37,665	0
<b>7</b> Other salaries and wages . . . . .	336,360,399	266,463,617	69,259,103	637,679
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	14,972,932	12,428,521	2,506,885	37,526
<b>9</b> Other employee benefits . . . . .	48,199,347	40,211,507	7,867,277	120,563
<b>10</b> Payroll taxes . . . . .	24,127,759	20,108,490	3,958,555	60,714
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .	0			
<b>b</b> Legal . . . . .	4,424,200	357,547	4,066,653	
<b>c</b> Accounting . . . . .	691,950		691,950	
<b>d</b> Lobbying . . . . .	176,635	5,731	170,904	
<b>e</b> Professional fundraising services. See Part IV, line 17	100,000			100,000
<b>f</b> Investment management fees . . . . .	585,492		585,492	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	82,862,398	66,907,819	15,886,861	67,718
<b>12</b> Advertising and promotion . . . . .	3,141,668	148,830	2,989,927	2,911
<b>13</b> Office expenses . . . . .	7,022,030	3,084,028	3,895,623	42,379
<b>14</b> Information technology . . . . .	15,100,861	2,106,982	12,961,983	31,896
<b>15</b> Royalties . . . . .	0			
<b>16</b> Occupancy . . . . .	16,714,887	4,704,940	12,009,947	
<b>17</b> Travel . . . . .	974,988	750,925	222,282	1,781
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0			
<b>19</b> Conferences, conventions, and meetings . . . . .	113,359	31,989	79,371	1,999
<b>20</b> Interest . . . . .	7,089,134	7,089,134		
<b>21</b> Payments to affiliates . . . . .	0			
<b>22</b> Depreciation, depletion, and amortization . . . . .	55,067,520	42,384,562	12,660,434	22,524
<b>23</b> Insurance . . . . .	2,950,146		2,950,146	
<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> PHARMACEUTICALS	80,756,336	80,756,115		221
<b>b</b> HEALTH SAFETY NET ASSESSMENT	7,902,828	7,902,828		
<b>c</b> PARTS AND REPAIRS	12,673,296	3,212,654	9,460,274	368
<b>d</b> MEDICAL SUPPLIES/LINENS	93,686,093	93,338,376	336,786	10,931
<b>e</b> All other expenses	16,998,451	13,443,802	3,336,998	217,651
<b>25</b> Total functional expenses. Add lines 1 through 24e	838,979,750	670,607,506	167,005,534	1,366,710
<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 . . . . .	0	<b>1</b>	0
	<b>2</b> Savings and temporary cash investments . . . . .	43,221,048	<b>2</b>	119,002,976
	<b>3</b> Pledges and grants receivable, net . . . . .	2,666,656	<b>3</b>	2,687,845
	<b>4</b> Accounts receivable, net . . . . .	94,997,684	<b>4</b>	73,025,028
	<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 . . . . .	0	<b>5</b>	0
	<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) . . . . .	0	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	14,533,382	<b>8</b>	17,122,174
	<b>9</b> Prepaid expenses and deferred charges . . . . .	11,556,297	<b>9</b>	10,812,782
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 891,767,305		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 544,354,070	352,241,516	<b>10c</b> 347,413,235
	<b>11</b> Investments—publicly traded securities . . . . .	337,651,657	<b>11</b>	494,124,465
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	64,863,106	<b>12</b>	69,735,270
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .	0	<b>13</b>	0
	<b>14</b> Intangible assets . . . . .	0	<b>14</b>	0
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	43,710,905	<b>15</b>	79,671,480
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	965,442,251	<b>16</b>	1,213,595,255	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	137,854,816	<b>17</b>	284,316,003
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b> Tax-exempt bond liabilities . . . . .	166,518,353	<b>20</b>	159,242,543
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D	0	<b>21</b>	0
	<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 . . . . .	0	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	51,487,266	<b>23</b>	45,147,333
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<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	34,268,132	<b>25</b>	61,462,377
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	390,128,567	<b>26</b>	550,168,256
<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 . . . . .	496,506,079	<b>27</b>	580,944,505
	<b>28</b> Net assets with donor restrictions . . . . .	78,807,605	<b>28</b>	82,482,494
	<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> Total net assets or fund balances . . . . .	575,313,684	<b>32</b>	663,426,999	
<b>33</b> Total liabilities and net assets/fund balances . . . . .	965,442,251	<b>33</b>	1,213,595,255	

**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>	936,796,802
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	838,979,750
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	97,817,052
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	575,313,684
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	-40,352,196
<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>	30,648,459
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	663,426,999

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990:  Cash  Accrual  Other \_\_\_\_\_  
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?  
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?  
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 22-2592333

**Name:** Southcoast Hospitals Group Inc

Form 990 (2019)

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

SOUTHCOAST PROVIDES INPATIENT AND OUTPATIENT HEALTH CARE SERVICES TO IMPROVE THE HEALTH AND WELLNESS OF INDIVIDUALS IN ITS COMMUNITIES. SOUTHCOAST RECORDED 190,634 INPATIENT DAYS, PERFORMED 15,408 SURGERIES AND 8,280 ENDOSCOPIES, PROVIDED 2,811,586 LABORATORY TESTS, PERFORMED 361,306 RADIOLOGICAL PROCEDURES, 164,465 PHYSICAL MEDICINE VISITS, 721 PCI CORONARY INTERVENTIONS, 1,916 DIAGNOSTIC CATHERIZATIONS, 282 OPEN HEART SURGERIES, 1,194 ELECTROPHYSIOLOGY CASES, 461 CORONARY DEVICE IMPLANTS, 2,992 NEWBORN ADMISSIONS, PERFORMED 35,599 RADIATION AND MEDICAL CHEMOTHERAPY TREATMENTS AND CARED FOR 155,586 EMERGENCY ROOM PATIENTS 24 HOURS A DAY 7 DAYS A WEEK REGARDLESS OF THEIR ABILITY TO PAY FOR SUCH SERVICES. IN FY2020 SHG HAD 3,400 COVID INTERACTIONS, MADE UP OF 512 INPATIENT DISCHARGES AND 2,888 OP VISITS.

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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			
KEITH HOVAN ..... PRESIDENT & CEO	60.0 ..... 12.5	X		X				2,211,564	0	342,254
ROBERT CALDAS MD ..... Senior VP & CMO(until 10/2019)	60.0 ..... 0.0				X			942,604	0	110,293
WADE BROUGHMAN ..... EVP FIN/CFO & Treasurer	60.0 ..... 12.5			X				869,813	0	139,019
RENEE CLARK ..... SVP/COO (SHG)/ ASST. CLERK	60.0 ..... 12.5			X				829,794	0	152,556
MICHAEL BARRETTI DO ..... EX-OFFICIO (UNTIL 12/2019)	1.5 ..... 44.5	X						0	739,028	29,539
LAUREN DESIMON JOHNSON ..... SVP/ CHRO	60.0 ..... 0.0				X			553,426	0	80,628
MICHAEL COFONE ..... SVP FINANCE	60.0 ..... 0.0					X		509,018	0	102,456
JAMES FEEN ..... SVP/CIO	60.0 ..... 0.0					X		495,411	0	33,257
STEPHEN CANESSA ..... SVP CHIEF BRAND STRATEGY OFFCR	60.0 ..... 0.0					X		412,457	0	93,066
CHRISTOPHER CHENEYMD ..... TRUSTEE (UNTIL 12/2019)	1.5 ..... 44.5	X						0	368,041	16,010

**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			
JAY S SCHACHNE MD ..... TRUSTEE (AS OF 1/2020)	1.5 ..... 44.5	X						0	349,891	23,910
GEORGINA NOUAIME MD ..... TRUSTEE (AS OF 1/2020)	1.5 ..... 46.0	X						0	331,697	29,856
JACK DRESSER ..... SVP/CPO (UNTIL 10/2019)	60.0 ..... 0.0					X		328,647	0	28,704
TONYA JOHNSON ..... VP OPERATIONS	60.0 ..... 0.0					X		308,838	0	38,857
DAVID DEJESUS JR ..... FORMER SVP & CHRO	0.0 ..... 0.0						X	182,876	0	3,850
JOHN LENTINI MD ..... TRUSTEE (UNTIL 12/2019)	1.5 ..... 4.5	X						6,200	0	0
SALMAN BASHIR MD ..... TRUSTEE	1.5 ..... 6.0	X						700	0	0
PAMELA MCNAMARA ..... TRUSTEE (UNTIL 12/2019)	1.5 ..... 4.5	X						0	0	0
ROBERT TRIPP JR DO ..... TRUSTEE	1.5 ..... 4.5	X						0	0	0
JASON RUA ..... TRUSTEE	1.5 ..... 7.0	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			
LOUIS CABRAL ..... CHAIR	2.5 ..... 9.0	X		X				0	0	0
JAMES JEROME COOGAN ..... Clerk	2.5 ..... 7.5	X		X				0	0	0
W HUGH M MORTON ..... Trustee	1.5 ..... 4.5	X						0	0	0
DENNIS J FUSCO ..... Trustee	1.5 ..... 4.5	X						0	0	0
DONALD G GIUMETTI ..... VICE CHAIR (AS OF 1/2020)	2.5 ..... 10.0	X		X				0	0	0
ELIZABETH HUIDEKOPER ..... TRUSTEE	1.5 ..... 6.0	X						0	0	0
CHRISTOPHER HODGSON ..... TRUSTEE	1.5 ..... 4.5	X						0	0	0
HELENA DASILVA HUGHES ..... TRUSTEE	1.5 ..... 4.5	X						0	0	0
JONATHAN L ROUNDS ..... TRUSTEE (AS OF 1/2020)	1.5 ..... 4.5	X						0	0	0
HEIDI A KOSTIN ..... TRUSTEE (AS OF 1/2020)	1.5 ..... 4.5	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			
CARMEN F SYLVESTER ..... TRUSTEE (AS OF 1/2020)	1.5 ..... 4.5	X						0	0	0

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

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

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

Department of the Treasury  
 Internal Revenue Service

**Name of the organization**  
 Southcoast Hospitals Group Inc

**Employer identification number**  
 22-2592333

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

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

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

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

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

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

**Section A. Public Support**

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
<b>7</b>	Amounts from line 4. . .						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
<b>10</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13</b>	<b>First five 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 2019 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>	
<b>15</b>	Public support percentage for 2018 Schedule A, Part II, line 14 . . . . .	<b>15</b>	
<b>16a</b>	<b>33 1/3% support test—2019.</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—2018.</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—2019.</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—2018.</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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b>	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b>	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
<b>c</b>	Add lines 7a and 7b. . . . .						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

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

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

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

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

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

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

**19a 33 1/3% support tests—2019.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . .

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

		Yes	No
<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 Part VI 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 Part VI 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 (b) and (c) 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 Part VI 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 Part VI 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 12a or 12b in Part I, answer (b) and (c) 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 Part VI 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 Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</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 (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</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 Part VI.</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 Part VI.</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 Part VI.</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 Part VI.</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
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
<b>b</b>	A family member of a person described in (a) above?		
<b>c</b>	A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i>		

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally-Integrated Supporting Organizations**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> ):		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions)		
<b>2</b>	Activities Test. <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	Yes	No
<b>b</b>	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>3</b>	Parent of Supported Organizations. <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>b</b>	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

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

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

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

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



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 22-2592333

**Name:** Southcoast Hospitals Group Inc

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

**Facts And Circumstances Test**

**SCHEDULE 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  
  
**2019**  
**Open to Public Inspection**

**If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

**If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

**If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then**

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization Southcoast Hospitals Group Inc	Employer identification number 22-2592333
--	--

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

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

**2** Political campaign activity expenditures (see instructions) ..... ▶ \$ \_\_\_\_\_

**3** Volunteer hours for political campaign activities (see instructions) .....

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

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

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

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

**4a** Was a correction made? .....  Yes  No

**b** If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

- A** Check  if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check  if the filing organization checked box A and "limited control" provisions apply.

