

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

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047
2019
Open to Public Inspection

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

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

C Name of organization
CIRCLES OF CARE INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
400 E SHERIDAN RD

City or town, state or province, country, and ZIP or foreign postal code
MELBOURNE, FL 32901

D Employer identification number
59-1101553

E Telephone number
(321) 722-5200

G Gross receipts \$ 43,489,661

F Name and address of principal officer:
DAVID FELDMAN
400 E SHERIDAN ROAD
MELBOURNE, FL 32901

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.CIRCLESOF CARE.ORG

K Form of organization: Corporation Trust Association Other ▶

L Year of formation:

M State of legal domicile: FL

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
THE MISSION OF CIRCLES OF CARE IS TO PROMOTE AND PROVIDE HIGH QUALITY MENTAL HEALTH, ALCOHOL, DRUG ABUSE AND RELATED SERVICES THROUGH ITS HOSPITAL BASED AND STATE AND COUNTY CONTRACTED PROGRAMS.

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

| | | |
|--|-----------|-----|
| 3 Number of voting members of the governing body (Part VI, line 1a) | 3 | 19 |
| 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 19 |
| 5 Total number of individuals employed in calendar year 2019 (Part V, line 2a) | 5 | 698 |
| 6 Total number of volunteers (estimate if necessary) | 6 | |
| 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0 |
| 7b Net unrelated business taxable income from Form 990-T, line 39 | 7b | |

| | Prior Year | Current Year |
|--|------------|--------------|
| 8 Contributions and grants (Part VIII, line 1h) | 17,379,253 | 20,120,764 |
| 9 Program service revenue (Part VIII, line 2g) | 23,478,971 | 22,211,235 |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 1,127,528 | 548,160 |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 174,429 | 609,502 |
| 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 42,160,181 | 43,489,661 |

| | Beginning of Current Year | End of Year |
|---|---------------------------|-------------|
| 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) | | 0 |
| 14 Benefits paid to or for members (Part IX, column (A), line 4) | | 0 |
| 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) | 25,817,090 | 26,368,916 |
| 16a Professional fundraising fees (Part IX, column (A), line 11e) | | 0 |
| b Total fundraising expenses (Part IX, column (D), line 25) ▶ | | |
| 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 14,617,798 | 15,739,660 |
| 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 40,434,888 | 42,108,576 |
| 19 Revenue less expenses. Subtract line 18 from line 12 | 1,725,293 | 1,381,085 |

| | Beginning of Current Year | End of Year |
|--|---------------------------|-------------|
| 20 Total assets (Part X, line 16) | 50,844,767 | 53,679,795 |
| 21 Total liabilities (Part X, line 26) | 8,234,760 | 9,709,074 |
| 22 Net assets or fund balances. Subtract line 21 from line 20 | 42,610,007 | 43,970,721 |

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: 2021-05-07

WILLIAM VINTROUX SENIOR VP/TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: Preparer's signature: Date: 2021-05-07

Check if self-employed PTIN: P00189512

Firm's name ▶ BERMAN HOPKINS WRIGHT LAHAM CPAS & ASSOC Firm's EIN ▶ 59-1152714

Firm's address ▶ 8035 SPYGLASS HILL RD MELBOURNE, FL 32940 Phone no. (321) 757-2020

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

THE MISSION OF CIRCLES OF CARE IS TO PROMOTE AND PROVIDE HIGH QUALITY MENTAL HEALTH, ALCOHOL, DRUG ABUSE AND RELATED SERVICES THROUGH ITS HOSPITAL BASED AND STATE AND COUNTY CONTRACTED PROGRAMS.

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 \$ including grants of \$) (Revenue \$)
See Additional Data

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

4c (Code:) (Expenses \$ 39,285,025 including grants of \$) (Revenue \$)
See Additional Data

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

4e Total program service expenses ▶ 39,285,025

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, and Yes/No columns. Rows include questions 22 through 38 regarding organizational reporting, compensation, and tax-exempt status.

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 ID, Question Text, and Yes/No columns. Rows include questions 1a, 1b, and 1c regarding Form 1096, Form W-2G, and gaming winnings.

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

Main form grid with questions 2a through 16 and sub-questions a through h, including input fields and checkboxes.

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, 1a, 1b, Yes, No. Rows include questions about voting members, family relationships, management control, and governance decisions.

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

Table with 5 columns: Question, Yes, No. Rows include questions about local chapters, written policies, conflict of interest, whistleblower, and document retention policies.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed (FL)
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: DAVID FELDMAN 400 E SHERIDAN ROAD MELBOURNE, FL 32901 (321) 722-5200

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 | | | | | | | | | | |
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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 | | | | | | | | | | |
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|--|--|-----------|---------|
| 1b Sub-Total | | | |
| c Total from continuation sheets to Part VII, Section A | | | |
| d Total (add lines 1b and 1c) | | 2,604,413 | 567,968 |

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 ▶ 11

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

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|--------------------------------|---------------------|
| AETNA HEALTH MANAGEMENT LLC 151 FARMINGTON AVE HARTFORD, CT 06156 | DENTAL&LIFE INS | 376,326 |
| HEALTH FIRST REFERENCE LABRATORY 3300 FISKE BLVD ROCKLEDGE, FL 32955 | LAB SERVICES | 134,653 |
| PALM BAY DEVELOPERS 1501 HARVARD CIRCLE MELBOURNE, FL 32904 | PROPERTY RENTAL | 134,155 |
| FLORIDA LINEN SERVICES SPACE COAST LLC 1895 MURRELL ROAD ROCKLEDGE, FL 329553231 | LINEN CLEANING | 118,397 |
| BORIS KAWLICHE MD, 737 ROSIER RD BRANDON, FL 33510 | CONTRACTED PHYS | 103,500 |

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 ▶ 5

Part VIII Statement of Revenue

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

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 | |
|---|--|---|----------------------|--|---|--|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | 1a | | | | | |
| | b Membership dues | 1b | | | | | |
| | c Fundraising events | 1c | | | | | |
| | d Related organizations | 1d | | | | | |
| | e Government grants (contributions) | 1e | 19,170,499 | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 950,265 | | | | |
| | g Noncash contributions included in lines 1a - 1f:\$ | 1g | 950,265 | | | | |
| | h Total. Add lines 1a-1f | | 20,120,764 | | | | |
| Program Service Revenue | 2a PATIENT SERVICE REVENUE | Business Code | 14,533,896 | 14,533,896 | | | |
| | b PHARMACY INCOME | | 6,879,446 | 6,879,446 | | | |
| | c MEDICAID | | 508,964 | 508,964 | | | |
| | d OTHER INCOME | | 288,929 | 288,929 | | | |
| | e | | | | | | |
| | f All other program service revenue. | | | | | | |
| | g Total. Add lines 2a-2f. | | 22,211,235 | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | 548,160 | | | 548,160 | |
| | 4 Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 Royalties | | | | | | |
| | 6a Gross rents | (i) Real | 609,502 | | | | |
| | | (ii) Personal | | | | | |
| | | b Less: rental expenses | | | | | |
| | | c Rental income or (loss) | 609,502 | | | | |
| | d Net rental income or (loss) | | 609,502 | 609,502 | | | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | | | | | |
| | | (ii) Other | | | | | |
| | | b Less: cost or other basis and sales expenses | | | | | |
| | | c Gain or (loss) | | | | | |
| | d Net gain or (loss) | | | | | | |
| | 8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 | | | | | | |
| | | b Less: direct expenses | | | | | |
| c Net income or (loss) from fundraising events | | | | | | | |
| 9a Gross income from gaming activities. See Part IV, line 19 | | | | | | | |
| | b Less: direct expenses | | | | | | |
| | c Net income or (loss) from gaming activities | | | | | | |
| 10a Gross sales of inventory, less returns and allowances | | | | | | | |
| | b Less: cost of goods sold | | | | | | |
| | c Net income or (loss) from sales of inventory | | | | | | |
| Miscellaneous Revenue | Business Code | | | | | | |
| 11a | | | | | | | |
| b | | | | | | | |
| c | | | | | | | |
| d All other revenue | | | | | | | |
| e Total. Add lines 11a-11d | | | | | | | |
| 12 Total revenue. See instructions | | 43,489,661 | 22,820,737 | | 548,160 | | |

