

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
2018
Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018, and ending 12-31-2018

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

C Name of organization
SUTTER VALLEY MEDICAL FOUNDATION
% CARLA WHITE-SNYDER
Doing business as
Number and street (or P O box if mail is not delivered to street address) Room/suite
C/O SH TAX 2200 RIVER PLAZA DR
City or town, state or province, country, and ZIP or foreign postal code
SACRAMENTO, CA 95833

D Employer identification number
68-0273974

E Telephone number
(916) 286-6665

G Gross receipts \$ 1,546,941,649

F Name and address of principal officer
THERESA FREI
C/O SH TAX 2200 RIVER PLAZA DR
SACRAMENTO, CA 95833

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.SUTTERHEALTH.ORG

L Year of formation 1992

M State of legal domicile CA

K Form of organization
Corporation Trust Association Other

Part I Summary

1 Briefly describe the organization's mission or most significant activities
SEE SCHEDULE O

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

Table with 2 columns: Line number, Amount. Rows 3-7b showing membership and revenue data.

Table with 3 columns: Line number, Prior Year, Current Year. Rows 8-12 showing revenue breakdown.

Table with 3 columns: Line number, Prior Year, Current Year. Rows 13-19 showing expenses and net revenue.

Table with 3 columns: Line number, Beginning of Current Year, End of Year. Rows 20-22 showing net assets and fund balances.

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: PAIGE TERRA CFO
Date: 2019-10-30

Paid Preparer Use Only
Print/Type preparer's name, Preparer's signature, Date, Firm's name, Firm's address, Firm's EIN, Phone 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

SEE SCHEDULE O

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

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

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

If "Yes," describe these changes on Schedule O

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

**4a** (Code ) (Expenses \$ 1,421,453,376 including grants of \$ 795,366 ) (Revenue \$ 1,543,967,072 )  
See Additional Data

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

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

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

**4e** Total program service expenses ▶ 1,421,453,376

Part IV Checklist of Required Schedules

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

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

		Yes	No	
<b>23</b>	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . . <input checked="" type="checkbox"/>	23	Yes	<input type="checkbox"/>
<b>24a</b>	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . . <input checked="" type="checkbox"/>	24a	Yes	<input type="checkbox"/>
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	24b		No <input type="checkbox"/>
<b>c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	24c		No <input type="checkbox"/>
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	24d		No <input type="checkbox"/>
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . . <input checked="" type="checkbox"/>	25a		No <input type="checkbox"/>
<b>b</b>	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . . <input checked="" type="checkbox"/>	25b		No <input type="checkbox"/>
<b>26</b>	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> . . . . . <input checked="" type="checkbox"/>	26		No <input type="checkbox"/>
<b>27</b>	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> . . . . . <input checked="" type="checkbox"/>	27		No <input type="checkbox"/>
<b>28</b>	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . . <input checked="" type="checkbox"/>	28a		No <input type="checkbox"/>
<b>b</b>	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . . <input checked="" type="checkbox"/>	28b	Yes	<input type="checkbox"/>
<b>c</b>	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> . . . . . <input checked="" type="checkbox"/>	28c		No <input type="checkbox"/>
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . . <input checked="" type="checkbox"/>	29	Yes	<input type="checkbox"/>
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . . <input checked="" type="checkbox"/>	30		No <input type="checkbox"/>
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	31		No <input type="checkbox"/>
<b>32</b>	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .	32		No <input type="checkbox"/>
<b>33</b>	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . . <input checked="" type="checkbox"/>	33	Yes	<input type="checkbox"/>
<b>34</b>	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . . <input checked="" type="checkbox"/>	34	Yes	<input type="checkbox"/>
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	<input type="checkbox"/>
<b>b</b>	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . . <input checked="" type="checkbox"/>	35b	Yes	<input type="checkbox"/>
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . . <input checked="" type="checkbox"/>	36		No <input type="checkbox"/>
<b>37</b>	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> <input checked="" type="checkbox"/>	37		No <input type="checkbox"/>
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	38	Yes	<input type="checkbox"/>