**Limits on Lobbying Expenditures**  
**(The term "expenditures" means amounts paid or incurred.)**

**(a)** Filing organization's totals      **(b)** Affiliated group totals

- 1a** Total lobbying expenditures to influence public opinion (grass roots lobbying) .....
- b** Total lobbying expenditures to influence a legislative body (direct lobbying) .....
- c** Total lobbying expenditures (add lines 1a and 1b) .....
- d** Other exempt purpose expenditures .....
- e** Total exempt purpose expenditures (add lines 1c and 1d) .....
- f** Lobbying nontaxable amount. Enter the amount from the following table in both columns.

<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.

- g** Grassroots nontaxable amount (enter 25% of line 1f) .....
- h** Subtract line 1g from line 1a. If zero or less, enter -0- .....
- i** Subtract line 1f from line 1c. If zero or less, enter -0- .....
- j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?  Yes  No

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

**Lobbying Expenditures During 4-Year Averaging Period**

Calendar year (or fiscal year beginning in)	<b>(a)</b> 2016	<b>(b)</b> 2017	<b>(c)</b> 2018	<b>(d)</b> 2019	<b>(e)</b> 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? .....	Yes		30
<b>e</b> Publications, or published or broadcast statements? .....		No	
<b>f</b> Grants to other organizations for lobbying purposes? .....		No	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body? .....	Yes		176,805
<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 .....			176,835
<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>a</b> Current year .....	<b>2a</b>	
<b>b</b> Carryover from last year .....	<b>2b</b>	
<b>c</b> Total .....	<b>2c</b>	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	<b>3</b>	
<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, LOBBYING ACTIVITIES	DURING FISCAL YEAR 2020, SOUTHCOAST RETAINED SEPARATE CONSULTANTS AT THE STATE AND FEDERAL LEVEL TO MONITOR HEALTH CARE RELATED ISSUES AND ADVOCATE ON BEHALF OF SOUTHCOAST HEALTH. AT THE STATE LEVEL, OUR STATE CONSULTANTS WORKED WITH OUR LEGISLATIVE DELEGATION ON THE SENATE AND HOUSE HEALTH CARE REFORM BILL, THE STATE BUDGET AND BUDGET AMENDMENTS, REGULATORY CHANGES, MEDICAID/DSH REIMBURSEMENT RATES, THE SOCIAL DETERMINANTS OF HEALTH, AND THE COVID-19 PANDEMIC. OUR CONSULTANT FOR FEDERAL MATTERS WORKED WITH OUR FEDERAL DELEGATION ON MEDICARE DSH FUNDING, THE RURAL FLOOR WAGE INDEX, CHANGES TO THE AFFORDABLE CARE ACT, PREVENTING MEDICARE CUTS, 340B AND CARES ACT FUNDING.
PART II-B, LINE 1D	DURING FISCAL YEAR 2020, ALL MAILINGS WERE SENT ELECTRONICALLY VIA EMAIL. THERE WERE NO PAPER MAILINGS SENT OUT.
PART II-B, LINE 1G	DURING FISCAL YEAR 2020, OUR STATE CONSULTANTS MONITORED AND COMMUNICATED WITH OUR STATE LEGISLATIVE DELEGATION REGARDING THE SENATE AND HOUSE HEALTH CARE REFORM BILLS, AND THE STATE BUDGET AND BUDGET AMENDMENTS. THEY ALSO MONITORED AND/OR SHARED SOUTHCOAST'S CONCERNS ON TOPICAL HEALTHCARE ISSUES, MEDICAID FUNDING/REIMBURSEMENTS, AND BEHAVIORAL HEALTH NEEDS, INCLUDING FUNDING, ACCESS AND COVERAGE IN OUR REGION AND THE COVID-19 PANDEMIC.

**SCHEDULE D**  
(Form 990)  
  
Department of the Treasury  
Internal Revenue Service

# Supplemental Financial Statements

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

▶ 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.

**Name of the organization**  
Southcoast Hospitals Group Inc

**Employer identification number**  
22-2592333

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

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

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

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

**4** Number of states where property subject to conservation easement is located ▶ \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

**a** Revenue included on Form 990, Part VIII, line 1 . . . . . ▶ \$ \_\_\_\_\_

**b** Assets included in Form 990, Part X . . . . . ▶ \$ \_\_\_\_\_

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

**Part V Endowment Funds.**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	78,807,606	81,441,455	76,128,987	70,838,207	70,276,136
<b>b</b> Contributions . . . . .	2,071,400	937,387	4,163,541	1,482,353	5,817,717
<b>c</b> Net investment earnings, gains, and losses	5,949,361	2,768,034	4,588,968	7,299,084	2,564,977
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .	4,345,872	6,339,270	3,440,041	3,490,657	7,820,623
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	82,482,495	78,807,606	81,441,455	76,128,987	70,838,207

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a** Board designated or quasi-endowment ▶ 0 %
  - b** Permanent endowment ▶ 66.000 %
  - c** Temporarily restricted endowment ▶ 34.000 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- |  | Yes              | No |
|--|------------------|----|
| <b>(i)</b> unrelated organizations . . . . .   | <b>3a(i)</b> Yes | No |
| <b>(ii)</b> related organizations . . . . .  | <b>3a(ii)</b>    | No |
| <b>b</b> If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . | <b>3b</b>        |    |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		10,196,962		10,196,962
<b>b</b> Buildings . . . . .		433,870,554	274,768,271	159,102,283
<b>c</b> Leasehold improvements		2,841,481	1,493,845	1,347,636
<b>d</b> Equipment . . . . .		417,313,743	268,091,954	149,221,789
<b>e</b> Other . . . . .		27,544,565	0	27,544,565
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				347,413,235

**Part VII Investments—Other Securities.**

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A) CASH INVESTMENTS	1,782,677	F
(B) PRIVATE EQUITY	8,913,850	F
(C) MULTISTRATEGY HEDGE FUNDS	15,733,788	F
(D) BENEFICIAL INT IN PERP TRUSTS	43,304,955	F
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.)	69,735,270	

**Part VIII Investments—Program Related.**

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

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

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1) OTHER ASSETS	22,899,798
(2) DUE FROM AFFILIATES	23,785,299
(3) OTHER RECEIVABLES	4,294,876
(4) RIGHT OF USE ASSETS OPERATING	26,187,064
(5) RIGHT OF USE ASSETS FINANCING	2,447,782
(6) UNBILLED RECEIVABLES	56,661
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 15.)	79,671,480

**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	0
(2) OTHER LONG-TERM LIABILITIES	20,999,841
(3) NON-PENSION POST RETIREMENT BE	7,485,082
(4) DUE TO/FROM AFFILIATE	5,256,741
(5) UNAMORTIZED BIC	-2,580,627
(6) ACCUMULATED AMORT BIC	1,186,922
(7) LEASE LIABILITY OPERATING	26,625,240
(8) LEASE LIABILITY FINANCING	2,489,178
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 25.)	61,462,377

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

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

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

<b>1</b>	Total revenue, gains, and other support per audited financial statements . . . . .		<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
<b>a</b>	Net unrealized gains (losses) on investments . . . . .	<b>2a</b>		
<b>b</b>	Donated services and use of facilities . . . . .	<b>2b</b>		
<b>c</b>	Recoveries of prior year grants . . . . .	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII.) . . . . .	<b>2d</b>		
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .		<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .		<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line <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:** 22-2592333

**Name:** Southcoast Hospitals Group Inc

## Supplemental Information

Return Reference	Explanation
PART V, LINE 4	SHG'S ENDOWMENT FUNDS ARE INTENDED TO PROVIDE A SOURCE OF INCOME TO SUPPORT SHG'S TAX EXEMPT PURPOSE OF PROVIDING QUALITY HEALTH CARE SERVICES TO PEOPLE IN SHG'S SERVICE AREA.

## Supplemental Information

Return Reference	Explanation
PART X, LINE 2	SHG ADOPTED FIN48 IN FISCAL YEAR 2008. THERE IS NO FOOTNOTE DISCLOSURE IN SHS' FISCAL SEPT EMBER 30, 2020 CONSOLIDATED AUDITED FINANCIAL STATEMENTS SINCE THE ADOPTION OF FIN 48 WAS NOT MATERIAL.

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

Department of the Treasury  
Internal Revenue Service

**Supplemental Information Regarding  
Fundraising or Gaming Activities**

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.  
▶ 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

**2019**

**Open to Public Inspection**

Name of the organization  
Southcoast Hospitals Group Inc

**Employer identification number**  
22-2592333

**Part I Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

- 1** Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- |   |  |
|---|--|
| <b>a</b> <input checked="" type="checkbox"/> Mail solicitations               | <b>e</b> <input checked="" type="checkbox"/> Solicitation of non-government grants |
| <b>b</b> <input checked="" type="checkbox"/> Internet and email solicitations | <b>f</b> <input checked="" type="checkbox"/> Solicitation of government grants     |
| <b>c</b> <input checked="" type="checkbox"/> Phone solicitations              | <b>g</b> <input checked="" type="checkbox"/> Special fundraising events            |
| <b>d</b> <input checked="" type="checkbox"/> In-person solicitations          |  |
- 2a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services?  Yes  No
- b** If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
HANOVER RESEARCH COUNCIL 4401 wilson blvd  arlington, VA 22203	GRANT WRITING		No	0	100,000	
<b>Total</b>				0	100,000	

**3** List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

MA

**Part II Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		<b>SPORTS EVENT</b> (event type)	(event type)	<b>0</b> (total number)	(add col. (a) through col. (c))
<b>Revenue</b>	<b>1</b> Gross receipts . . . . .	33,721			33,721
	<b>2</b> Less: Contributions . . . . .	721			721
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	33,000			33,000
<b>Direct Expenses</b>	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .	1,161			1,161
	<b>6</b> Rent/facility costs . . . . .	6,337			6,337
	<b>7</b> Food and beverages . . . . .	3,846			3,846
	<b>8</b> Entertainment . . . . .				
	<b>9</b> Other direct expenses . . . . .	353			353
	<b>10</b> Direct expense summary. Add lines 4 through 9 in column (d) . . . . . ▶				11,697
	<b>11</b> Net income summary. Subtract line 10 from line 3, column (d) . . . . . ▶				21,303

**Part III Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col.(a) through col.(c))
		<b>1</b> Gross revenue . . . . .			
<b>Direct Expenses</b>	<b>2</b> Cash prizes . . . . .				
	<b>3</b> Noncash prizes . . . . .				
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .				
	<b>6</b> Volunteer labor . . . . .	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	<b>7</b> Direct expense summary. Add lines 2 through 5 in column (d) . . . . . ▶				
	<b>8</b> Net gaming income summary. Subtract line 7 from line 1, column (d) . . . . . ▶				

**9** Enter the state(s) in which the organization conducts gaming activities: \_\_\_\_\_

**a** Is the organization licensed to conduct gaming activities in each of these states? . . . . .  Yes  No

**b** If "No," explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**10a** Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? . . . . .  Yes  No

**b** If "Yes," explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- 11** Does the organization conduct gaming activities with nonmembers?  Yes  No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13** Indicate the percentage of gaming activity conducted in:
 

<b>a</b> The organization's facility	<b>13a</b>	%
<b>b</b> An outside facility	<b>13b</b>	%

**14** Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ .....

Address ▶ .....