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|------------------------------|--|---|------------------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | | | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | | | | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 Other salaries and wages | 20,291,420 | 18,733,658 | 1,557,762 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | | | | |
| 9 Other employee benefits | 4,646,570 | 4,445,291 | 201,279 | |
| 10 Payroll taxes | 1,430,926 | 1,336,431 | 94,495 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | | | | |
| b Legal | 25,620 | 24,140 | 1,480 | |
| c Accounting | | | | |
| d Lobbying | | | | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 1,385,449 | 1,283,250 | 102,199 | |
| 12 Advertising and promotion | | | | |
| 13 Office expenses | 178,060 | 166,988 | 11,072 | |
| 14 Information technology | 553,807 | 520,381 | 33,426 | |
| 15 Royalties | | | | |
| 16 Occupancy | 917,142 | 807,469 | 109,673 | |
| 17 Travel | 276,182 | 250,152 | 26,030 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 Conferences, conventions, and meetings | 23,330 | 12,322 | 11,008 | |
| 20 Interest | 154,586 | 146,586 | 8,000 | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 828,758 | 316,577 | 512,181 | |
| 23 Insurance | 695,679 | 647,262 | 48,417 | |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a PHARMACY | 7,545,999 | 7,545,999 | | |
| b BAD DEBT EXPENSE | 1,033,274 | 1,033,274 | | |
| c FOOD | 1,017,720 | 1,002,459 | 15,261 | |
| d REPAIRS AND MAINTENANCE | 666,472 | 610,892 | 55,580 | |
| e All other expenses | 437,582 | 401,894 | 35,688 | |
| 25 Total functional expenses. Add lines 1 through 24e | 42,108,576 | 39,285,025 | 2,823,551 | 0 |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). | | | | |

Part X Balance Sheet

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

| | | (A) Beginning of year | | (B) End of year |
|---|--|--------------------------|------------|--------------------|
| Assets | 1 Cash—non-interest-bearing | 8,950,592 | 1 | 12,533,745 |
| | 2 Savings and temporary cash investments | 3,801,211 | 2 | 3,863,385 |
| | 3 Pledges and grants receivable, net | 2,235,748 | 3 | 1,517,995 |
| | 4 Accounts receivable, net | 1,520,000 | 4 | 1,605,000 |
| | 5 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) | | 6 | |
| | 7 Notes and loans receivable, net | | 7 | |
| | 8 Inventories for sale or use | 1,390,890 | 8 | 1,426,972 |
| | 9 Prepaid expenses and deferred charges | 774,042 | 9 | 754,366 |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 24,413,876 | | |
| | b Less: accumulated depreciation | 14,326,655 | | |
| | 11 Investments—publicly traded securities | 12,808,104 | 11 | 13,294,089 |
| | 12 Investments—other securities. See Part IV, line 11 | | 12 | |
| | 13 Investments—program-related. See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | | 14 | |
| | 15 Other assets. See Part IV, line 11 | 8,617,393 | 15 | 8,597,022 |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 50,844,767 | 16 | 53,679,795 | |
| Liabilities | 17 Accounts payable and accrued expenses | 4,413,727 | 17 | 4,866,558 |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | | 19 | |
| | 20 Tax-exempt bond liabilities | | 20 | |
| | 21 Escrow or custodial account liability. Complete Part IV of Schedule D | | 21 | |
| | 22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 22 | |
| | 23 Secured mortgages and notes payable to unrelated third parties | | 23 | |
| | 24 Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D | 3,821,033 | 25 | 4,842,516 |
| | 26 Total liabilities. Add lines 17 through 25 | 8,234,760 | 26 | 9,709,074 |
| Net Assets or Fund Balances | Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33. | | | |
| | 27 Net assets without donor restrictions | 41,992,614 | 27 | 43,373,699 |
| | 28 Net assets with donor restrictions | 617,393 | 28 | 597,022 |
| | Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33. | | | |
| | 29 Capital stock or trust principal, or current funds | | 29 | |
| | 30 Paid-in or capital surplus, or land, building or equipment fund | | 30 | |
| | 31 Retained earnings, endowment, accumulated income, or other funds | | 31 | |
| 32 Total net assets or fund balances | 42,610,007 | 32 | 43,970,721 | |
| 33 Total liabilities and net assets/fund balances | 50,844,767 | 33 | 53,679,795 | |

Part XI Reconciliation of Net Assets

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

| | | | |
|-----------|--|-----------|------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 43,489,661 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 42,108,576 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 1,381,085 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 42,610,007 |
| 5 | Net unrealized gains (losses) on investments | 5 | |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -20,371 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 43,970,721 |

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 |
|-----------|-----|----|
| 2a | | No |
| 2b | Yes | |
| 2c | Yes | |
| 3a | Yes | |
| 3b | Yes | |

Additional Data

Software ID:

Software Version:

EIN: 59-1101553

Name: CIRCLES OF CARE INC

Form 990 (2019)

Form 990, Part III, Line 4a:

ALCOHOL, DRUG ABUSE, & MENTAL HEALTH - MEDICAL OUTPATIENT ALCOHOL, DRUG ABUSE, & MENTAL HEALTH - DAY/NIGHT, CASEMGT ADAMH

Form 990, Part III, Line 4b:

ALCOHOL, DRUG ABUSE, & MENTAL HEALTH - RESIDENTIAL 2 & 3 ALCOHOL, DRUG ABUSE, & MENTAL HEALTH - INPATIENT, DETOX ALCOHOL, DRUG ABUSE, & MENTAL HEALTH - CRISIS SUPPORT

Form 990, Part III, Line 4c:

ADAMH-OVERLAY, INTERVENTION, SUBSTANCE ABUSE, INPATIENT AND OUTPATIENT TREATMENT.