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

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

		Yes	No	
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	1a	319	<input type="checkbox"/>
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	1b	0	<input type="checkbox"/>
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	1c	Yes	<input type="checkbox"/>

<p><b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .</p>	<b>2a</b>	5,270		
<p><b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b>If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)</p>			<b>2b</b>	Yes
<p><b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .</p>			<b>3a</b>	Yes
<p><b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .</p>			<b>3b</b>	Yes
<p><b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .</p>			<b>4a</b>	No
<p><b>b</b> If "Yes," enter the name of the foreign country <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)</p>				
<p><b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .</p>			<b>5a</b>	No
<p><b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>			<b>5b</b>	No
<p><b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .</p>			<b>5c</b>	
<p><b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .</p>			<b>6a</b>	No
<p><b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .</p>			<b>6b</b>	
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>				
<p><b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .</p>			<b>7a</b>	Yes
<p><b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .</p>			<b>7b</b>	Yes
<p><b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .</p>			<b>7c</b>	No
<p><b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .</p>	<b>7d</b>			
<p><b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>			<b>7e</b>	No
<p><b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .</p>			<b>7f</b>	No
<p><b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .</p>			<b>7g</b>	
<p><b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .</p>			<b>7h</b>	
<b>8 Sponsoring organizations maintaining donor advised funds.</b>				
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .</p>			<b>8</b>	
<p><b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .</p>			<b>9a</b>	
<p><b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .</p>			<b>9b</b>	
<b>10 Section 501(c)(7) organizations.</b> Enter				
<p><b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .</p>	<b>10a</b>			
<p><b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	<b>10b</b>			
<b>11 Section 501(c)(12) organizations.</b> Enter				
<p><b>a</b> Gross income from members or shareholders . . . . .</p>	<b>11a</b>			
<p><b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .</p>	<b>11b</b>			
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?				
<p><b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	<b>12b</b>			
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>				
<p><b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O</p>			<b>13a</b>	
<p><b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .</p>	<b>13b</b>			
<p><b>c</b> Enter the amount of reserves on hand . . . . .</p>	<b>13c</b>			
<p><b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .</p>			<b>14a</b>	No
<p><b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .</p>			<b>14b</b>	
<p><b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .</p>			<b>15</b>	No
<p><b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .</p>			<b>16</b>	No

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



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (18); 1b Enter the number of voting members included in line 1a, above, who are independent (15); 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? (No); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (Yes); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (Yes); 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? (Yes); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (Yes); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (Yes); b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official (Yes); b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (Yes); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? (Yes).

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (CA); 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply: Own website, Another's website, Upon request, Other (explain in Schedule O); 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records (CARLA WHITE-SNYDER, 9100 FOOTHILLS BLVD, ROSEVILLE, CA 95747 (916) 286-6665).

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

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

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

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

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

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

<b>1b Sub-Total</b>			
<b>1c Total from continuation sheets to Part VII, Section A</b>			
<b>1d Total (add lines 1b and 1c)</b>		1,586,244	3,888,181

**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 ▶ 643

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
MEDICINE PHYSICIANS INC, PO BOX 2743 ELK GROVE, CA 95757	STAFFING SERVICES	3,957,941
QUEST DIAGNOSTICS INC, PO BOX 912512 PASADENA, CA 91102512	LABORATORY SERVICES	3,520,899
DEACON CONSTRUCTION LLC, 7745 GREENBACK LN STE 250 CITRUS HEIGHTS, CA 956105865	Construction SRVCS	2,607,275
WEST FORK CONSTRUCTION INC, 6050 WAREHOUSE WY SACRAMENTO, CA 95826	CONSTRUCTION COMPANY	1,929,798
HSS INC, PO BOX 17033 DENVER, CO 80217	SECURITY SERVICES	1,364,931