**15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue?  Yes  No

**b** If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_.

**c** If "Yes," enter name and address of the third party:

Name ▶ .....

Address ▶ .....

**16** Gaming manager information:

Name ▶ .....

Gaming manager compensation ▶ \$ .....

Description of services provided ▶ .....

- Director/officer                       Employee                       Independent contractor

**17** Mandatory distributions:

**a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?  Yes  No

**b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ \_\_\_\_\_

**Part IV Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

Return Reference	Explanation
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**SCHEDULE H (Form 990)**  
 Department of the Treasury  
 Internal Revenue Service

**Hospitals**

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

**Name of the organization**  
 Southcoast Hospitals Group Inc

**Employer identification number**  
 22-2592333

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

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

		Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input checked="" type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<b>3a</b>	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<b>3b</b>	Yes	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? . . . . .	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? . . . . .	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	<b>5b</b>	Yes	
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? . . . . .	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public? . . . . .	<b>6b</b>	Yes	

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**

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			9,782,438	3,434,901	6,347,537	0.760 %
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			184,591,627	160,199,245	24,392,382	2.910 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			194,374,065	163,634,146	30,739,919	3.670 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4). . . . .			21,760,071	390,005	21,370,066	2.550 %
<b>f</b> Health professions education (from Worksheet 5) . . . . .			4,481,949	0	4,481,949	0.530 %
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			5,688,442	1,723,242	3,965,200	0.470 %
<b>h</b> Research (from Worksheet 7) . . . . .						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			637,186	0	637,186	0.080 %
<b>j Total.</b> Other Benefits . . . . .			32,567,648	2,113,247	30,454,401	3.630 %
<b>k Total.</b> Add lines 7d and 7j . . . . .			226,941,713	165,747,393	61,194,320	7.300 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing	1		369,110	0	369,110	0.040 %
2 Economic development						
3 Community support			143,250	0	143,250	0.020 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	2		7,295	0	7,295	0 %
7 Community health improvement advocacy			41,480	0	41,480	0 %
8 Workforce development						
9 Other						
<b>10 Total</b>	<b>3</b>		<b>561,135</b>	<b>0</b>	<b>561,135</b>	<b>0.060 %</b>

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

**Section A. Bad Debt Expense**

		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	8,851,433
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	5,252,678
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

**Section B. Medicare**

5	Enter total revenue received from Medicare (including DSH and IME)	5	371,700,734
6	Enter Medicare allowable costs of care relating to payments on line 5	6	415,792,521
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-44,091,787
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input checked="" type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Yes

**Part IV Management Companies and Joint Ventures**

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



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

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

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

1

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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): \_\_\_\_\_

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>6b</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 . . . . .	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):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SCHEDULE H, PART V, SECTION C</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 checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>SEE SCHEDULE H, PART V, SECTION C</u>	Yes	
<b>10b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

SOUTHCOAST HOSPITALS GROUP INC

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE SCH H, PART V, SECT C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE SCH H, PART V, SECT C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE SCH H, PART V, SECT C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

SOUTHCOAST HOSPITALS GROUP INC

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

		Yes	No
<b>17</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	17	Yes
<b>18</b>	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP: <b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b>	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged: <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)	19	No
<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 type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b>	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . . If "No," indicate why: <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)	21	Yes
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**Part V Facility Information** *(continued)*

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

SOUTHCOAST HOSPITALS GROUP INC

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

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

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

Name and address	Type of Facility (describe)
<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>	

**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 3C	DISCOUNTS ARE AFFORDED TO A "QUALIFYING PATIENT" - PATIENT WHO IS NOT ELIGIBLE FOR OTHER FINANCIAL ASSISTANCE AND WHO IS UNINSURED FOR MEDICALLY NECESSARY HOSPITAL SERVICES. ELIGIBLE BALANCES ARE THOSE AMOUNTS FOR WHICH QUALIFYING PATIENTS HAVE FULL RESPONSIBILITY DUE TO LACK OF INSURANCE. OBLIGATIONS DO NOT INCLUDE CO-INSURANCE, DEDUCTIBLES OR BALANCES DUE AFTER INSURANCE OR OUT-OF-NETWORK SERVICES. A DISCOUNT OF 25% OF THE TOTAL CHARGES WILL BE APPLIED AT THE TIME OF INITIAL BILLING. ADDITIONAL DISCOUNTS MAY BE POSSIBLE BASED ON THE SIZE OF THE BALANCE, TIMELINESS OF PAYMENT AND FINANCIAL NEED. THESE ARE GIVEN INDIVIDUAL CONSIDERATION. SHG WILL SEEK TO ADVISE QUALIFYING PATIENTS WITH RESPECT TO AVAILABILITY OF DISCOUNT PURSUANT TO THIS POLICY AS WELL AS THE AVAILABILITY OF LOW INCOME AND MASSHEALTH BENEFITS.



## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	ACTUAL COST FOR ALL SHG PATIENT SEGMENTS WAS USED TO CALCULATE THE VALUE OF CHARITY CARE.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G	INCLUDED IN SUBSIDIZED HEALTH SERVICES AT COST ARE COSTS AND OFFSETTING REVENUES ASSOCIATED WITH SHG'S LEVEL II NURSERY AND INPATIENT REHABILITATIVE SERVICES. SHG IS THE SOLE PROVIDER OF THESE SERVICES IN ITS COMMUNITIES AND PROVIDES SUCH SERVICES AS A COMMUNITY BENEFIT DESPITE THE LOSSES INCURRED.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II	<p>Southcoast engages in a number of community building activities that promote infrastructure improvement in communities and the development of policies and programs that address social determinants of health such as housing, behavioral health, education and workforce development. Southcoast is the co-leader of the Bristol County Opioid Alliance, a regional coalition focused on increasing communication and collaboration of all entities working to address the Opioid Epidemic across the South Coast Region. We also lead collaborative groups that have helped expand housing options in the town of Wareham and the city of New Bedford and address groups that address other social conditions that influence health. Southcoast has provided leadership training and support on health advocacy issues such as regulations to limit tobacco access and has worked to increase access to healthy food through food rescue programs, through supporting local initiatives led by community partners. Due to the COVID-19 pandemic the hosting of weekly farm stands at our three hospital sites to benefit employees and other community members was discontinued. However, Southcoast was still able to support mobile markets in the community via donations as well helping them with promotion.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 2	THE COSTING METHODOLOGY USED TO CALCULATE BAD DEBT EXPENSE REPORTED IN PART III, LINE 2 WAS BASED ON A RATIO OF COST TO CHARGE METHODOLOGY. DISCOUNTS AND PAYMENTS ON ACCOUNTS CONSIDERED AS BAD DEBT OFFSET THE TOTAL BAD DEBT EXPENSE RECORDED. PART III, LINE 3 PER SHG'S ASSESSMENT OF THE COMMUNITY IT SERVES, A CERTAIN PERCENTAGE OF THE POPULATION WOULD QUALIFY FOR FINANCIAL ASSISTANCE BUT DO NOT APPLY. DUE TO THIS SHG CONSIDERS THIS AMOUNT OF BAD DEBT AS A COMMUNITY BENEFIT EXPENSE. PART III, LINE 4 FOR PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, SHG RECOGNIZES REVENUE ON THE BASIS OF ITS STANDARD RATES FOR SERVICES PROVIDED BY POLICY. ON THE BASIS OF HISTORICAL EXPERIENCE, A PORTION OF SHG'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED. THUS, SHG RECORDS A PROVISION FOR BAD DEBTS RELATED TO UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED. FOOTNOTE 1 (PAGE 8) OF THE AUDITED FINANCIAL STATEMENTS DESCRIBES THE BAD DEBT EXPENSE.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	THE COST ACCOUNTING METHODOLOGY USED IS THE SAME METHODOLOGY USED FOR THE MEDICARE SHORTFALL. THE MEDICARE SHORTFALL SHOULD BE RECOGNIZED AS A COMMUNITY BENEFIT SINCE SHG IS REQUIRED TO PROVIDE SERVICES TO ALL REGARDLESS OF THE ABILITY TO PAY FOR SUCH SERVICES.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B	<p>SHG'S CREDIT AND COLLECTION POLICY CONTAINS PROVISIONS REGARDING COLLECTION PRACTICES TO BE FOLLOWED FOR PATIENTS KNOWN TO QUALIFY FOR CHARITY CARE OR OTHER FINANCIAL ASSISTANCE. FOR INDIVIDUALS DETERMINED TO BE LOW INCOME PATIENTS ANY SERVICES PROVIDED PRIOR TO SUCH DETERMINATION DATE AND NOT COVERED UNDER THE SAFETY NET (HSN) WILL BE WRITTEN OFF AS CHARITY CARE. ANY SERVICE DENIED BY THE HSN FOR MEDICALLY NECESSARY SERVICES WILL ALSO BE CONSIDERED CHARITY CARE. ANY COPAYMENTS OR DEDUCTIBLES FOR MASSHEALTH AND MASSHEALTH MANAGED CARE RECIPIENTS WILL BE CONSIDERED CHARITY CARE IF UNRESOLVED AT THE CONCLUSION OF SHG'S COLLECTION PROCESS. THE FOLLOWING ARE EXEMPT FROM ANY COLLECTION OR BILLING PROCEDURES BEYOND THE INITIAL BILL PURSUANT TO STATE REGULATIONS: 1. PATIENTS ENROLLED IN A PUBLIC HEALTH INSURANCE PROGRAM, EXCEPT SHG MAY SEEK COLLECTION ACTION AGAINST ANY PATIENT ENROLLED IN A PUBLIC HEALTH INSURANCE PROGRAM FOR THEIR REQUIRED COPAYMENTS AND DEDUCTIBLES AS SET FORTH IN EACH PLAN; 2. SHG MAY INITIATE BILLING AND COLLECTION FOR A PATIENT ALLEGING TO PARTICIPATE IN A FINANCIAL ASSISTANCE PROGRAM THAT COVERS THE COSTS OF SHG SERVICES BUT FAILS TO PROVIDE PROOF OF PARTICIPATION; 3. SHG MAY CONTINUE COLLECTION ACTION ON ANY LOW INCOME PATIENT FOR SERVICES RENDERED PRIOR TO THE LOW INCOME DETERMINATION, HOWEVER, COLLECTION ACTION WILL CEASE ONCE ELIGIBILITY IS DETERMINED; AND 4. SHG WILL NOT SEEK COLLECTION FROM AN INDIVIDUAL WHO HAS BEEN APPROVED FOR MEDICAL HARDSHIP UNDER THE MASSACHUSETTS HSN WITH RESPECT TO THE AMOUNT OF THE BILL EXCEEDING THE MEDICAL HARDSHIP CONTRIBUTION. SHG WILL NOT PURSUE COLLECTION FROM A PATIENT INVOLVED IN BANKRUPTCY PROCEEDING AND WILL NOT CHARGE INTEREST IN AN OVERDUE BALANCE OF A LOW INCOME PATIENT.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 2	<p>In addition to completing a comprehensive, regional community health needs assessment every three years, Southcoast participates in and leads over 30 community coalitions and actively participates in a number of projects every year that collect and analyze information about the social and health care needs of the residents living in the South Coast Region. These activities include tracking hospital data such as the number of patients reporting homelessness, overdose data, and food insecurity; to working with coalition partners to conduct outreach/surveys and focus groups on a number of topics (aligning with our priorities). We meet regularly to discuss the success of these projects and to make sure that we are having the desired impact within the community. In 2020, Southcoast Health completed its fifth year of the Community Benefits Impact Opportunity Grant program. This is a competitive grant process focused on addressing unmet health needs on the South Coast. The grant proposals aligned with the five priority areas, identified through the 2019 Community Health Needs Assessment. We received 29 applications and awarded 14 grants for a total of \$120,000, plus in-kind donations. Grantees are expected to set at least 2 SMART goals and evaluate the success of their programs, submitting data at six months and one year. Finally, through community benefits programs, such as the Mobile Health Van, we are able to document and track pressing health needs as reported by staff conducting outreach and through the patients served.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	Southcoast posts notifications of insurance eligibility in multiple languages throughout all of our inpatient and outpatient facilities and provides information on our website. Southcoast also utilizes multilingual outreach brochures, displayed in our facilities and distributed at a number of health insurance outreach events and through regular outreach on our Mobile Health Van. In Fiscal 2020, our Patient Financial Services Department was only able to hold 17 community outreach events due to COVID-19.