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 | | | |
| DR BRENDA FETTROW CHAIR | | X | | | | | | 0 | 0 | 0 |
| SCOTT WIDERMAN VICE-CHAIR | | X | | | | | | 0 | 0 | 0 |
| JACK MASSON DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| JERRY W ALLENDER DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| BENJAMIN GLOVER DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| DEWEY L HARRIS DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| HEIDAR HESHMATI MD PHD DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| SHERIFF WAYNE IVEY DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| NEIL M JACKSON DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| ALICE M JONES PHD DIRECTOR | | 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 | | | |
| DARCIA JONES-FRANCEY DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| GEORGE KAMBOURELIS DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| MARY BETH KENKEL PHD DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| RICHARD LAIRD DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| BRIAN L LIGHTLE DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| ANDREW PICKETT DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| JUDGE CHARLES J ROBERTS DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| ROBERT SALONEN DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| STOCKTON WHITTEN DIRECTOR | | X | | | | | | 0 | 0 | 0 |
| DAVID FELDMAN PRESIDENT | 41.00 | | | X | | | | 340,494 | 0 | 69,942 |

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 | | | |
| WILLIAM VINTROUX SENIOR VP/TR | 48.00 | | | X | | | | 211,356 | 0 | 62,648 |
| STEPHEN LORD VP INFORMATI | 45.00 | | | X | | | | 197,663 | 0 | 61,681 |
| BARRY HENSEL VP CLINICAL | 43.00 | | | | X | | | 246,228 | 0 | 60,983 |
| LINDA BRANNON VP HUMAN RES | 43.00 | | | | X | | | 173,350 | 0 | 31,943 |
| JASON WIESELER EXECUTIVE VI | 42.00 | | | | X | | | 189,414 | 0 | 38,242 |
| REHAN FAROOQUI PSYCHIATRIST | 56.00 | | | | | X | | 318,732 | 0 | 64,434 |
| LUIS VINUELA PSYCHIATRIST | 31.00 | | | | | X | | 259,604 | 0 | 56,935 |
| JOSEPH MINGOIA PSYCHIATRIST | 40.00 | | | | | X | | 227,797 | 0 | 45,784 |
| JAMES MILLER PSYCHIATRIST | 40.00 | | | | | X | | 220,117 | 0 | 52,312 |
| APARNA KOPURI PSYCHIATRIST | 27.00 | | | | | X | | 219,658 | 0 | 23,064 |

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CIRCLES OF CARE INC

Employer identification number
59-1101553

Employer identification number
59-1101553

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

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

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

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

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|--|------------|------------|------------|------------|------------|------------|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . . | 15,176,388 | 15,348,111 | 15,072,806 | 17,379,253 | 20,120,764 | 83,097,322 |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge.. | | | | | | |
| 4 Total. Add lines 1 through 3 | 15,176,388 | 15,348,111 | 15,072,806 | 17,379,253 | 20,120,764 | 83,097,322 |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) . . . | | | | | | |
| 6 Public support. Subtract line 5 from line 4. | | | | | | 83,097,322 |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
|---|------------|------------|------------|------------|------------|------------|
| 7 Amounts from line 4. . . | 15,176,388 | 15,348,111 | 15,072,806 | 17,379,253 | 20,120,764 | 83,097,322 |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources . . . | 196,105 | 520,135 | 1,787,580 | 1,127,528 | 548,160 | 4,179,508 |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on. . . | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . . | 595,838 | 619,327 | 142,945 | 174,429 | 609,502 | 2,142,041 |
| 11 Total support. Add lines 7 through 10 | | | | | | 89,418,871 |

12 Gross receipts from related activities, etc. (see instructions) **12** 22,820,737

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

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|----------|
| 14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) | 14 | 92.930 % |
| 15 Public support percentage for 2018 Schedule A, Part II, line 14 | 15 | 91.340 % |

16a 33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

b 33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

17a 10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization

b 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization

18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions

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

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

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a 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 |
|------------|--|-----|----|
| 1 | 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> | | |
| | 1 | | |
| 2 | Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <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> | | |
| | 2 | | |
| 3a | 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> | | |
| | 3a | | |
| b | Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i> | | |
| | 3b | | |
| c | 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> | | |
| | 3c | | |
| 4a | 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> | | |
| | 4a | | |
| 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> | | |
| | 4b | | |
| c | Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <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> | | |
| | 4c | | |
| 5a | 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> | | |
| | 5a | | |
| b | Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | | |
| | 5b | | |
| c | Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| | 5c | | |
| 6 | Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i> | | |
| | 6 | | |
| 7 | Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| | 7 | | |
| 8 | 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> | | |
| | 8 | | |
| 9a | Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i> | | |
| | 9a | | |
| b | Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| | 9b | | |
| c | Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| | 9c | | |
| 10a | Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i> | | |
| | 10a | | |
| 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> | | |
| | 10b | | |

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

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 |
| |

990 Schedule A, Supplemental Information

| Return Reference | Explanation |
|------------------|-------------------------|
| PART II, LINE 10 | RENTAL INCOME 2,142,041 |

SCHEDULE D (Form 990)

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 for instructions and the latest information.

Department of the Treasury Internal Revenue Service

Name of the organization CIRCLES OF CARE INC

Employer identification number 59-1101553

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4: Total number at end of year, Aggregate value of contributions to (during year), Aggregate value of grants from (during year), 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?
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?

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)
Protection of natural habitat
Preservation of open space
Preservation of an historically important land area
Preservation of a certified historic structure

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

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?
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)?
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:
(ii) Revenue included on Form 990, Part VIII, line 1
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:

- c** Beginning balance
- d** Additions during the year
- e** Distributions during the year
- f** Ending balance

| | Amount |
|-----------|--------|
| 1c | |
| 1d | |
| 1e | |
| 1f | |

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

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

Part V Endowment Funds.

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

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

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

- a** Board designated or quasi-endowment ▶
- b** Permanent endowment ▶
- c** Temporarily restricted endowment ▶

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

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

- (i)** unrelated organizations
- (ii)** related organizations

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

- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 1,110,682 | | 1,110,682 |
| b Buildings | | | | |
| c Leasehold improvements | | | | |
| d Equipment | | | | |
| e Other | | 23,303,194 | 14,326,655 | 8,976,539 |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶ | | | | 10,087,221 |

Part VII Investments—Other Securities.

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

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

Part VIII Investments—Program Related.

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

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

Part IX Other Assets.

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

| (a) Description | (b) Book value |
|--|----------------|
| (1) RENOVATIONS AND REPLACEMENTS | 8,000,000 |
| (2) BENEFICIAL INT PERPETUAL TRUST | 597,022 |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) | 8,597,022 |

Part X Other Liabilities.