**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 ▶ 91



**Part VIII Statement of Revenue**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b> 708			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b> 75,063			
	<b>d</b> Related organizations . . . . .	<b>1d</b> 7,176			
	<b>e</b> Government grants (contributions)	<b>1e</b>			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b> 1,415,377			
	<b>g</b> Noncash contributions included in lines 1a - 1f \$ _____	300,357			
	<b>h Total.</b> Add lines 1a-1f . . . . .		1,498,324		

<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> PATIENT SERVICE REVENUE		621110	1,529,648,076	1,529,648,076		
<b>b</b> HEALTHCARE RELATED JV INCOME		621110	12,648,419	12,648,419			
<b>c</b> RENTAL TO AFFILIATES		621110	1,046,619	1,046,619			
<b>d</b> GUARANTEED PAYMENT JV INCOME		621110	623,958	623,958			
<b>e</b> _____							
<b>f</b> All other program service revenue							
<b>g Total.</b> Add lines 2a-2f . . . . .			1,543,967,072				

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			1,178,530			1,178,530	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0				
	<b>5</b> Royalties . . . . .			0				
	<b>6a</b> Gross rents	(i) Real	(ii) Personal					
			66,111					
		<b>b</b> Less rental expenses		12,364				
		<b>c</b> Rental income or (loss)		53,747		0		
	<b>d</b> Net rental income or (loss) . . . . .			53,747			53,747	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
					176,694			
		<b>b</b> Less cost or other basis and sales expenses				0		
		<b>c</b> Gain or (loss)			176,694			
	<b>d</b> Net gain or (loss) . . . . .			176,694			176,694	
	<b>8a</b> Gross income from fundraising events (not including \$ 75,063 of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>			17,337			
		<b>b</b> Less direct expenses . . . . .	<b>b</b>		26,610			
<b>c</b> Net income or (loss) from fundraising events . . . . .				-9,273			-9,274	
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>			619				
	<b>b</b> Less direct expenses . . . . .	<b>b</b>		0				
	<b>c</b> Net income or (loss) from gaming activities . . . . .			619			619	
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>			0				
	<b>b</b> Less cost of goods sold . . . . .	<b>b</b>		0				
	<b>c</b> Net income or (loss) from sales of inventory . . . . .			0				
Miscellaneous Revenue		Business Code						
<b>11a</b> SFSC ADMIN FEE		541610	36,962		36,962			
<b>b</b> _____								
<b>c</b> _____								
<b>d</b> All other revenue . . . . .								
<b>e Total.</b> Add lines 11a-11d . . . . .			36,962					
<b>12 Total revenue.</b> See Instructions . . . . .			1,546,902,675	1,543,967,072	36,962		1,400,316	