Form and Line Reference	Explanation
PART VI, LINE 4	<p>Southcoast Hospitals Group serves a diverse region along the South Coast Region of Massachusetts, including several urban centers with a number of demographic challenges, and rural and suburban towns. Overall, the South Coast's population increased by 2.8 percent since the beginning of the century and by 12.2 percent since 1970, both of which lag behind the statewide population growth rates for those periods. This gap appears to be mostly driven by long-term population declines in Fall River and New Bedford, although the population of New Bedford has increased slightly since 2010. Perhaps the most significant demographic trend in the region is its changing racial makeup. This is particularly true in the city of New Bedford, where non-White residents account for 36.6 percent of the city's population. Communities throughout the South Coast are becoming more diverse. Between the 2006-2010 and 2013-2017 periods, the minority population in the region increased by 4.7 percent (16,945 people). Fall River experienced the largest percentage increase in its minority population (7.7% or 6,895 residents), followed by New Bedford (6.7% or 6,433 residents), Fairhaven (6.6% or 1,056 residents), and Wareham (5.4% or 1,329 residents). The schools of the South Coast are often more diverse than the communities as a whole. For example, New Bedford's public schools are now majority non-white with Hispanic and Black students representing 40.5 and 12.5 percent of the total student population, respectively. The higher share of minorities in the school system compared to the community is, in part, a product of the national trend of minority births exceeding white births. As this trend continues, the student population in the region will only grow more diverse. The South Coast has long been an attractive place to settle for immigrants, as evidenced by foreign-born residents representing 14.5 percent of the region's population. As Gateway Cities, New Bedford and Fall River have been traditional destinations for new arrivals to America since the late 18th century. During the 2013-2017 period, 18.7 percent of residents in Fall River and 20.0 percent of residents in New Bedford were born outside of the country. In both cities, Portuguese immigrants make up the majority of the foreign-born residents. However, as emigration from Europe to the U.S. has slowed, Latin American and Asian immigrants make up increasing shares of the populations in New Bedford and Fall River. As major destinations for the region's newly arrived immigrants, New Bedford and Fall River have the highest shares of residents reporting limited English proficiency, 14.0 percent and 17.5 percent, respectively. The age cohorts in the South Coast generally reflect their counterparts at the state level. However, the region has a slightly higher share of residents 65 years of age or older, which is more pronounced in the region's towns. Fall River and New Bedford have larger shares of the population under the age of 35 when compared to their metro areas and the South Coast overall. As a region, the South Coast has long struggled with low levels of educational attainment. Although the regional average is primarily driven by the low levels of educational attainment in Fall River and New Bedford, many of the region's towns also lag behind the state in educational attainment of post-secondary degrees. In both cities, the majority of the population 25 years of age or older has never attended a college or university. Additionally, when compared to the adult population statewide, both Fall River and New Bedford have nearly three times the percentage of adults who have not completed high school (27.9% and 27.3%, respectively) compared to the Commonwealth (9.7%). Inflation-adjusted median household income increased in seven South Coast communities from the 2006-2010 to the 2013-2017 periods. Seven South Coast communities have median incomes that are above the state average. Median incomes are particularly low in Fall River (4th lowest in Massachusetts) and New Bedford (7th lowest in Massachusetts). Acushnet, Fairhaven, Somersett, and Wareham also have median incomes below the state average. While the South Coast has a higher share of people living in poverty than the state, the region's cities are home to disproportionate shares of people in poverty. Over 20 percent (20.2%) of all people in Fall River and 23.1 percent of people in New Bedford live in households with annual incomes below the poverty level. This translates to 39,247 individuals living in poverty in just the cities of the South Coast alone. Poverty rates decreased in five South Coast communities between the 2008-2012 and 2013-2017 periods, while rates increased in eight communities. In Fall River and New Bedford, these measures of poverty are higher than the region and the state as a whole. For example, less than 10 percent of all families statewide live in poverty (7.8%), compared with 11.9 percent of all families in th</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>e South Coast and 17.5 percent of families in Fall River and 19.3 percent of families in New Bedford. In addition, the percentage of families with children living in poverty in Fall River and New Bedford is more than double the statewide percentage. The region's changing racial makeup and continued socioeconomic struggles place unique stresses on healthcare delivery, particularly in addressing health disparities based on race, income, and education. The region's health is affected by the physical conditions of the South Coast. A person's physical environment can profoundly affect health outcomes. Environmental factors that affect health outcomes include, but are not limited to, access to healthy food, air quality, water quality, and environmental contamination. In particular, exposure to contaminants through pathways from the air, water, soil, and food can lead to extreme health issues. The analysis shows that South Coast residents face environmental factors that may be a detriment to their health. For example: - Bristol County, which comprises most of the Southcoast Service area, has the highest rate of food insecurity in southeastern Massachusetts, with 10.3 percent of all county residents lacking access, at times, to enough food for an active, healthy life. - Walkable communities allow residents to reduce or even eliminate their use of automobiles, typically the second largest household expense in the U.S. These communities also convey immediate benefits to the environment since, unlike motorized transportation, walking produces no pollutants. Walking has the potential to confer beneficial effects for health, personal finances, the environment and more. The South Coast cities of Fall River and New Bedford scored a WalkScore of 66 and 65 out of 100. This means they are characterized as "somewhat walkable" communities. However, the more rural town of Wareham, is much less walkable and scored a 48 out of 100, characterizing the town as "car-dependent". - The South Coast is home to a number of sites that contain and/or generate contaminants that can negatively affect residents' health. The South Coast is home to 57 of the state's 1,012 brownfield sites. Twelve of these are located in Fall River and 28 are located in New Bedford. On a per square mile and per 1,000 population basis, these cities have higher ratios of brownfield sites compared to the state.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5	<p>Southcoast Hospitals Group invests in direct services and programs designed to address pressing health issues across our region. We collaborate with hundreds of community partners to adopt best practices in community benefits needs assessment, planning and implementation, with the shared goal of improving the health of our communities. Targeted activities included: Behavioral Health Issues: Adoption of a new resource platform Southcoast Resource Connect, which has replaced the previously utilized Behavioral Health Connect platform. Southcoast Resource Connect is a resource directory for free or low-cost services that patients may need. There is a wide range of behavioral health and community resources to assist individuals and families who may be facing difficult life challenges. A number of our staff also played a leadership role in 12 local and regional coalitions to address the opioid crisis, including supporting the availability of Narcan in our region. Smoking Cessation: Continued work on smoking cessation and prevention that encompasses regulatory system and environment change along with education and clinical support for smoking cessation. The Southcoast Health Van continued work on a grant from the Thoracic Foundation to expand smoking cessation support for public housing residents throughout the region, as more municipal Housing Authorities in our region embrace smoke-free regulations and increase the age of which a person may purchase cigarettes or other tobacco products from 18 to 21 years old. Health Screenings: Outreach to vulnerable residents with a range of health screenings, referrals, and education. In FY20, pre-pandemic our Health Van provided 613 health screenings and vaccinations. This included screenings for cardiovascular disease, cancer, diabetes and stroke. We targeted our most vulnerable and underserved populations. In FY20, pre-pandemic we continued our partnership with the New Bedford Health Department and New Bedford Public Schools to assist with 6 pediatric clinics that assisted students receive necessary school vaccinations. Overall, 55 students received vaccinations for a total number of 129 vaccinations given. In May 2020, the Health Van began providing COVID-19 testing and education in response to the COVID-19 pandemic. In total, there were 2,286 patient visits to the Health Van. Health Insurance: Targeted outreach that helped residents obtain health insurance. Due to COVID-19 circumstances, our patient access team conducted 17 outreach events that reached hundreds of vulnerable residents who still lack health insurance or have difficulty renewing their health insurance. Community Health Workers: Collaboration and programming to address health equity issues in our region by working to increase the capacity and training of community health workers, particularly those serving residents who face cultural, linguistic and economic barriers to health care. This past year we were able to expand CHW outreach for chronic disease management and helped organize supervisor and other CHW trainings. Collaboration: Coalition building and engagement that helped make meaningful connections across communities and our region. We participated over 30 coalitions region wide to address the pressing social conditions that impact health including access to safe and affordable housing, transportation, food security, educational attainment, employment, environmental justice and mental health and substance use disorders. Grant Support: This past year we offered a Community Benefits Impact grant program to provide funding which better aligns Southcoast community benefits priorities with projects undertaken by community partners. We supported 14 community partners with \$120,000 in funding for projects ranging from outreach to the homeless to providing opportunities for physical activities for inner city youth. This program has not only supported worthwhile projects in the community but also has enhanced collaboration and common goal setting with our community partners. residents who still lack health insurance or have difficulty renewing their health insurance.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 6	<p>The Southcoast Health Community Benefits program works with other Southcoast affiliates including, Southcoast Behavioral Health, Southcoast Visiting Nurses Association, Southcoast Physicians Group, Southcoast Health System and Southcoast Network, to coordinate all community benefit activities designed to address pressing health issues in our region and improve access to health care. The overall approach incorporates the social determinants of health framework, and takes into account environmental, social and other demographic factors that may influence health status. Representatives from affiliated systems participate as active members of an internal Community Benefits Leadership team that meets bi-monthly to share program information, discuss needs assessment, develop strategies, implementation process, evaluation and reporting of all community benefits programs. This team consists of individuals from departments that regularly engage in outreach in the community, including staff from our Southcoast Health Van, Social Services, Stroke Outreach, Diabetes Management, Behavioral Health Services, Patient Access Services, Cancer Outreach, Smoking Cessation, Youth Risk Behaviors program, Urgent Care and the Southcoast Physicians Group. The Community Benefits Director oversees Southcoast's day-to-day community benefits activities and leads the internal Community Benefits Leadership Team and the external Community Benefits Advisory Council. Southcoast also shares regular updates and presentations on community benefits activities to all Southcoast Hospital staff and affiliates through leadership meetings, employee communications and in digital media campaigns.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7	YES, AN ANNUAL REPORT IS FILED WITH THE OFFICE OF THE MASSACHUSETTS ATTORNEY GENERAL.