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

| 1. (a) Description of liability | (b) Book value |
|--|----------------|
| (1) Federal income taxes | |
| (2) BONDS PAYABLE | 3,176,749 |
| (3) SBA PPP LOAN | 1,336,633 |
| (4) CURRENT PORTION OF LT DEBT | 329,134 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| (10) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) | 4,842,516 |

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

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

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

| | | | | |
|----------|--|-----------|-----------|------------|
| 1 | Total revenue, gains, and other support per audited financial statements | | 1 | 43,489,661 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | | |
| a | Net unrealized gains (losses) on investments | 2a | | |
| b | Donated services and use of facilities | 2b | | |
| c | Recoveries of prior year grants | 2c | | |
| d | Other (Describe in Part XIII.) | 2d | | |
| e | Add lines 2a through 2d | | 2e | |
| 3 | Subtract line 2e from line 1 | | 3 | 43,489,661 |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1: | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | |
| b | Other (Describe in Part XIII.) | 4b | | |
| c | Add lines 4a and 4b | | 4c | |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | | 5 | 43,489,661 |

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

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

| | | | | |
|----------|---|-----------|-----------|------------|
| 1 | Total expenses and losses per audited financial statements | | 1 | 42,108,576 |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25: | | | |
| a | Donated services and use of facilities | 2a | | |
| b | Prior year adjustments | 2b | | |
| c | Other losses | 2c | | |
| d | Other (Describe in Part XIII.) | 2d | | |
| e | Add lines 2a through 2d | | 2e | |
| 3 | Subtract line 2e from line 1 | | 3 | 42,108,576 |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | |
| b | Other (Describe in Part XIII.) | 4b | | |
| c | Add lines 4a and 4b | | 4c | |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | | 5 | 42,108,576 |

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 | |
|------------------|-------------|--|
|------------------|-------------|--|

Part XIII **Supplemental Information (continued)**

| Return Reference | Explanation |
|------------------|-------------|
|------------------|-------------|

**SCHEDULE H
(Form 990)**

Department of the
Treasury

Internal Revenue Service
Name of the organization
CIRCLES OF CARE INC

Hospitals

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

Employer identification number
59-1101553

OMB No. 1545-0047

2019
**Open to Public
Inspection**

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|--|--------------------------------------|--|--------------------------------------|--|-------------------------------------|
| a Financial Assistance at cost (from Worksheet 1) | | | 6,858,941 | | 6,858,941 | 16.290 % |
| b Medicaid (from Worksheet 3, column a) | | | 176,654 | 508,964 | | |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | 25,919,984 | 9,377,619 | 16,542,365 | 39.290 % |
| d Total Financial Assistance and Means-Tested Government Programs | | | 32,955,579 | 9,886,583 | 23,401,306 | 55.570 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4). | | | | | | |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | 2,317,212 | 331,003 | 1,986,209 | 4.720 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total. Other Benefits | | | 2,317,212 | 331,003 | 1,986,209 | 4.720 % |
| k Total. Add lines 7d and 7j | | | 35,272,791 | 10,217,586 | 25,387,515 | 60.290 % |

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

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

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

| | (a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions) | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|----|---|---|--|--|---|
| 1 | | | | | |
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| 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 |
|---------------------------|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| | | | | | | | | | | |
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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)
CIRCLES OF CARE 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): _____ 1 _____

| | | Yes | No |
|--|--|-----|----|
| Community Health Needs Assessment | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply): | Yes | |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u> | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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 | |
| 6a | 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 | |
| 6b | 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 | |
| 7 | Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply): | Yes | |
| a | <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.CIRCLESOFCARE.ORG</u> | | |
| b | <input type="checkbox"/> Other website (list url): _____ | | |
| c | <input type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u> | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>WWW.CIRCLESOFCARE.ORG</u> | Yes | |
| 10b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | No |
| 12b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c | If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

CIRCLES OF CARE 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: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP: | Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>400.000000000000</u> % | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | Yes | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | Yes | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.CIRCLESOFCARE.ORG</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.CIRCLESOFCARE.ORG</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.CIRCLESOFCARE.ORG</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | |
| h | <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |

Part V Facility Information (continued)

Billing and Collections

CIRCLES OF CARE INC

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

CIRCLES OF CARE 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 |
|-----------|-----|----|
| 23 | | No |
| 24 | | 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 | |
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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? 9

| Name and address | Type of Facility (describe) |
|---|--------------------------------------|
| 1 TWIN RIVERS 400 EAST SHERIDAN ROAD MELBOURNE, FL 32901 | INPATIENT ADULT SUBSTANCE ABUSE |
| 2 CHILDRENS CRISIS STABILIZATION UNIT 400 EAST SHERIDAN ROAD MELBOURNE, FL 32901 | CHILDREN'S CRISIS STABILIZATION UNIT |
| 3 ADULT CRISIS STABILIZATION UNIT 880 DR MLK JR BLVD MELBOURNE, FL 32901 | ADULT CRISIS STABILIZATION UNIT |
| 4 PSYCHIATRIC OUTPATIENT SERVICES 6700 S WASHINGTON AVE TITUSVILLE, FL 32718 | PSYCHIATRIC OUTPATIENT SERVICES |
| 5 PSYCHIATRIC OUTPATIENT SERVICES 1770 CEDAR STREET ROCKLEDGE, FL 32955 | PSYCHIATRIC OUTPATIENT SERVICES |
| 6 PSYCHIATRIC OUTPATIENT SERVICES 2020 COMMERCE DRIVE MELBOURNE, FL 32904 | PSYCHIATRIC OUTPATIENT SERVICES |
| 7 CHILDREN'S OUTREACH SERVICES 4450 W EAU GALLIE BLVD MELBOURNE, FL 32934 | CHILDREN'S OUTREACH SERVICES |
| 8 ADULT RESIDENTIAL SERVICES 200 COMMERCE DRIVE MELBOURNE, FL 32904 | ADULT RESIDENTIAL SERVICES |
| 9 ADULT RESIDENTIAL SERVICES 1770 CEDAR STREET ROCKLEDGE, FL 32955 | ADULT RESIDENTIAL SERVICES |
| 10 | |