**Part IX Statement of Functional Expenses**

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

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

	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	794,541	794,541		
<b>2</b> Grants and other assistance to domestic individuals See Part IV, line 22	825	825		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
<b>4</b> Benefits paid to or for members	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees	0			
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
<b>7</b> Other salaries and wages	250,601,275	230,592,555	19,903,306	105,414
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	21,337,552	19,633,901	1,703,651	
<b>9</b> Other employee benefits	119,544,456	109,999,686	9,460,877	83,893
<b>10</b> Payroll taxes	21,511,821	19,794,256	1,717,565	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management	2,094,158	104,678	1,989,480	
<b>b</b> Legal	389,715	389,715		
<b>c</b> Accounting	2,300		2,300	
<b>d</b> Lobbying	0			
<b>e</b> Professional fundraising services See Part IV, line 17	0			
<b>f</b> Investment management fees	218,758		218,758	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	595,908,648	581,850,655	14,057,993	0
<b>12</b> Advertising and promotion	90,516		90,516	
<b>13</b> Office expenses	12,139,980	7,723,952	4,415,241	787
<b>14</b> Information technology	40,651,845	23,140,341	17,511,504	
<b>15</b> Royalties	0			
<b>16</b> Occupancy	47,756,096	44,750,147	3,005,949	
<b>17</b> Travel	1,773,112	1,493,763	279,349	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
<b>19</b> Conferences, conventions, and meetings	323,936	113,370	210,566	
<b>20</b> Interest	6,628,398	6,628,398		
<b>21</b> Payments to affiliates	0			
<b>22</b> Depreciation, depletion, and amortization	43,923,299	40,378,808	3,544,491	
<b>23</b> Insurance	2,630,260	1,171,675	1,458,585	
<b>24</b> Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
<b>a</b> CAPITATED SERVICES	120,649,036	120,649,036		
<b>b</b> PURCHASED SERVICES	96,630,023	85,724,567	10,905,456	
<b>c</b> MEDICAL SUPPLIES	80,076,856	80,076,856		
<b>d</b> SYSTEM ALLOCATIONS	61,635,208	34,290,134	27,345,074	
<b>e</b> All other expenses	15,948,571	12,151,517	3,654,262	142,792
<b>25</b> Total functional expenses. Add lines 1 through 24e	1,543,261,185	1,421,453,376	121,474,923	332,886
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				
Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	0	<b>1</b>	0
	<b>2</b> Savings and temporary cash investments . . . . .	58,277,321	<b>2</b>	89,621,827
	<b>3</b> Pledges and grants receivable, net . . . . .	86,382	<b>3</b>	63,718
	<b>4</b> Accounts receivable, net . . . . .	87,031,602	<b>4</b>	89,520,181
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L . . . . .	0	<b>5</b>	0
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L . . . . .	0	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	9,286,740	<b>8</b>	9,413,905
	<b>9</b> Prepaid expenses and deferred charges . . . . .	677,384	<b>9</b>	749,356
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 755,935,981		
	<b>b</b> Less accumulated depreciation	<b>10b</b> 440,815,491	329,728,935	<b>10c</b> 315,120,490
	<b>11</b> Investments—publicly traded securities . . . . .	435,119	<b>11</b>	571,022
	<b>12</b> Investments—other securities See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b> Investments—program-related See Part IV, line 11 . . . . .	16,357,289	<b>13</b>	15,832,291
	<b>14</b> Intangible assets . . . . .	24,283,299	<b>14</b>	24,283,299
	<b>15</b> Other assets See Part IV, line 11 . . . . .	14,714,581	<b>15</b>	14,803,852
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	540,878,652	<b>16</b>	559,979,941	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	153,857,416	<b>17</b>	186,731,143
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b> Tax-exempt bond liabilities . . . . .	202,287,649	<b>20</b>	191,334,459
	<b>21</b> Escrow or custodial account liability Complete Part IV of Schedule D . . . . .	0	<b>21</b>	0
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L . . . . .	0	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0	<b>23</b>	0
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D . . . . .	6,819,268	<b>25</b>	6,654,404
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	362,964,333	<b>26</b>	384,720,006
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	176,634,376	<b>27</b>	173,212,974
	<b>28</b> Temporarily restricted net assets . . . . .	1,166,918	<b>28</b>	1,904,616
	<b>29</b> Permanently restricted net assets	113,025	<b>29</b>	142,345
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
<b>33</b> Total net assets or fund balances . . . . .	177,914,319	<b>33</b>	175,259,935	
<b>34</b> Total liabilities and net assets/fund balances . . . . .	540,878,652	<b>34</b>	559,979,941	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,546,902,675
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,543,261,185
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	3,641,490
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	177,914,319
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	3,382
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-6,299,256
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	175,259,935

**Part XII Financial Statements and Reporting**

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

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

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 68-0273974

**Name:** SUTTER VALLEY MEDICAL FOUNDATION

Form 990 (2018)

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

SEE SCHEDULE O

**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			
DAVID ADKINS MD ..... DIRECTOR	2 0 .....	X						0	0	0
TIMOTHY BYRD ..... DIRECTOR	2 0 .....	X						0	0	0
JAMES CONFORTI ..... DIRECTOR/SH SVP/COO	2 0 4 0	X		X				0	1,323,800	482,604
VIVA ETTIN MD ..... DIRECTOR	2 0 .....	X						0	0	0
BRONWYN FIELDS RN ..... DIRECTOR	2 0 .....	X						0	0	0
DAN FLORES ..... DIRECTOR	2 0 .....	X						0	0	0
GARY HOOPER ..... DIRECTOR	2 0 .....	X						0	0	0
SCOTT HOWELL ..... DIRECTOR	2 0 .....	X						0	0	0
I-MEI HSIU MD ..... DIRECTOR	2 0 .....	X						0	0	0
PETER HULL MD ..... DIRECTOR/CME SVH	2 0 4 0	X						0	403,550	52,484