**Additional Data****Software ID:****Software Version:****EIN:** 22-2592333**Name:** Southcoast Hospitals Group Inc**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	SOUTHCOAST HOSPITALS GROUP INC 101 Page Street New Bedford, MA 02740 <a href="http://www.southcoast.org/V113">http://www.southcoast.org/V113</a>	X	X					X		ACUTE CARE HOSPITAL	

**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 3E	<p>AS A COMMUNITY BASED HEALTH DELIVERY SYSTEM, SOUTHCOAST HEALTH SYSTEM CONTINUALLY STRIVES TO IDENTIFY THE PRIORITY HEALTH NEEDS OF THE COMMUNITY AND TO ENSURE THAT ITS SERVICES ARE ALIGNED WITH THESE NEEDS. THE COMMUNITY NEEDS ASSESSMENT ASSISTS WITH THIS GOAL BY DOCUMENTING THE MAJOR DEMOGRAPHIC, SOCIOECONOMIC, AND HEALTH TRENDS AMONG SOUTHCOAST RESIDENTS AND BY ENGAGING THE COMMUNITY TO DEVELOP INFORMATION-DRIVEN PRIORITIES AND STRATEGIES THAT CAN BE IMPLEMENTED TO IMPROVE THE OVERALL HEALTH OF SOUTHCOAST RESIDENTS. ALL SIGNIFICANT HEALTH NEEDS ARE IDENTIFIED IN THE CHNA. PART V, SECTION B, LINE 5 In October 2019, Southcoast completed the conduction of a major, three-year health needs assessment with a particular focus on addressing health equity issues in and around the communities that we serve. The CHNA documents the major demographic, socioeconomic, and health trends among South Coast residents, with a focus on health care access, the physical environment, health behaviors, children's health, and health disparities. The analysis is enhanced by qualitative data gathered through stakeholder interviews, focus groups, and surveys of community members and service providers. The goal of the assessment is to inform data-driven objectives and strategies that can be used to improve the overall health of South Coast residents. Our needs assessment was conducted in collaboration with the University of Massachusetts Dartmouth Public Policy Center, who completed a retrospective analysis of local, regional and national health and demographic data. In addition to health data analysis, we also conducted over 31 stakeholder interviews with community partner and service providers, 6 focus groups, a survey for service providers in which 142 people working in a variety of healthcare settings and professions completed and a community member survey, which was completed by 430 residents of the South Coast and its neighboring communities. Stakeholder Interviews: Fall River EMS GateHouse Media New England Father Bill's and Mainspring New Bedford Fire Department New Bedford Police Department Wareham Police Department Community Economic Development Center New Bedford Fishing Partnership Commission for Citizens with Disabilities Cape Verdean Association Old Rochester Regional School District Plymouth County District Attorney's Office Achushnet Council on Aging Community Health Consultant Junior Achievement of Southeastern MA St. Luke's Hospital Steppingstone, Inc. Fall River WIC Children's Advocacy Center of Bristol County New Beginnings Southcoast Health Interchurch Council of Greater New Bedford Boys and Girls Club of New Bedford and Wareham Charlton Memorial Hospital Greater New Bedford Community Health Center United Neighbors of Fall River Focus Groups: 1. Consisted of Wareham-based service providers representing a wide range of care settings and health care professionals. 2. A support group for cancer survivors and their family members from across the region at 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
PART V, SECTION B, LINE 3E	<p>Southcoast Cancer Center in Fairhaven. 3. Conducted as part of the Mental Health Provider s Network's regular meeting. Members include mental health professionals working in a variety of settings throughout the Greater New Bedford region. 4. Primary Spanish-speaking residents of the North end of New Bedford. Convened by the Community Economic Development Center of New Bedford. 5. Consisted of families who have engaged with programming provided by the United Way of Greater New Bedford's Family Resource &amp; Development Center. The group was very racially and ethnically diverse and multigenerational. 6. Consisted of community members and service providers working in Greater Fall River. Convened by Representative Carole Fiola as part of her regular "Coffee with Carole" event.</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
PART V, SECTION B, LINE 6A	SOUTHCOAST HOSPITALS GROUP, INC. CONDUCTS ITS CHNA WITH SOUTHCOAST BEHAVIORAL HEALTH. PART V, SECTION B, LINE 6B SOUTHCOAST HOSPITALS GROUP, INC. COLLABORATES WITH THE UNIVERSITY OF MASSACHUSETTS DARTMOUTH PUBLIC POLICY CENTER.

**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.southcoast.org/wp-content/uploads/2019/10/Southcoast-Health-CH_NA-2019-Final_PPC.pdf">https://www.southcoast.org/wp-content/uploads/2019/10/Southcoast-Health-CH_NA-2019-Final_PPC.pdf</a>

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINES 7D	Our needs assessment is widely shared with community partners and is often used in grant writing and collaborative strategic planning. In FY 2020, our needs assessment data was shared with and utilized by: Greater New Bedford Allies for Health and Wellness (CHNA 26), Partners for a Healthier Community (CHNA 25), Wareham Community Services Collaborative, Near North End Alliance, BMC Healhnet Plan, Coastal FoodShed, Laundry of Love, Leadership SouthCoast, Homeless Service Providers Network, Age Friendly New Bedford, Boys and Girls Club of New Bedford and Wareham, New Bedford Health Department, New Bedford Housing Authority, Substance Exposed Newborn Committee of SEMA, Greater New Bedford Community Health Center, Wareham Health Department, Wareham Public Schools' Beyond School Time, YMCA Southcoast.

**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.southcoast.org/community-benefits/community-benefits-reporting/">https://www.southcoast.org/community-benefits/community-benefits-reporting /</a>

**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 11	<p>Southcoast's Community Benefits Strategic Action Plan was first formulated in 1998 as the result of an extensive needs assessment and since is updated annually. Our current plan is based on the community health needs assessment completed in October 2019. Through the needs assessment process, Southcoast identified five priorities for 2020-2022 that will address the most pressing health needs of the community. These priorities are: 1. Chronic Disease, Prevention &amp; Treatment: Reduction of the high rate of chronic disease (including diabetes, asthma, cancer, and other diseases) in our region. 2. Educational Attainment &amp; Income : Enhancement of South Coast resident's employment skills, increased job opportunities and access to education. Minimization of the skills gap across all sectors through assisting adults continue or expand their educational attainment (ex. a high school diploma or certificate), and to assist adults further their skills/advance in their careers through additional job training and readiness skills. Increase early literacy by boosting enrollment and access to early head start and preschool programs. Reducing Health Disparities including racial and ethnic disparities, income-based disparities, and education-based disparities. One other aspect of this is increasing access to health care for vulnerable populations through insurance enrollment and outreach and creating innovative approaches to population health, i.e. improving health and wellness for defined populations such as specific demographic or geographic groups. 3. Housing &amp; Homelessness: The development of programs and services that support the reduction of homelessness in our region including strategies for increased collaboration among agencies serving homeless residents. 4. Behavioral Health: Behavioral health issues that include substance abuse and mental health, including improved coordination of behavioral health providers and systems. Maternal and Children's Health, including fetal and infant health, abuse and neglect, hospitalizations, substance abuse, healthy weight, and mortality. 5. Environmental Health &amp; Wellness: Development of healthy "System and Environment" change, including healthy food options, increased access to free and low-cost opportunities for active living, such as public parks, bike trails etc., and reduction in the high rate of smoking in our communities. Reduction in the incidence of youth risk behaviors such as teen violence, high rates of teen pregnancy and substance abuse. Increasing Emergency Preparedness in our cities and towns, including basic infrastructure equipment. All activities of Community Benefits are completed in accordance with these priorities and include: conducting ongoing community health needs assessments, awarding Community Benefits Impact Opportunity Grants to community organizations working on projects aligned with CHNA priorities, coalition-building, and collaborating with community partners in the planning, implementing, mo</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
PART V, SECTION B, LINE 11	<p>monitoring and evaluating of Community Benefits programs as described below: Smoking Cessation and Prevention, Community Health Worker Projects, Maternal Child Health Education and Outreach, Cancer Screenings and Outreach, Mobile Health Van, Health Access Outreach, Emergency Preparedness, Coalition to End and Prevent Homelessness, Behavioral Health/Substance Use Intervention, Healthy Systems &amp; Environment Change. To address needs, target populations are determined by our comprehensive health needs assessment and are reviewed on an annual basis. Our 2020 target populations included: - South Coast residents who suffer disproportionately from chronic disease such as cardiovascular disease, diabetes, cancer and respiratory disease. Particular focus is given to residents who experience barriers to care due to language, culture, race, income or education. - Area youth who are at high risk for problems such as teen pregnancy, violence, substance abuse, lack of educational attainment and other risky behaviors that affect health and wellbeing. This includes Gay/Lesbian/Bisexual/Transgender (GLBT) youth. - Residents who lack access to regular primary health care due to lack of health insurance or other barriers. - Residents and their families who are impacted by mental/behavioral health issues, including substance use disorder, particularly those who experience barriers to or breaks in care and are forced to rely on the South Coast Emergency Department for regular care. - Area Boards of Health, Emergency Medical Services and other municipal agencies whose programs impact a number of aspects of health for their residents, and who have experienced severe budget cuts that have impacted these programs. This may include smoking cessation and prevention, chronic disease management and emergency preparedness. - Public housing residents, who suffer disproportionately from health disparities and have high rates of unhealthy risk factors including smoking, obesity and hypertension. - Homeless residents on the South Coast, particularly in the town of Wareham, where the rate of unsheltered homeless exceeds other towns in the region and approaches South Coast cities that have five times the population. - Those in our communities who experience health disparities due to racial, ethnic or economic factors. These include residents for whom English is not a first language, especially undocumented immigrants. - The fishing community in New Bedford, who experience higher rates of chronic health issues due to barriers to health access and care.</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
PART V, SECTION B, LINE 16A	<a href="https://www.southcoast.org/wp-content/uploads/2016/09/Credit-Coll-Pol-2016 -FAP-Final.pdf">https://www.southcoast.org/wp-content/uploads/2016/09/Credit-Coll-Pol-2016 -FAP-Final.pdf</a>

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16B	<a href="https://www.southcoast.org/wp-content/uploads/2016/09/Application-for-Financial-Assistance-aca-3-english-4.16-1.pdf">https://www.southcoast.org/wp-content/uploads/2016/09/Application-for-Financial-Assistance-aca-3-english-4.16-1.pdf</a>



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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16C	<a href="https://www.southcoast.org/wp-content/uploads/2016/09/Plain-Language-Summary-FAP-overview-2016-1.pdf">https://www.southcoast.org/wp-content/uploads/2016/09/Plain-Language-Summary-FAP-overview-2016-1.pdf</a>

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 20A-D	SHG DID NOT ENGAGE IN ANY OF THE ACTIONS IN LINE 19 DURING FY2020.

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

Schedule I (Form 990)

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

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

Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization

Southcoast Hospitals Group Inc

Employer identification number

22-2592333

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance...
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.