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-----------------------------|---|
| SCHEDULE H, PART I, LINE 7G | AMOUNTS REPORTED ON PSYCHIATRIC INPATIENT UNIT REVENUE AND EXPENSES BASED ON COST ACCOUNTING SYSTEM. |
| SCHEDULE H, PART I, LINE 7 | COSTING INFORMATION CALCULATED USING THE WEIGHTED AVERAGE OF THE INPATIENT COST TO CHARGE RATIO USED FOR THE PROVIDER'S MEDICARE COST REPORT AND THE OUTPATIENT COST TO CHARGE RATIO DEVELOPED USING THE PROVIDER'S COST ACCOUNTING SYSTEM. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|------------------------------|--|
| SCHEDULE H, PART III, LINE 2 | COSTING INFORMATION IS CALCULATED USING THE WEIGHTED AVERAGE OF THE INPATIENT COST TO CHARGE RATIO USED FOR THE PROVIDER'S 2020 MEDICARE COST REPORT AND THE OUTPATIENT COST TO CHARGE RATIO DEVELOPED USING THE PROVIDER'S COST ACCOUNTING SYSTEM. THE AMOUNT OF BAD DEBT EXPENSE (AT COST) ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY IS BASED ON AN ANALYSIS OF PATIENTS WHOSE COVERAGE UNDER THIRD PARTY PAYORS OR OTHER AGENCIES WAS REJECTED DUE TO INCOMPLETE OR ERRONEOUS INFORMATION BEING PROVIDED UPON ADMISSION. GROSS PATIENT SERVICE REVENUE IS ADJUSTED FOR CONTRACTUAL AND POLICY ADJUSTMENTS TO DETERMINE NET PATIENT SERVICE REVENUE. ACCORDINGLY, ALL AMOUNTS WRITTEN OFF AS BAD DEBT EXCLUDE THESE CONTRACTUAL AND POLICY ADJUSTMENTS. |
| SCHEDULE H, PART III, LINE 8 | REVENUE RECEIVED UNDER THE MEDICARE REIMBURSEMENT AGREEMENT IS SUBJECT TO AUDIT AND RETROACTIVE ADJUSTMENT BY THE MEDICARE INTERMEDIARY AGENCY. THE RETROACTIVE MEDICARE ADJUSTMENTS ARE REPORTED IN NET PATIENT SERVICE REVENUE IN THE YEAR IN WHICH THE FUNDS ARE PAID OUT OR RECEIVED. ALL MEDICARE REPORTS, FOR THE YEARS ENDED JUNE 30, 2020 AND PRIOR, HAVE BEEN AUDITED OR SUBJECTED TO A DESK REVIEW AND FINAL SETTLEMENTS HAVE BEEN DETERMINED. MANAGEMENT RECORDS ADDITIONAL RECEIVABLES AND PAYABLES RELATING TO MEDICARE BASED ON THE MEDICARE COST REIMBURSEMENT REPORTS. THE TOTAL INPATIENT REVENUE RECEIVED FROM MEDICARE AND ALLOWABLE COSTS OF CARE RELATING TO THOSE PAYMENTS ARE TAKEN DIRECTLY FROM THE 2020 MEDICARE COST REPORT SETTLEMENT SUMMARY. NO BAD DEBTS WERE TAKEN INTO CONSIDERATION WHEN CALCULATING THESE AMOUNTS. THE TOTAL OUTPATIENT REVENUE RECEIVED FROM MEDICARE ARE TAKEN DIRECTLY FROM THE 2020 MEDICARE COST REPORT. COSTS ASSOCIATED WITH THSE REVENUES ARE BASED ON THE COST TO CHARGE RATIO DEVELOPED FOR OUTPATIENT SERVICES USING THE PROVIDER'S COST ACCOUNTING SYSTEM. NO BAD DEBTS WERE TAKEN INTO CONSIDERATION WHEN CALCULATING THESE AMOUNTS. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------------|--|
| SCHEDULE H, PART III, LINE 9B | INSURED CLIENTS ARE RESPONSIBLE FOR CO-PAYS REGARDLESS OF THEIR INCOME BY LAW. THE INPATIENT COLLECTION POLICY MANDATES THAT THE PROVIDER MAKE THREE ATTEMPTS (LETTERS, TELEPHONE) TO COLLECT PRIOR TO WRITING A RECEIVABLE OFF AS A BAD DEBT. IF THE PATIENT MEETS THE CRITERIA FOR CHARITY CARE AS INDIGENT UNDER THE FEDERAL POVERTY GUIDELINES, NO ATTEMPT TO COLLECT IS MADE. IF THE PROVIDER IS UNABLE TO COLLECT THE CLIENT VIA MAIL OR PHONE, THE RELATED RECEIVABLE IS WRITTEN OFF AS BAD DEBT. |
| SCHEDULE H, PART VI, LINE 2 | CIRCLES OF CARE, INC. MAINTAINS COMMUNICATION WITH THE DEPARTMENT OF CHILDREN AND FAMILIES, THE STATE'S MENTAL HEALTH AND SUBSTANCE ABUSE AUTHORITY. THE ORGANIZATION ALSO CONDUCTS IT'S OWN LOCAL SURVEYS AND COLLABORATES WITH OTHER LOCAL HOSPITAL ORGANIZATIONS AND THE SPACE COAST HEALTH FOUNDATION TO ACCESS THE CURRENT NEEDS OF THE COMMUNITY. IN ADDITION, THE ORGANIZATION IS A MEMBER OF THE HEALTH SYSTEMS AGENCY OF EAST CENTRAL FLORIDA THAT CONDUCTS REGIONAL AND STATEWIDE NEEDS ASSESSMENTS. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-----------------------------|---|
| SCHEDULE H, PART VI, LINE 3 | AFTER ADMISSION TO THE INPATIENT UNITS, CLIENT FINANCIAL REPRESENTATIVES MEET WITH THE CLIENT TO DISCUSS THE CLIENT'S INSURANCE COVERAGE. DURING THIS DISCUSSION, ALONG WITH A FINANCIAL ELIGIBILITY APPLICATION, THE FINANCIAL REPRESENTATIVES INFORMS THE CLIENT OF ANY AVAILABLE FINANCIAL ASSISTANCE WHICH INCLUDES FREE OR DISCOUNTED SERVICES. UPON DISCHARGE, THIS INFORMATION IS ONCE AGAIN REVIEWED WITH THE CLIENT. |
| SCHEDULE H, PART VI, LINE 4 | CIRCLES OF CARE , INC. SERVES BREVARD COUNTY FLORIDA. BREVARD COUNTY, A COASTAL REGION BORDERED ON THE EAST BY THE ATLANTIC OCEAN. BREVARD IS AN EXTRA-LONG COUNTY, EXTENDING 72 MILES FROM NORTH TO SOUTH, BUT AVERAGING 26.5 MILES INLAND FROM THE SEACOAST AT ANY POINT. BREVARD COUNTY IS APPROXIMATELY 35 MILES EAST OF ORLANDO AND "HALFWAY" DOWN FLORIDA. THERE IS NO MAJOR URBAN CENTER IN THE COUNTY. THE RACIAL MAKEUP OF THE COUNTY ACCORDING TO THE MOST RECENT POPULATION ESTIMATES BASED ON 2010 CENSUS DATA, RACE WAS: WHITE 83.0%; BLACK OR AFRICAN AMERICAN 10.1%; ASIAN 2.1%; SOME OTHER RACE 2.2%; TWO OR MORE RACES 2.6%. THE HISPANIC OR LATINO POPULATION IS 8.1%. THE POPULATION OF 590,000 WAS DISTRIBUTED AS FOLLOWS: 18.5% UNDER THE AGE OF 18, 58.2% FROM 18 TO 64, AND 23.3% WHO WERE 65 YEARS OF AGE OR OLDER. THE PERCENT OF FEMALES WAS 51.2%. THERE WERE 227,223 WITH AN AVERAGE HOUSEHOLD SIZE OF 2.47. THE MEDIAN HOUSEHOLD INCOME IN 2017 DOLLARS WAS 51,536. THE PERCENT OF PERSONS IN POVERTY WAS 12.4%. THOSE WITHOUT INSURANCE UNDER AGE 65 WAS 13.2%. INDIVIDUALS WITH A DISABILITY UNDER 65 IS 10.0% |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-----------------------------|---|
| SCHEDULE H, PART VI, LINE 5 | A VOLUNTARY CITIZEN BOARD OF TWENTY-TWO PERSONS WHO LIVE AND WORK IN BREVARD COUNTY GOVERNS CIRCLES OF CARE, INC. THIS ACTIVE AND INVOLVED BOARD OF DIRECTORS IS CHARGED WITH: ESTABLISHING ALL POLICIES GOVERNING THE CORPORATION, APPROVING ANNUALLY THE GOALS, OBJECTIVES AND A PLAN OF OPERATION FOR THE DELIVERY OF SERVICES, APPROVAL OF AN ANNUAL BUDGET, OVERSIGHT OF FINANCIAL RECORDS AND AUDITS, ASSURING THOSE PERSONS OF THE BREVARD COMMUNITY ARE SERVED WITH QUALITY, APPROPRIATE AND EFFICIENT PROGRAMS. BOARD MEMBERS ARE SELECTED FOR THEIR INTEREST AND DESIRE IN THE PROVISION OF QUALITY BEHAVIORAL HEALTHCARE SERVICES IN BREVARD COUNTY. THE BOARD MEMBERS ARE REFLECTIVE OF THE DIFFERENT GEOGRAPHICAL AREAS OF THE COUNTY AND MANY REPRESENT CONSUMERS AND FAMILY MEMBERS WITH SPECIAL INTEREST IN OUR VARIOUS PROGRAMS. |
| SCHEDULE H, PART VI, LINE 6 | N/A |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|-------------------------|--|
| SCHEDULE H, PART VI | CHARITY CARE CIRCLES OF CARE IDENTIFIES CHARITY CARE PATIENTS USING THE SAME CRITERIA USED BY THE STATE OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION. IT IS THEIR POLICY THAT A PATIENT, WHOSE INCOME DOES NOT EXCEED 200 PERCENT OF THE CURRENT FEDERAL POVERTY GUIDELINES, WILL BE CLASSIFIED AS A CHARITY CARE PATIENT. ADDITIONALLY, IF THE PATIENT'S TOTAL CHARGES EXCEED 25 PERCENT OF THE PATIENT'S ANNUAL INCOME, THE PATIENT WILL BE CLASSIFIED AS A CHARITY CARE PATIENT, UNLESS THE PATIENT'S INCOME EXCEEDS FOUR TIMES THE FEDERAL POVERTY LEVEL FOR A FAMILY OF FOUR. BECAUSE CIRCLES OF CARE DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE SUCH AMOUNTS ARE NOT REPORTED AS GROSS PATIENT SERVICE REVENUE. |