**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			
SARAH KREVANS ..... DIRECTOR/PRESIDENT & CEO, SH	4 0 .....	X		X				0	2,850,301	1,935,821
MARIA PALLAVICINI ..... DIRECTOR	2 0 .....	X						0	0	0
PAT PATHIPATI ..... DIRECTOR	2 0 .....	X						0	0	0
FATIMA SEWARD ..... DIRECTOR/CHAIR F & P	4 0 .....	X		X				0	0	0
KURT SHULER MD ..... DIRECTOR	2 0 .....	X						0	4,000	0
TODD SMITH MD ..... DIRECTOR	2 0 .....	X						0	0	0
HELEN THOMSON ..... DIRECTOR/CHAIR	4 0 .....	X		X				0	0	0
JERRY TOKUNAGA ..... DIRECTOR	2 0 .....	X						0	0	0
THERESA FREI ..... CEO, SVMF	2 0 .....			X				0	687,921	126,061
PAIGE TERRA ..... CFO, SH VALLEY AREA	2 0 .....			X				0	712,555	101,349

**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			
PENNY WESTFALL ..... CHIEF LEGAL OFFICER, SH VALLEY	2 0 ..... 40 0			X				0	570,753	76,422
JEFF SZCZESNY ..... VP, HR SH VALLEY AREA	0 0 ..... 40 0				X			0	551,184	79,076
GARY ZUFELT ..... CEO, SUTTER GOULD MED FDN	0 0 ..... 40 0				X			0	614,309	120,991
JONATHAN K BARENG ..... DIR, RADIATION PHYSICS	40 0 ..... 0 0					X		285,333	0	31,449
VIRGINIA JOYCE ..... MED DIR, QUAL & PATIENT SAFETY	40 0 ..... 0 0					X		268,725	0	28,978
ERIC RASMUSSEN ..... DIR FND GROWTH & MED GRP STRT	40 0 ..... 0 0					X		221,345	0	33,350
ZULFIQAR A SANDHU ..... DIR SERVICE AREA	40 0 ..... 0 0					X		245,280	0	34,774
STANLEY SKUBIC ..... LEAD PHYSICIST - pd	40 0 ..... 0 0					X		240,435	0	27,603
PAMELA ADDY ..... REG DIR OUTPATIENT IMAGING	40 0 ..... 0 0						X	210,132	0	26,528
THOMAS BLINN ..... FRMR CEO, VALLEY AREA FNDTN	0 0 ..... 0 0						X	0	291,377	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			
GLENN GROVES ..... REGIONAL ADMIN DIRECTOR	40 0 ..... 0 0						X	114,994	4,919	6,123
SUHEIR HADDAD ..... CFO, SH VALLEY AREA FDN	0 0 ..... 40 0						X	0	494,164	75,735
KATHERINE T MANUEL ..... COO, SGMF	0 0 ..... 40 0						X	0	441,979	47,275
MICHAEL MARINO ..... VP, HR FOUNDATIONS, SH VALLEY	0 0 ..... 40 0						X	0	295,040	40,237
CHARLES SANDERS III ..... CFO FNDTN - SGMF/NORTH	0 0 ..... 40 0						X	0	328,739	42,211
JEFF SPRAGUE ..... SH SVP & CFO	0 0 ..... 40 0						X	0	1,204,864	519,110

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

**Public Charity Status and Public Support**

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

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization

SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number

68-0273974

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

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

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

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

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

	Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

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

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

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

**16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization **b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization **17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization **b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization **18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b>	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b>	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b>	Add lines 7a and 7b						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