Table with 8 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section (if applicable), (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation (book, FMV, appraisal, other), (g) Description of noncash assistance, (h) Purpose of grant or assistance. Rows 1-12.

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 15
3 Enter total number of other organizations listed in the line 1 table 0

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

Part III can be duplicated if additional space is needed.

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

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

Return Reference	Explanation
SCHEDULE I, PART I, LINE 2	SOUTHCOAST COMMUNITY BENEFITS DEPARTMENT REQUIRES ALL GRANTEES TO SUBMIT SIX AND TWELVE MONTH REPORTS ON PROJECT RESULTS INCLUDING RESULTS OF "SMART" GOALS THAT ARE A REQUIREMENT OF THE GRANT APPLICATION. SHG ALSO MAINTAINS COMMUNICATION WITH GRANTEES DURING THE GRANT PERIOD TO DETERMINE OPPORTUNITIES FOR COLLABORATION WITH OTHER COMMUNITY BENEFITS PROGRAMMING.

## Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 22-2592333  
**Name:** Southcoast Hospitals Group Inc

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
GREATER NEW BEDFORD COMMUNITY HEALTH CENTER 874 PURCHASE STREET NEW BEDFORD, MA 02740	04-2675800	501(C)(3)	100,000				COMMUNITY OUTREACH
NORTHSTAR LEARNING CENTER INC 53 LINDEN STREET NEW BEDFORD, MA 02740	51-0200575	501(C)(3)	100,000				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
CHILDREN'S ADVOCACY CNTR OF BRISTOL COUNTY 58 ARCH STREET FALL RIVER, MA 02724	04-3135548	501(C)(3)	25,000				COMMUNITY OUTREACH
TOWN OF WAREHAM 54 MARION ROAD WAREHAM, MA 02571	04-6001336	Gov't	219,110				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
STANLEY STREET TREATMENT & RESOURCE CENTER 386 STANLEY STREET FALL RIVER, MA 02720	04-2604426	501(C)(3)	100,000				COMMUNITY OUTREACH
HEALTHFIRST FAMILY CARE CENTER 387 QUARRY STREET FALL RIVER, MA 02723	04-2503444	501(C)(3)	100,000				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
BOYS AND GIRLS CLUB OF GREATER NEW BEDFORD 166 JENNEY STREET NEW BEDFORD, MA 02740	04-2104752	501(C)(3)	50,000				COMMUNITY OUTREACH
THE MARION INSTITUTE 202 SPRING STREET MARION, MA 02738	04-3206583	501(C)(3)	50,000				COMMUNITY OUTREACH



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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
BOYS AND GIRLS CLUB OF FALL RIVER 803 BEDFORD STREET FALL RIVER, MA 02723	04-2103923	501(C)(3)	50,000				COMMUNITY OUTREACH
CHILD AND FAMILY SERVICES INC 3057 ACUSHNET AVENUE NEW BEDFORD, MA 02745	04-2104754	501(C)(3)	20,000				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
YWCA SOUTHEASTERN MASS 20 SOUTH SIXTH STREET NEW BEDFORD, MA 02740	04-2104747	501(C)(3)	10,750				COMMUNITY OUTREACH
SOUTHEASTERN MA VETERANS HOUSING PROGRAM (VTH) 1297 PURCHASE STREET NEW BEDFORD, MA 02740	22-3068653	501(C)(3)	10,000				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
FATHER BILL'S & MAIN SPRING 430 BELMONT STREET BROCKTON, MA 02301	22-2538039	501(C)(3)	10,000				COMMUNITY OUTREACH
GREATER FALL RIVER COMMUNITY FOOD PANTRY 235 NASHUA STREET FALL RIVER, MA 02721	22-3128989	501(C)(3)	10,000				COMMUNITY OUTREACH

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
MASSACHUSETTS TAXPAYERS FOUNDATION 333 WASHINGTON STREET SUITE 853 BOSTON, MA 02108	04-1590310	501(C)(3)	5,665				MEMBERSHIP CONTRIBUTIONS FOR PROGRAM SUPPORT

**Schedule J**  
(Form 990)

**Compensation Information**

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Southcoast Hospitals Group Inc

Employer identification number  
22-2592333

**Part I Questions Regarding Compensation**

	Yes	No
<p><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.</p> <p> <input type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input checked="" type="checkbox"/> Tax idemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                 </p> <p> <input type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </p>		
<p><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</p>	1b Yes	
<p><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?</p>	2 Yes	
<p><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.</p> <p> <input checked="" type="checkbox"/> Compensation committee  <input checked="" type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                 </p> <p> <input type="checkbox"/> Written employment contract  <input checked="" type="checkbox"/> Compensation survey or study  <input checked="" type="checkbox"/> Approval by the board or compensation committee                 </p>		
<p><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:</p> <p><b>a</b> Receive a severance payment or change-of-control payment?</p> <p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>	4a Yes	4b Yes
	4c	No
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p> <p><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:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p>	5a No	5b No
<p><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:</p> <p><b>a</b> The organization?</p> <p><b>b</b> Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p>	6a No	6b No
<p><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.</p>	7 Yes	
<p><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.</p>	8	No
<p><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)?</p>	9	

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

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

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

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

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 1A	ONE KEY EMPLOYEE RECEIVED A GROSS UP FOR RELOCATION REIMBURSEMENTS. THIS BENEFIT WAS INCLUDED IN THEIR W-2 TAXABLE INCOME. PART I, LINE 4A THE FOLLOWING INDIVIDUALS RECEIVED A SEVERENCE PAYMENT FROM THE ORGANIZATION: DAVID DEJESUS - \$182,876 ROBERT CALDAS - \$80,167 JACK DRESSER - \$48,333
PART I, LINE 4B	OFFICERS, DIRECTORS, AND KEY EMPLOYEES WHO ARE EMPLOYEES OF SHG PARTICIPATE IN SHG'S 457(F) SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN. CONTRIBUTION CREDITS UNDER THE PLAN ARE INCLUDED IN SCHEDULE J, PART, II, COLUMN (C). ONLY UPON TERMINATIONS OF EMPLOYMENT DO FULLY VESTED PARTICIPANTS RECEIVE DISTRIBUTIONS FROM THE PLAN. CONTRIBUTIONS VEST THE EARLIER OF: JULY 1 OF THE 3RD CALENDAR YEAR FOLLOWING THE CALENDAR YEAR IN WHICH THE CONTRIBUTION CREDIT IS MADE; UPON REACHING AGE 62; DEATH; DISABILITY; OR INVOLUNTARY SEPARATION. THE AMOUNT REFLECTED IN SCHEDULE J, PART II, COLUMN B(III) FOR THE FOLLOWING INDIVIDUALS INCLUDES THE VESTED PORTION OF CONTRIBUTIONS MADE TO THE PLAN WHICH ARE NO LONGER SUBJECT TO THE RISK OF FORFEITURE. KEITH HOVAN - \$309,434 ROBERT CALDAS - \$89,468 RENEE CLARK - \$77,740 MICHAEL COFONE - \$53,833 IN ADDITION TO THE ABOVE OUTLINED PLAN, THE FOLLOWING INDIVIDUAL ALSO HAS A SEPARATE SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN. KEITH HOVAN - SOUTHCOAST HOSPITAL GROUP, INC. ESTABLISHED AN EXECUTIVE BENEFIT PLAN FOR THE BENEFIT OF KEITH HOVAN. UNDER THE TERMS OF THE PLAN, MR. HOVAN BECAME FULLY VESTED AS OF JUNE 30, 2018. ANNUAL CREDITS TO THE PLAN ARE IMMEDIATELY VESTED AND INCLUDED IN SCH J, PART II, COLUMN (B)(iii). PURSUANT TO THE PLAN \$132,400 WAS INCLUDED IN MR. HOVAN'S 2019 FORM W-2 AND SCH J, PART II, COLUMN B(III).
PART I, LINE 7	The Southcoast Health System Executive Compensation Plan (the Plan) established 10/15/2008, and updated from time to time, is governed by the Compensation Committee (the Committee) of the Board of Trustees (Board) of Southcoast Health System. The Plan outlines goals, administration, eligibility, participation, performance measurement, and plan funding. Lump-sum cash awards are earned by designated executives at specific target levels based on job level: both award amounts paid and eligibility are determined solely at the Board's discretion. The Plan remains in effect at the discretion and judgement of the Committee.

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 22-2592333  
**Name:** Southcoast Hospitals Group Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 KEITH HOVAN PRESIDENT & CEO	(i)	1,170,000	585,000	456,564	320,798	21,456	2,553,818	241,828
	(ii)	0	0	0	0	0	0	0
1 ROBERT CALDAS MD Senior VP & CMO(until 10/2019)	(i)	400,833	72,150	469,621	88,950	21,343	1,052,897	86,970
	(ii)	0	0	0	0	0	0	0
2 WADE BROUGHMAN EVP FIN/CFO & Treasurer	(i)	613,000	229,900	26,913	121,069	17,950	1,008,832	0
	(ii)	0	0	0	0	0	0	0
3 RENEE CLARK SVP/COO (SHG)/ ASST. CLERK	(i)	575,000	172,500	82,294	131,100	21,456	982,350	75,570
	(ii)	0	0	0	0	0	0	0
4 MICHAEL BARRETTI DO EX-OFFICIO (UNTIL 12/2019)	(i)	0	0	0	0	0	0	0
	(ii)	425,001	169,847	144,180	15,600	13,939	768,567	0
5 LAUREN DESIMON JOHNSON SVP/ CHRO	(i)	395,000	98,800	59,626	59,250	21,378	634,054	0
	(ii)	0	0	0	0	0	0	0
6 MICHAEL COFONE SVP FINANCE	(i)	360,000	90,000	59,018	81,000	21,456	611,474	52,500
	(ii)	0	0	0	0	0	0	0
7 JAMES FEEN SVP/CIO	(i)	394,911	100,500	0	11,200	22,057	528,668	0
	(ii)	0	0	0	0	0	0	0
8 STEPHEN CANESSA SVP CHIEF BRAND STRATEGY OFFCR	(i)	303,957	108,500	0	71,610	21,456	505,523	0
	(ii)	0	0	0	0	0	0	0
9 CHRISTOPHER CHENEY MD TRUSTEE (UNTIL 12/2019)	(i)	0	0	0	0	0	0	0
	(ii)	228,373	105,830	33,838	15,600	410	384,051	0
10 JAY S SCHACHNE MD TRUSTEE (AS OF 1/2020)	(i)	0	0	0	0	0	0	0
	(ii)	186,879	136,412	26,600	15,600	8,310	373,801	0
11 GEORGINA NOUAIMA MD TRUSTEE (AS OF 1/2020)	(i)	0	0	0	0	0	0	0
	(ii)	253,846	22,000	55,851	15,600	14,256	361,553	0
12 JACK DRESSER SVP/CPO (UNTIL 10/2019)	(i)	241,667	38,647	48,333	14,500	14,204	357,351	0
	(ii)	0	0	0	0	0	0	0
13 TONYA JOHNSON VP OPERATIONS	(i)	235,838	73,000	0	16,800	22,057	347,695	0
	(ii)	0	0	0	0	0	0	0
14 DAVID DEJESUS JR FORMER SVP & CHRO	(i)	0	0	182,876	0	3,850	186,726	0
	(ii)	0	0	0	0	0	0	0



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

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds

Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization Southcoast Hospitals Group Inc

Employer identification number

22-2592333

Part I Bond Issues

Table with 10 columns: (a) Issuer name, (b) Issuer EIN, (c) CUSIP #, (d) Date issued, (e) Issue price, (f) Description of purpose, (g) Deceased (Yes/No), (h) On behalf of issuer (Yes/No), (i) Pool financing (Yes/No). Rows include Mass Health and Educational Facilities Authority, Mass Development Finance Agency, and MASS DEVELOPMENT AND FINANCE AGENCY.