Additional Data**Software ID:****Software Version:****EIN:** 59-1101553**Name:** CIRCLES OF CARE INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

| Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1 | | 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 | CIRCLES OF CARE INC 400 E SHERIDAN ROAD MELBOURNE, FL 32901 | X | | | | | | | | MENTAL HEALTH SERVICES | |

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 |
|--|---|
| FACILITY 1, CIRCLES OF CARE, INC - PART V, LINE 3E | CIRCLES OF CARE IS ADDRESSING TWO PRIORITY AREAS FROM THE CHNA: (1) COUNTY SUICIDE RATE AND (2) ACCESS TO BEHAVIORAL HEALTH SERVICES. |
| FACILITY 1, CIRCLES OF CARE, INC - PART V, LINE 5 | THE CHNA IS THE PRODUCT OF TWO UMBRELLA ORGANIZATIONS , CENTRAL FLORIDA CARES HEALTH SYSTEM (CFCHS) AND SPACE COAST HEALTH FOUNDATION (SCHF) EACH OF WHICH RECEIVES INPUT FROM CIRCLES OF CARE. CFCHS FOCUSES PRIMARILY ON BEHAVIORAL HEALTHCARE NEEDS AND REPRESENTS THE FOLLOWING ORGANIZATIONS: 211 BREVARD ASPIRE HEALTH PARTNERS , INC. BREVARD C.A.R.E.S CHILDREN'S HOME SOCIETY OF FLORIDA, INC. COMMUNITY COUNSELING CENTER OF CENTRAL FLORIDA CIRCLES OF CARE , INC. DEVEREUX ECKERD CONNECTS GULF COAST JEWISH FAMILY AND COMMUNITY SERVICES HEART OF FLORIDA UNITED WAY 211 HOUSE OF FREEDOM IMPOWER KINDER KONSULTING & PARENTS TOO LIFESTREAM BEHAVIORAL CENTER, INC . MENTAL HEALTH ASSOCIATION MENTAL HEALTH RESOURCE CENTER (MHRC) BREVARD COUNTY FACT TEAM METRO TREATMENT OF FLORIDA, L.P. (NEW SEASON) ORLANDO HEALTH / THE HEALING TREE PARK PLACE BEHAVIORAL HEALTH CARE RASE PROJECT SPACE COAST RECOVERY SPECIALIZED TREATMENT, EDUCATION AND PREVENTION SERVICES (STEPS) THE TRANSITION HOUSE , INC. UCF RESTORES UNIVERSITY BEHAVIORAL CENTER WAYNE DENSCH CENTER SPACE COAST HEALTH FOUNDATION FOCUSES ON THE MEDICAL AND BEHAVIORAL HEALTHCARE NEEDS OF BREVARD COUNTY RESIDENTS AND REPRESENTS THE FOLLOWING HOSPITALS AND ORGANIZATIONS: 211 BREVARD BREVARD C.A.R.E.S BREVARD COUNTY COURTS BREVARD COUNTY SHERIFFS OFFICE BREVARD FAMILY PARTNERSHIP BREVARD HEALTH ALLIANCE BREVARD HOMELESS COALITION BREVARD PUBLIC SCHOOLS BREVARD SCHOOLS CATHOLIC CHARITIES OF CENTRAL FLORIDA CENTRAL FLORIDA CARES HEALTH SYSTEM INC. CHILDREN'S ADVOCACY CENTER CIRCLES OF CARE COASTAL HEALTH SYSTEMS OF BREVARD FLORIDA INSTITUTE OF TECHNOLOGY HOUSING AND HUMAN SERVICES LIFETIME COUNSELING CENTER NAMI BREVARD COUNTY ONE SENIOR PLACE PARRISH MEDICAL CENTER SPACE COAST HEALTH FOUNDATION |