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

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

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

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

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

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

**19a 33 1/3% support tests—2018.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

**b 33 1/3% support tests—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> )		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions).		
<b>2</b>	Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>b</b>	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>3</b>	Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b>	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>b</b>	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

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

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

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

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



**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)

<b>Facts And Circumstances Test</b>

**990 Schedule A, Supplemental Information**

Return Reference	Explanation
A	a

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

**Supplemental Financial Statements**  
**▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.**  
**▶ Attach to Form 990.**  
**▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.**

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

**Name of the organization**  
SUTTER VALLEY MEDICAL FOUNDATION

**Employer identification number**  
68-0273974

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

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

- 5** Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?  Yes  No
- 6** Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?  Yes  No

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

- 1** Purpose(s) of conservation easements held by the organization (check all that apply)
- Preservation of land for public use (e.g., recreation or education)  Preservation of an historically important land area
- Protection of natural habitat  Preservation of a certified historic structure
- Preservation of open space

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

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

- 3** Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ \_\_\_\_\_
- 4** Number of states where property subject to conservation easement is located ▶ \_\_\_\_\_
- 5** Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?  Yes  No
- 6** Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \_\_\_\_\_
- 7** Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ \_\_\_\_\_
- 8** Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?  Yes  No
- 9** In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

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

- 1a** If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items
- b** If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items
- (i)** Revenue included on Form 990, Part VIII, line 1 ▶ \$ \_\_\_\_\_
- (ii)** Assets included in Form 990, Part X ▶ \$ \_\_\_\_\_
- 2** If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items
- a** Revenue included on Form 990, Part VIII, line 1 ▶ \$ \_\_\_\_\_
- b** Assets included in Form 990, Part X ▶ \$ \_\_\_\_\_

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	113,025	100,600			
<b>b</b> Contributions . . . . .	29,320	12,425	100,600		
<b>c</b> Net investment earnings, gains, and losses	2,366				
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	144,711	113,025	100,600		

- 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 ▶ 98 370 %
  - c** Temporarily restricted endowment ▶ 1 630 %
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- |  |     |    |
|--|-----|----|
| <b>(i)</b> unrelated organizations . . . . .   | Yes | No |
| <b>(ii)</b> related organizations . . . . .  | No  | No |
| <b>b</b> If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . |     |    |
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .	0	43,649,238		43,649,238
<b>b</b> Buildings . . . . .	0	346,559,450	142,753,436	203,806,014
<b>c</b> Leasehold improvements	0	72,683,438	57,337,590	15,345,848
<b>d</b> Equipment . . . . .	0	262,692,968	225,570,504	37,122,464
<b>e</b> Other . . . . .	0	30,350,887	15,153,961	15,196,926
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c) ) . . . ▶				315,120,490

**Part VII Investments—Other Securities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

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

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

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15 )	▶

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
INSURANCE LIABILITIES	975,058
THIRD PARTY SETTLEMENTS	313,655
OTHER LIABILITIES	5,365,691
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25 )	▶ 6,654,404

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

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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 68-0273974

**Name:** SUTTER VALLEY MEDICAL FOUNDATION

## Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	INTENDED USE OF ENDOWMENT FUNDS THE EARNINGS ON THE ENDOWMENT ARE TO BE SPENT FOR THE PURPOSE OF PROVIDING SCHOLARSHIP SUPPORT FOR DISADVANTAGED HIGH SCHOOL STUDENTS PURSUING MEDICAL CAREERS