Part II Proceeds

Table with 13 rows and 8 columns (A-D, Yes/No). Rows include Amount of bonds retired, Amount of bonds legally defeased, Total proceeds of issue, Issuance costs from proceeds, and questions about bond issuance (14-17).

Part III Private Business Use

Table with 2 rows and 8 columns (A-D, Yes/No). Questions include: Was the organization a partner in a partnership... and Are there any lease arrangements that may result in private business use of bond-financed property?

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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .		X	X			X	X	
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?			X				X	
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X		X		X
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶		0 %		0.030 %		0 %		0.100 %
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶				0.130 %				0.060 %
<b>6</b> Total of lines 4 and 5 . . . . .				0.160 %				0.160 %
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X		X		X
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X		X		X
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of. . . . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .		X		X		X		X
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X		X		X		X	

**Part IV Arbitrage**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . . .		X		X		X		X
<b>2</b> If "No" to line 1, did the following apply? . . . . .								
<b>a</b> Rebate not due yet? . . . . .		X		X		X	X	
<b>b</b> Exception to rebate? . . . . .		X		X		X		X
<b>c</b> No rebate due? . . . . .	X		X		X			X
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .		X		X		X	X	
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
<b>b</b> Name of provider . . . . .	0		0		0		0	
<b>c</b> Term of hedge . . . . .								
<b>d</b> Was the hedge superintegrated? . . . . .								
<b>e</b> Was the hedge terminated? . . . . .								

**Part IV Arbitrage** (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
<b>b</b> Name of provider . . . . .	0		0		0		0	
<b>c</b> Term of GIC . . . . .								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .								
<b>6</b> Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
<b>7</b> Has the organization established written procedures to monitor the requirements of section 148? . . . . .	X		X		X		X	

**Part V Procedures To Undertake Corrective Action**

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

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

Return Reference	Explanation
PART IV, LINE 2C	REBATE COMPUTATIONS WERE PERFORMED ON THE FOLLOWING DATES: A - 10/22/2019 B - 02/28/2020 C - 10/22/2019

Schedule L (Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No. 1545-0047

2019

Open to Public Inspection

Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b. Attach to Form 990 or Form 990-EZ. Go to www.irs.gov/Form990 for instructions and the latest information.

Department of the Treasury Internal Revenue Service

Name of the organization Southcoast Hospitals Group Inc

Employer identification number

22-2592333

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only). Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

Table with 5 columns: (a) Name of disqualified person, (b) Relationship between disqualified person and organization, (c) Description of transaction, (d) Corrected? (Yes/No)

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. \$
3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. \$

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

Table with 9 columns: (a) Name of interested person, (b) Relationship with organization, (c) Purpose of loan, (d) Loan to or from the organization (To/From), (e) Original principal amount, (f) Balance due, (g) In default? (Yes/No), (h) Approved by board or committee? (Yes/No), (i) Written agreement? (Yes/No)

Total \$

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

Table with 5 columns: (a) Name of interested person, (b) Relationship between interested person and the organization, (c) Amount of assistance, (d) Type of assistance, (e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
See Additional Data Table					

**Part V Supplemental Information**

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

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 22-2592333

**Name:** Southcoast Hospitals Group Inc

### Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SHEPARD GROUP INC	35% CONTROLLED ENTITY	217,581	SERVICES		No
(1) PATRICK HIGHAM	FAMILY MEMBER OF KEY EMPLOYEE	66,573	COMPENSATION		No

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(3) LAUREN CALDAS HIGHAM	FAMILY MEMBER OF KEY EMPLOYEE	55,594	COMPENSATION		No
(1) SHAWN MYERS	FAMILY MEMBER OF OFFICER	41,459	COMPENSATION		No

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

<b>(a)</b> Name of interested person	<b>(b)</b> Relationship between interested person and the organization	<b>(c)</b> Amount of transaction	<b>(d)</b> Description of transaction	<b>(e)</b> Sharing of organization's revenues?	
				<b>Yes</b>	<b>No</b>
(5) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	193,660	SERVICES		No
(1) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	2,575,560	SERVICES		No



**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(7) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR AND EMPLOYEE	641,005	SUPPLIES		No
(1) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	4,282,483	SERVICES		No

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

<b>(a)</b> Name of interested person	<b>(b)</b> Relationship between interested person and the organization	<b>(c)</b> Amount of transaction	<b>(d)</b> Description of transaction	<b>(e)</b> Sharing of organization's revenues?	
				<b>Yes</b>	<b>No</b>
(9) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	3,219,333	SERVICES		No

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No. 1545-0047

**2019**

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

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Southcoast Hospitals Group Inc

Employer identification number  
22-2592333

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . . .				
2 Art—Historical treasures . . . . .				
3 Art—Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities—Publicly traded . . . . .	X	8	162,743	Market Value
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .				
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ See Additional Data				
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement **29** 0

30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? **30a** Yes No

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

31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? **31** Yes No

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? **32a** Yes No

b If "Yes," describe in Part II.

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

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

Return Reference	Explanation
PART I, COLUMN (B)	THE AMOUNT REPORTED IN COLUMN (B) REPRESENTS THE NUMBER OF CONTRIBUTIONS.

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 22-2592333

**Name:** Southcoast Hospitals Group Inc

### Part I, Lines 25-28

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
Other ► ( event items )	X	5	3,066	cost/sales price
Other ► ( PPE )	X	69	94,326	COST/SALES PRICE
Other ► ( OTHER )	X	4	1,950	COST/SALES PRICE
Other ► ( COVID SIGNAGE )	X	1	2,851	COST/SALES PRICE
Other ► ( PHOTOCOPIES )	X	1	1,499	COST/SALES PRICE
Other ► ( NEW YEAR'S BABY BASKETS )	X	1	200	COST/SALES PRICE
Other ► ( HAND SANITIZER )	X	1	6,000	COST/SALES PRICE

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

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2019****Open to Public Inspection**

Department of the Treasury

Name of the organization

Southcoast Hospitals Group Inc

Employer identification number

22-2592333

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
PART I, LINE 1 AND PART III, LINE 1:	SOUTHCOAST HOSPITALS GROUP (SHG) OWNS AND OPERATES THREE COMMUNITY BASED ACUTE CARE HOSPITALS - CHARLTON MEMORIAL HOSPITAL IN FALL RIVER, ST LUKES HOSPITAL IN NEW BEDFORD AND TOBEY HOSPITAL IN WAREHAM, MA. SHG SERVES AS THE SAFETY NET PROVIDER TO A CULTURALLY DIVERSE AND ECONOMICALLY CHALLENGED REGION WITH GOVERNMENT SPONSORED PROGRAMS COVERING APPROXIMATELY 70% OF ITS PATIENTS. IN SOME COMMUNITIES, SHG IS THE SOLE PROVIDER OF HOSPITAL SERVICES AND IN ITS REGION THE SOLE PROVIDER OF ADVANCED CLINICAL SERVICES SUCH AS OPEN HEART SURGERY AND OTHER ADVANCED CARDIAC SERVICES, MATERNITY AND NEONATAL INTENSIVE CARE SERVICES. SOUTHCOAST PROVIDES ADVANCED EMERGENCY CARE 24 HOURS PER DAY, 7 DAYS A WEEK AT ALL THREE HOSPITALS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION A, LINE 1:	THE EXECUTIVE COMMITTEE SHALL, EXCEPT AS PROHIBITED BY LAW OR LIMITED BY THE BOARD, HAVE ALL THE POWERS OF THE BOARD IN CONNECTION WITH THE MANAGEMENT AND OPERATION OF SHG BETWEEN MEETINGS OF THE BOARD RELATED TO URGENT MATTERS WHICH THE COMMITTEE DETERMINES CANNOT WAIT FOR THE NEXT REGULARLY SCHEDULED BOARD MEETING, INCLUDING DELEGATION OF AUTHORITY, EXCEPT IN REMOVING ANY MEMBER OF THE MEDICAL STAFF. ANY ACTION TAKEN BY THE EXECUTIVE COMMITTEE SHALL BE FULLY REPORTED TO THE BOARD AT ITS NEXT MEETING.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION A, LINE 2:	CERTAIN OFFICERS AND TRUSTEES OF SHG ARE OFFICERS OR TRUSTEES OF RELATED ORGANIZATIONS. INDIVIDUALS WITH REPORTABLE COMPENSATION FROM RELATED ORGANIZATIONS IN PART VII, SECTION A, COLUMN (E), ARE EMPLOYEES OF RELATED ORGANIZATIONS.