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 |
|--|--|
| FACILITY 1, CIRCLES OF CARE, INC - PART V, LINE 6A | OTHER HOSPITALS WITH WHICH THE CHNA WAS CONDUCTED INCLUDE PARRISH MEDICAL CENTER AND ASPIRE HEALTH PARTNERS, INC. |
| FACILITY 1, CIRCLES OF CARE, INC - PART V, LINE 6B | OTHER NON-HOSPITAL ORGANIZATIONS WITH WHICH THE CHNA WAS CONDUCTED INCLUDE: 211 BREVARD BREVARD C.A.R.E.S BREVARD COUNTY COURTS BREVARD COUNTY SHERIFF'S OFFICE BREVARD FAMILY PARTNERSHIP BREVARD HEALTH ALLIANCE BREVARD HOMELESS COALITION BREVARD PUBLIC SCHOOLS BREVARD SCHOOLS CATHOLIC CHARITIES OF CENTRAL FLORIDA CENTRAL FLORIDA CARES HEALTH SYSTEM INC. CHILDREN'S ADVOCACY CENTER COASTAL HEALTH SYSTEMS OF BREVARD FLORIDA INSTITUTE OF TECHNOLOGY HOUSING AND HUMAN SERVICES LIFETIME LEARNING CENTER NAMI BREVARD COUNTY ONE SENIOR PLACE SPACE COAST HEALTH FOUNDATION CHILDREN'S HOME SOCIETY OF FLORIDA, INC. COMMUNITY COUNSELING CENTER OF CENTRAL FLORIDA DEVEREUX ECKERD CONNECTS GULF COAST JEWISH FAMILY AND COMMUNITY SERVICES HEART OF FLORIDA UNITED WAY 211 HOUSE OF FREEDOM IMPOWER KINDER KONSULTING & PARENTS TOO LIFE STREAM BEHAVIORAL CENTER, INC. MENTAL HEALTH ASSOCIATION MENTAL HEALTH RESOURCE CENTER (MHRC) BREVARD COUNTY FACT TEAM MENTAL HEALTH RESOURCE CENTER, INC. OSCEOLA COUNTY FACT TEAM METRO TREATMENT OF FLORIDA, L.P. (NEW SEASON) ORLANDO HEALTH / THE HEALING TREE PARK PLACE BEHAVIORAL HEALTH CARE RASE PROJECT SPACE COAST RECOVERY SPECIALIZED TREATMENT, EDUCATION AND PREVENTION SERVICES (STEPS) THE TRANSITION HOUSE, INC. UCF RESTORES UNIVERSITY BEHAVIORAL CENTER WAYNE DENSCH 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 |
|--|---|
| FACILITY 1, CIRCLES OF CARE, INC - PART V, LINE 11 | CIRCLES OF CARE IS ADDRESSING TWO PRIORITY AREAS FROM THE CHNA: (1) COUNTY SUICIDE RATE AND (2) ACCESS TO BEHAVIORAL HEALTH SERVICES. TO ADDRESS THE COUNTY SUICIDE RATE, CIRCLES OF CARE INTENDS TO: (1) CIRCLES WILL LOBBY THE FLORIDA LEGISLATURE FOR DESIGNATION AS A CENTRAL RECEIVING SYSTEM THAT CAN BE BROUGHT HOME TO DIRECTLY EXPAND THE AVAILABLE CRISIS SERVICES INCLUDING MOBILE CRISIS SUPPORT FOR BREVARD COUNTY RESIDENTS. (2) CIRCLES OF CARE WILL EXPAND ITS ENHANCED RISK ASSESSMENTS OF THE INPATIENT POPULATIONS TO ALL AMBULATORY PROGRAMS. (3) BY EXPANDING ACCESS TO CARE, PRIORITY AREA 1, CIRCLES OF CARE WILL INTERFACE WITH MORE SUICIDAL RESIDENTS AFFORDING A HIGHER OPPORUNITY FOR INTERVENTION. TO ADDRESS THE ACCESS TO BEHAVIORAL HEALTH SERVICES, CIRCLES OF CARE INTENDS TO: (1) CIRCLES OF CARE WILL UTILIZE CONTRACTED INCIDENTAL FUNDING TO PROVIDE TRANSPORTATION AND REDUCE MISSED APPOINTMENTS FOR CLIENTS WITH TRANSPORTATION CHALLENGES. (2) INCREASE CAPACITY OF SUBSTANCE USE DISORDERS, INCLUDING MAT AND CHILD WELFARE PROGRAMS. (3) CIRCLES WILL INCREASE THE NUMBER OF DESIGNATED DETOXIFICATION BEDS. OTHER PRIORITIES IDENTIFIED BY THE CHNA THAT WERE NOT ADDRESSED AT THIS TIME AS THEY REPRESENTED MORE MEDICALLY-CENTERED ISSUES VERSUS THE BEHAVIORAL HEALTHCARE MARKET THAT CIRCLES OF CARE SERVES. |

Schedule J
(Form 990)

Compensation Information

OMB No. 1545-0047

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

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
CIRCLES OF CARE INC

Employer identification number
59-1101553

Part I Questions Regarding Compensation

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

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

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

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

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

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 CIRCLES OF CARE INC

Employer identification number

59-1101553

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 |
| (1) SARAH BEST | WIFE - OFFICER | 62,969 | WAGES | | No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Part V Supplemental Information

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

| Return Reference | Explanation |
|------------------|-------------|
| | |

**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 for the latest information.**

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
CIRCLES OF CARE INC

Employer identification number
59-1101553

Part I Types of Property

| | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|--|----------------------------|---|--|---|
| 1 Art—Works of art | | | | |
| 2 Art—Historical treasures | | | | |
| 3 Art—Fractional interests | | | | |
| 4 Books and publications | | | | |
| 5 Clothing and household goods | | | | |
| 6 Cars and other vehicles | | | | |
| 7 Boats and planes | | | | |
| 8 Intellectual property | | | | |
| 9 Securities—Publicly traded | | | | |
| 10 Securities—Closely held stock | | | | |
| 11 Securities—Partnership, LLC, or trust interests | | | | |
| 12 Securities—Miscellaneous | | | | |
| 13 Qualified conservation contribution—Historic structures | | | | |
| 14 Qualified conservation contribution—Other | | | | |
| 15 Real estate—Residential | | | | |
| 16 Real estate—Commercial | | | | |
| 17 Real estate—Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | | | | |
| 20 Drugs and medical supplies | X | 1 | 900,000 | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ▶ (OTHER) | X | 1 | 50,265 | |
| 26 Other ▶ (_____) | | | | |
| 27 Other ▶ (_____) | | | | |
| 28 Other ▶ (_____) | | | | |

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

| | |
|----|--|
| 29 | |
|----|--|

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

| | Yes | No |
|-----|-----|----|
| 30a | | No |
| 31 | | No |
| 32a | | No |

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

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

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

b If "Yes," describe in Part II.

33 If the organization 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 |
|------------------|-------------|
|------------------|-------------|

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 for the latest information.