**Supplemental Information**

Return Reference	Explanation
SCHEDULE D, PART X, LINE 2	<p>ASC 740 AUDIT FOOTNOTE THIS ORGANIZATION WAS PART OF A CONSOLIDATED FINANCIAL SYSTEM AUDIT THE ASC 740 AUDIT FOOTNOTE DISCLOSURE FOR THE SUTTER SYSTEM IS AS FOLLOWS SUTTER HEALTH , THE LEGAL ENTITY, AND MANY AFFILIATES HAVE BEEN DETERMINED TO BE EXEMPT ORGANIZATIONS BY THE INTERNAL REVENUE SERVICE AND THE CALIFORNIA FRANCHISE TAX BOARD AND GENERALLY ARE NOT SUBJECT TO TAXES ON INCOME CERTAIN ACTIVITIES OF SUTTER ARE SUBJECT TO INCOME TAXES, HOWEVER, SUCH ACTIVITIES ARE NOT SIGNIFICANT TO THE CONSOLIDATED FINANCIAL STATEMENTS WITH RESPECT TO ITS TAXABLE ACTIVITIES, SUTTER RECORDS INCOME TAXES USING THE LIABILITY METHOD, UNDER WHICH DEFERRED TAX ASSETS AND LIABILITIES ARE DETERMINED BASED ON THE DIFFERENCES BETWEEN THE FINANCIAL ACCOUNTING AND TAX BASIS OF ASSETS AND LIABILITIES DEFERRED TAX ASSETS OR LIABILITIES AT THE END OF EACH PERIOD ARE DETERMINED USING THE CURRENTLY ENACTED TAX RATE EXPECTED TO APPLY TO TAXABLE INCOME IN THE PERIODS THAT THE DEFERRED TAX ASSET OR LIABILITY IS EXPECTED TO BE REALIZED OR SETTLED SUTTER RECOGNIZES THE TAX BENEFIT FROM UNCERTAIN TAX POSITIONS, ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITIONS WILL BE SUSTAINED ON EXAMINATION BY THE TAX AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION THE TAX BENEFIT IS MEASURED BASED ON THE LARGEST BENEFIT THAT HAS A GREATER THAN 50% LIKELIHOOD OF BEING REALIZED UPON ULTIMATE SETTLEMENT THE STATUTE OF LIMITATIONS FOR TAX YEARS 2015 THROUGH 2017 REMAIN OPEN IN U S TAX JURISDICTIONS IN WHICH SUTTER AND ITS AFFILIATES ARE SUBJECT TO TAXATION SUTTER RECOGNIZES INTEREST AND PENALTIES RELATED TO INCOME TAX MATTERS IN OPERATING EXPENSES AT DECEMBER 31, 2018 AND 2017, THERE WERE NO SUCH UNCERTAIN TAX POSITIONS</p>



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

Department of the Treasury  
Internal Revenue Service

## Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a  
 Attach to Form 990 or Form 990-EZ.  
 Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information

OMB No 1545-0047

# 2018

**Open to Public Inspection**

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

**Employer identification number**  
68-0273974

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

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

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
<b>Total</b>				▶		

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

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

Revenue		(a) Event #1	(b) Event #2	(c) Other events	(d)
		<b>SWING INTO HLTH</b> (event type)	(event type)	<b>0</b> (total number)	Total events (add col (a) through col (c))
Revenue	<b>1</b> Gross receipts . . . . .	92,400			92,400
	<b>2</b> Less Contributions . . . . .	75,063			75,063
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	17,337			17,337
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .	5,454			5,454
	<b>6</b> Rent/facility costs . . . . .	11,062			11,062
	<b>7</b> Food and beverages . . . . .	6,348			6,348
	<b>8</b> Entertainment . . . . .				
	<b>9</b> Other direct expenses . . . . .	3,746			3,746
	<b>10</b> Direct expense summary Add lines 4 through 9 in column (d) . . . . . ▶				26,610
<b>11</b> Net income summary Subtract line 10 from line 3, column (d) . . . . . ▶				-9,273	

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

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

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

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

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

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

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

- 11** Does the organization conduct gaming activities with nonmembers?  Yes  No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13** Indicate the percentage of gaming activity conducted in
- |          |                             |   |
|----------|-----------------------------|---|
| <b>a</b> | The organization's facility | % |
| <b>b</b> | An outside facility         | % |

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

Name ▶ .....

Address ▶ .....

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

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

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

Name ▶ .....

Address ▶ .....

**16** Gaming manager information

Name ▶ .....

Gaming manager compensation ▶ \$ .....