**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION A, LINE 6:	THE SOLE MEMBER OF SHG IS SOUTHCOAST HEALTH SYSTEM, INC (SHS), A CHARITABLE ORGANIZATION ACTING THROUGH ITS BOARD OF TRUSTEES.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION A, LINE 7A:	TRUSTEES ARE ELECTED AND REMOVED AND SHALL OTHERWISE SERVE AS SET FORTH IN THE BYLAWS OF ITS SOLE CORPORATE MEMBER, SHS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION A, LINE 7B:	THE GOVERNANCE OF SHG IS VESTED IN THE BOARD OF TRUSTEES AND IT MAY EXERCISE ALL POWERS OF THE CORPORATION EXCEPT THOSE POWERS RESERVED TO SHS BY LAW, THE ARTICLES OF ORGANIZATION, OR SHG'S BYLAWS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION B, LINE 11B:	THE ORGANIZATION PREPARES THE FORM 990 WITH THE ASSISTANCE OF A PAID PREPARER. A DRAFT OF THE FORM 990 IS PRESENTED TO THE MANAGEMENT FOR REVIEW AND COMMENT. A DRAFT OF THE FORM 990 IS ALSO PROVIDED TO THE ORGANIZATION'S AUDIT COMMITTEE FOR REVIEW. A FINAL COPY OF THE FORM 990 IS PROVIDED TO EACH MEMBER OF THE BOARD OF TRUSTEES PRIOR TO FILING WITH THE IRS. AN OFFICER OF THE ORGANIZATION AND ITS PAID PREPARER, RESPECTIVELY, SIGN THE FINAL FORM 990.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
PART VI, SECTION B, LINE 12C:	<p>SHS HAS CONFLICT OF INTEREST, LEGAL COMPLIANCE AND CODE OF CONDUCT POLICIES THAT APPLY TO ALL TRUSTEES, OFFICERS, DIRECTORS AND EMPLOYEES (REFERRED TO AS "MEMBERS"). ON AN ANNUAL BASIS, EACH MEMBER WILL COMPLETE THE CONFLICT OF INTEREST QUESTIONNAIRE WHICH AFFIRMS THAT EACH PERSON HAS: (1) RECEIVED A COPY OF THE POLICY; (2) READ AND UNDERSTOOD THE POLICY; (3 ) AGREED TO COMPLY WITH THE POLICY, AND (4) UNDERSTOOD THAT THE SYSTEM ENTITIES ARE CHARITABLE ORGANIZATIONS AND THAT TO MAINTAIN THEIR FEDERAL TAX EXEMPTION, SUCH ENTITIES MUST ENGAGE PRIMARILY IN ACTIVITIES WHICH ACCOMPLISH ONE OR MORE OF ITS TAX-EXEMPT PURPOSES. TO ENSURE THE SYSTEM OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABLE PURPOSES, DOES NOT ENGAGE IN ACTIVITIES THAT COULD JEOPARDIZE ITS STATUS AS AN ORGANIZATION EXEMPT FROM FEDERAL TAXATION, AND IN CONNECTION WITH ITS COMPLIANCE PROGRAM, SYSTEM'S MANAGEMENT SHALL CONDUCT PERIODIC REVIEWS OF THE CONFLICT OF INTEREST POLICY AND THE OPERATION AND APPLICATION OF IT. MEMBERS SHALL DISCLOSE ANY INTERESTS OR ACTIVITIES IN WHICH THEY ARE INVOLVED OR BECOME INVOLVED THAT DO RESULT, OR MAY APPEAR TO RESULT IN A CONFLICT OF INTEREST OR POTENTIAL CONFLICT OF INTEREST AND SHALL COMPLY WITH, AND MAKE ALL REQUIRED DISCLOSURES UNDER THE CONFLICT OF INTEREST POLICY PRIOR TO COMMENCING, CONTINUING, OR CONSUMMATING ANY ACTIVITY OR TRANSACTION WHICH RAISES A CONFLICT OF INTEREST OR A POTENTIAL CONFLICT OF INTEREST. EACH MEMBER IS UNDER AN ONGOING DUTY TO UPDATE AND KEEP CURRENT THE INFORMATION CONTAINED IN THEIR QUESTIONNAIRE. AT LEAST ANNUALLY, OR AS NECESSARY BASED ON DISCLOSURES, THE GENERAL COUNSEL WILL SUMMARIZE AND REPORT ALL DISCLOSURES TO THE PRESIDENT AND CEO AND THE CHAIRMAN OF THE BOARD OF TRUSTEES (OR HIS/HER DESIGNEE). UPON DISCLOSURE OF FINANCIAL OR NON-FINANCIAL INTERESTS ("INTERESTS") AND ALL MATERIAL FACTS RELATED THERETO BY MEMBER OR AN INTERESTED PERSON, THE CHAIR OF THE SYSTEM'S GOVERNANCE COMMITTEE SHALL DETERMINE IN CONJUNCTION WITH THE GENERAL COUNSEL WHETHER A CONFLICT OF INTERESTS EXISTS. THE GOVERNANCE COMMITTEE CAN CONTINUE TO DISCUSS THE ISSUE WITH THE MEMBER OR INTERESTED PERSON TO CLARIFY OR OBTAIN ADDITIONAL INFORMATION. HOWEVER, BEFORE THE GOVERNANCE COMMITTEE DISCUSSES OR DETERMINES WHETHER THE MEMBER OR OTHER INTERESTED PERSON'S INTERESTS CONSTITUTE A CONFLICT OF INTEREST, THE MEMBER OR INTERESTED PERSON MUST LEAVE THE MEETING. IN THE EVENT THE INTEREST INVOLVES THE CHAIR OR CEO, THE REMAINING GOVERNANCE COMMITTEE MEMBERS SHALL APPOINT ONE OR MORE DISINTERESTED TRUSTEES TO MAKE SUCH A DETERMINATION. ONCE THE DETERMINATION OF THE CONFLICT OF INTEREST IS MADE BY THE GOVERNANCE COMMITTEE, SUCH DETERMINATION, ALONG WITH APPROPRIATE MITIGATION PLANS, WILL BE SUBMITTED BY THE GOVERNANCE COMMITTEE FOR REVIEW AND APPROVAL. IF ANY BOARD OR BOARD COMMITTEE HAS REASONABLE CAUSE TO BELIEVE THAT A MEMBER HAS FAILED TO DISCLOSE AN ACTUAL CONFLICT OF INTEREST OR A POTENTIAL CONFLICT OF INTEREST, IT SHALL INFORM SUCH PERSON OF THE</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION B, LINE 12C:	BASIS FOR SUCH BELIEF AND AFFORD SUCH A MEMBER AN OPPORTUNITY TO EXPLAIN THE ALLEGED FAILURE TO DISCLOSE IT. IF, AFTER HEARING THE RESPONSE OF SUCH PERSON AND MAKING FURTHER INQUIRY OR INVESTIGATION AS WARRANTED BY THE CIRCUMSTANCES, THE BOARD OR BOARD COMMITTEE DETERMINES THAT SUCH PERSON HAS IN FACT FAILED TO DISCLOSE AN ACTUAL CONFLICT OF INTEREST OR A POTENTIAL CONFLICT OF INTEREST, THE APPROPRIATE DISCIPLINARY AND CORRECTIVE ACTION SHALL BE TAKEN.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION B, LINE 15:	COMPENSATION FOR ALL VICE PRESIDENTS AND THE SENIOR LEADERSHIP TEAM (SLT) IS ESTABLISHED USING THE FOLLOWING PROCEDURES:(1) REVIEW AND APPROVAL BY THE COMPENSATION COMMITTEE OF SHS WITHOUT THE INVOLVEMENT OF PERSONS WITH CONFLICT OF INTEREST IN RESPECT TO THE COMPENSATION ARRANGEMENT AT ISSUE; (2) USE OF DATA AS TO COMPARABLE COMPENSATION FOR SIMILARLY QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED HEALTH SYSTEMS. THE COMPENSATION COMMITTEE ENGAGED THE SERVICES OF AN INDEPENDENT HUMAN RESOURCE CONSULTING FIRM ("CONSULTANT") TO PROVIDE UPDATED COMPENSATION DATA AND ASSESS THE REASONABLENESS OF THE TOTAL COMPENSATION PROVIDED TO SHG EXECUTIVES. THIS INCLUDED RELATIVE COMPETITIVE MARKET PRACTICE INFORMATION FOR THE NORTHEAST REGION MARKET OBTAINED FROM TWO HEALTHCARE EXECUTIVE COMPENSATION SURVEYS THAT WERE PREPARED BY INDEPENDENT FIRMS. THE CONSULTANT ALSO COMPILED NATIONAL MARKET DATA FROM THREE COMMERCIALY AVAILABLE HEALTHCARE EXECUTIVE COMPENSATION SURVEYS PREPARED BY INDEPENDENT FIRMS: AND (3) CONTEMPORANEOUS DOCUMENTATION AND RECORD KEEPING WITH RESPECT TO DELIBERATIONS AND DECISIONS REGARDING THE COMPENSATION ARRANGEMENTS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VI, SECTION C, LINE 19:	SHG MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.



**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART VII, SECTION A, LINE 1:	TRUSTEES AND OFFICERS ARE COMPENSATED FOR THEIR ROLES OUTSIDE OF THEIR CAPACITY AS TRUSTEES AND OFFICERS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART XI, LINE 9:	TRANSFERS AMONG AFFILIATES (\$34,247,026) POST RET. AND OTHER CHANGES IN NET ASSETS \$63,587,465 CHANGE IN VALUE OF PERPETUAL TRUSTS \$ 1,308,020 _____ TOTAL \$30,648,459

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
PART XII, LINE 2A & 2B:	FINANCIAL RESULTS FOR SHG ARE INCLUDED IN THE SOUTHCOAST HEALTH SYSTEM, INC AND AFFILIATES CONSOLIDATED FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2019 AND 2020 WHICH WERE ISSUED WITH AN INDEPENDENT AUDITOR'S REPORT WITH AN UNQUALIFIED AUDIT OPINION. INCLUDED IN THESE AUDITED FINANCIAL STATEMENTS IS SUPPLEMENTAL CONSOLIDATED INFORMATION FOR THE YEAR ENDED SEPTEMBER 30, 2020. NO STAND ALONE AUDITED FINANCIAL STATEMENTS WERE ISSUED FOR SHG FOR THE YEAR ENDED SEPTEMBER 30, 2020.

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2019**

**Open to Public  
Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
Southcoast Hospitals Group Inc

**Employer identification number**

22-2592333

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

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

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

(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
<b>(1)</b> SOUTHCOAST HEALTH SYSTEM INC 101 PAGE ST  NEW BEDFORD, MA 02740 04-2794625	SUPP. SHG	MA	501(c)(3)	12, Type I	NA		No
<b>(2)</b> SOUTHCOAST PHYSICIANS GROUP INC 200 MILL RD STE 180  FAIRHAVEN, MA 02719 22-2703314	PHYS. SVCS.	MA	501(c)(3)	10	SHS	Yes	
<b>(3)</b> SOUTHCOAST VENTURES INC 101 PAGE ST  NEW BEDFORD, MA 02740 04-3003172	PHYS. SVCS.	MA	501(c)(3)	12, Type I	SHS	Yes	
<b>(4)</b> CHARLTON LONG TERM CARE SVCS INC 363 HIGHLAND AVE  FALL RIVER, MA 02720 04-3109579	SUPP. SHG	MA	501(c)(3)	12, Type I	SHS	Yes	
<b>(5)</b> SOUTHCOAST VISITING NURSE ASSN INC 200 MILL RD  FAIRHAVEN, MA 02719 04-2105745	HOME CARE	MA	501(c)(3)	10	SHS	Yes	
<b>(6)</b> Saint Luke's Nursing Home Inc 101 Page St  NEW BEDFORD, MA 02740 04-2984542	Inactive	MA	501(c)(3)	12, Type I	SHS	Yes	

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
<b>(1)</b> COASTLINE PROFESSIONAL ASSURANCE CO PO Box Grand Cayman GRAND CAYMAN CJ 98-0445031	INSURANCE	CJ	SHS	Corp				Yes	
<b>(2)</b> SOUTHCOAST PHYSICIANS NETWORK INC 101 PAGE ST NEW BEDFORD, MA 02740 45-0568782	IPA	MA	SHS	Corp				Yes	
<b>(3)</b> HEALTH MANAGEMENT INITIATIVES INC 363 HIGHLAND AVE FALL RIVER, MA 02720 04-2998712	COMM RENTAL	MA	SHS	Corp				Yes	

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

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

		Yes	No
<b>1</b> During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
<b>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) . . . . .		No
<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) . . . . .	Yes	
<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) . . . . .	Yes	
<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) . . . . .		No
<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 . . . . .	Yes	
<b>r</b>	Other transfer of cash or property to related organization(s) . . . . .	Yes	
<b>s</b>	Other transfer of cash or property from related organization(s) . . . . .	Yes	

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

See Additional Data Table

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

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

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

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

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

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

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



## Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 22-2592333  
**Name:** Southcoast Hospitals Group Inc

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
Southcoast Physicians Group Inc	J	1,669,011	CASH
Southcoast Physicians Group Inc	O	1,544,913	CASH
Southcoast Physicians Group Inc	P	33,133,528	CASH
Southcoast Physicians Group Inc	Q	4,922,984	CASH
Southcoast Visiting Nurse Assoc Inc	O	293,018	CASH
Southcoast Visiting Nurse Assoc Inc	Q	985,691	CASH
Southcoast Visiting Nurse Assoc Inc	S	103,500	CASH
Coastline Professional Assurance Corp	P	2,489,002	CASH