OMB No. 1545-0047

2019**Open to Public Inspection**

Department of the Treasury

Name of the organization
CIRCLES OF CARE INC

Employer identification number

59-1101553

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-------------------------------------|--|
| FORM 990, PAGE 6, PART VI, LINE 11B | THE PREPARER EMAILS A COPY OF THE FINAL VERSION OF FORM 990 TO THE CHAIRMAN OF THE AUDIT AND FINANCE COMMITTEE BEFORE IT IS FILED. THE CHAIRMAN THEN DISTRIBUTES THE COPY OF THE FINAL VERSION TO THE BOARD MEMBERS FOR REVIEW. AFTER REVIEWING THE RETURN, THE AUDIT AND FINANCE COMMITTEE APPROVES THE RELEASE OF THE FORM 990 PENDING ANY APPLICABLE CHANGES. THE RETURN IS THEN MODIFIED AS NECESSARY AND FILED. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|-------------------------------------|--|
| FORM 990, PAGE 6, PART VI, LINE 12C | <p>THE ORGANIZATION'S CONFLICT OF INTEREST POLICY REQUIRES EACH DIRECTOR, OFFICER AND MANAGEMENT STAFF TO SIGN A STATEMENT ANNUALLY THAT ADDIRMS THAT EACH PERSON (A) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY; (B) HAS READ AND UNDERSTANDS THE POLICY; (C) HAS AGREED TO COMPLY WITH THE POLICY AND (D) UNDERSTANDS THAT CIRCLE OF CARE IS A CHARITABLE ORGANIZATION AND THAT IN ORDER TO MAINTAIN ITS FEDERAL TAX EXEMPTION, IT MUST ENGAGE PRIMARILY IN ACTIVITIES THAT ACCOMPLISH ONE OR MORE OF ITS TAX EXEMPT PURPOSES. THE ORGANIZATION'S CONFLICT OF INTEREST POLICY HAS THREE ESSENTIAL ELEMENTS. (1) FULL DISCLOSURE BOARD MEMBERS AND STAFF MEMBERS IN DECISION- MAKING ROLES SHOULD MAKE KNOWN THEIR CONNECTIONS WITH GROUPS DOING BUSINESS WITH THE ORGANIZATION. THIS INFORMATION SHOULD BE PROVIDED ANNUALLY. (2) BOARD MEMBER ABSTENTION FROM DISCUSSION AND VOTING BOARD MEMBERS WHO HAVE AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST SHOULD NOT PARTICIPATE IN DISCUSSIONS OR VOTE ON MATTERS AFFECTING TRANSACTIONS BETWEEN THE ORGANIZATION AND OTHER GROUPS. (3) STAFF MEMBER ABSTENTION FROM DECISION-MAKING STAFF MEMBERS WHO HAVE AN ACTUAL OR POTENTIAL CONFLICT SHOULD NOT BE SUBSTANTIALLY INVOLVED IN DECISION-MAKING AFFECTING SUCH TRANSACTIONS. IF THERE IS REASONABLE CAUSE TO BELIEVE THAT A DIRECTOR, OFFICER OR MANAGEMENT STAFF MEMBER IS INVOLVED IN OR IS AWARE OF ANY TRANSACTIONS OR SITUATION THAT RESULTS IN A CONFLICT, OR THE APPEARANCE OF A CONFLICT, DIRECTLY, OR INDIRECTLY THROUGH BUSINESS, INVESTMENT OR FAMILY, THEN SUCH PERSON SHALL PROMPTLY DISCLOSE THE EXISTENCE AND NATURE OF HIS OR HER CONFLICT. A FULL DISCLOSURE OF ALL THE FACTS PERTAINING TO ANY TRANSACTION THAT IS SUBJECT TO ANY DOUBT CONCERNING THE POSSIBLE EXISTENCE OF A CONFLICT OF INTEREST SHALL BE MADE BEFORE CONSUMMATION OF THE TRANSACTION. IF THERE IS REASONABLE CAUSE TO BELIEVE THAT A DIRECTOR, OFFICER OR MANAGEMENT STAFF MEMBER HAS FAILED TO DISCLOSE ACTUAL OR POSSIBLE CONFLICTS OF INTEREST, THE INDIVIDUAL SHALL BE INFORMED OF THE BASIS FOR SUCH BELIEF AND SHALL BE AFFORDED AN OPPORTUNITY TO EXPLAIN THE ALLEGED FAILURE TO DISCLOSE. IF AFTER HEARING THE RESPONSE OF THE DIRECTOR, OFFICER OR MANAGEMENT STAFF MEMBER AND MAKING SUCH FURTHER INVESTIGATION AS MAY BE WARRANTED IN THE CIRCUMSTANCES, IT IS DEEMED THE DIRECTOR, OFFICER OR MANAGEMENT STAFF MEMBER HAS IN FACT FAILED TO DISCLOSE AN ACTUAL OR POSSIBLE CONFLICT OF INTEREST, APPROPRIATE DISCIPLINARY ACTION SHALL BE TAKEN.</p> |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
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| FORM 990, PAGE 6, PART VI, LINE 15A | THE EXECUTIVE COMMITTEE OF THE BOARD UTILIZED STATE-WIDE (FLORIDA COUNCIL OF COMMUNITY MENTAL HEALTH) AND NATIONAL (MENTAL HEALTH CORPORATION OF AMERICA) COMPENSATION SURVEYS OF CEOs IN THE MENTAL HEALTH INDUSTRY. USING THE RESULTS OF THE SURVEYS, THE EXECUTIVE COMMITTEE DRAFTED A PROPOSED COMPENSATION PACKAGE FOR THE CEO AND FORWARDED IT TO THE ADULT AND FINANCE COMMITTEE FOR REVIEW PRIOR TO ITS INCORPORATION INTO THE BUDGET. PARAMETERS UTILIZED IN SETTING THE COMPENSATION PACKAGE FOR THE CEO INCLUDES SERVICE DELIVERY TO THE COMMUNITY AND COMPLIANCE WITH INDUSTRY STANDARDS/REGULATIONS. COMPENSATION IS NOT BASED ON THE REVENUES OR NET EARNINGS OF THE ORGANIZATION. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
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| FORM 990, PAGE 6, PART VI, LINE 15B | USING AVAILABLE STATEWIDE (FLORIDA COUNCIL OF COMMUNITY MENTAL HEALTH) AND NATIONAL (MENTAL HEALTH CORPORATION OF AMERICA) INDUSTRY DATA, THE CEO FORMULATES COMPENSATION PACKAGES FOR ALL OTHER OFFICERS AND KEY EMPLOYEES. FACTORS CONSIDERED IN FORMULATING COMPENSATION INCLUDE EDUCATION, EXPERIENCE AND COST OF LIVING DIFFERENCES WHERE APPLICABLE. COMPENSATION IS NOT BASED OF THE REVENUE OR NET EARNINGS OF THE ORGANIZATION. ONCE THE COMPENSATION PACKAGES FOR OFFICER AND KEY EMPLOYEES ARE ASSEMBLED, THE CEO FORWARDS HIS PROPOSALS TO THE AUDIT AND FINANCE COMMITTEE FOR INCORPORATION INTO THE BUDGET. ONCE THE AUDIT AND FINANCE COMMITTEE RECEIVES THE PROPOSED COMPENSATION PACKAGES FOR THE CEO AND OTHER OFFICERS AND KEY EMPLOYEES, THEY ARE REVIEWED AND INCORPORATED INTO THE BUDGET PROCESS. ONCE THE BUDGET IS COMPLETED, IT IS FORWARDED TO THE FULL BOARD FOR APPROVAL. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
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| FORM 990, PAGE 6, PART VI, LINE 19 | THE ORGANIZATION PROVIDES MEMBERS OF THE PUBLIC COPIES OF ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS FREE OF CHARGE UPON RECEIPT OF A WRITTEN REQUEST FOR SUCH INFORMATION. FINANCIAL STATEMENTS ARE ALSO AVAILABLE ON THE ORGANIZATION'S WEBSITE. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
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| FORM 990, PART VIII | LINE 2B: PHARMACY INCOME IS EXCLUSIVE OF 900,000 IN DONATED PHARMACEUTICALS. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
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| FORM 990, PART XI, LINE 9 | CHANGE IN UNREALIZED GAINS AND LOSSES -20,371 |