Description of services provided ▶ .....

- Director/officer                       Employee                       Independent contractor

**17** Mandatory distributions

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

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

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

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

# Hospitals

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

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

**Name of the organization**  
 SUTTER VALLEY MEDICAL FOUNDATION

**Employer identification number**  
 68-0273974

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

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

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			659,906		659,906	0.040 %
<b>b</b> Medicaid (from Worksheet 3, column a)			124,005,297	65,743,606	58,261,691	3.780 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			2,691,871	1,216,353	1,475,518	0.100 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			127,357,074	66,959,959	60,397,115	3.920 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)	8	2,898	350,557	0	350,557	0.020 %
<b>f</b> Health professions education (from Worksheet 5)	1	0	1,748,000	1,308,644	439,356	0.030 %
<b>g</b> Subsidized health services (from Worksheet 6)	6	0	5,151,642	3,821,756	1,329,886	0.090 %
<b>h</b> Research (from Worksheet 7)	1	0	571,481	291,697	279,784	0.020 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)	8	0	2,023,277	0	2,023,277	0.130 %
<b>j Total.</b> Other Benefits	24	2,898	9,844,957	5,422,097	4,422,860	0.290 %
<b>k Total.</b> Add lines 7d and 7j	24	2,898	137,202,031	72,382,056	64,819,975	4.210 %

**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?		No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME)	5	9,675,228
6 Enter Medicare allowable costs of care relating to payments on line 5	6	14,040,992
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-4,365,764
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 checked="" 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** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 STANISLAUS SURG HOSP	MEDICAL SERVICES	31 %	0 %	30.77 %
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

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

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

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

2

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .		No
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

TWIN CITIES SURGICAL HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 400 _____ % and FPG family income limit for eligibility for discounted care of 0 _____ %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		



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

TWIN CITIES SURGICAL HOSPITAL

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

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

**Policy Relating to Emergency Medical Care**

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

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

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

TWIN CITIES SURGICAL HOSPITAL

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

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

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

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

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

**Part V Facility Information** (continued)

**Section 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)  
 STANISLAUS SURGICAL HOSPITAL

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

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA <u>20 18</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	Yes	
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url) _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 19</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>SEE PART V, SECTION C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**

STANISLAUS SURGICAL HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>350</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, SECTION C</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

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

STANISLAUS SURGICAL HOSPITAL

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

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

**Policy Relating to Emergency Medical Care**

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

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

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

STANISLAUS SURGICAL HOSPITAL

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

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a**  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
  - b**  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
  - c**  The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
  - d**  The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

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



**Part V** Facility Information *(continued)***Section 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? 70

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



**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINES 3A & 3C	FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA SUTTER VALLEY MEDICAL FOUNDATION OWNS 100% OF TWIN CITIES SURGICAL HOSPITAL, WHICH PROVIDES PREDOMINANTLY ELECTIVE SURGERIES AND DOES NOT PROVIDE EMERGENCY CARE FOR UNINSURED PATIENTS TO BE ELIGIBLE FOR FREE CARE THIS FACILITY USES THE FEDERAL POVERTY GUIDELINES (FPG) FOR FAMILY INCOMES THAT ARE AT OR BELOW 400% OF FPG IN ADDITION TWIN CITIES SURGICAL HOSPITAL HAS A HIGH MEDICAL COST CHARITY CARE CATEGORY IN WHICH A WRITE OFF OF THE PATIENT RESPONSIBILITY FOR HOSPITAL SERVICES CAN OCCUR IF THE INSURED PATIENT HAS FAMILY INCOME AT OR BELOW 400% FPG AND EXPENSES INCURRED FOR THEMSELVES OR THEIR FAMILY EXCEED 10% OF THE PATIENTS FAMILY INCOME SUTTER VALLEY MEDICAL FOUNDATION ACQUIRED A 31% OWNERSHIP INTEREST STANISLAUS SURGICAL HOSPITAL IN 2016 THIS HOSPITAL PROVIDES PREDOMINANTLY ELECTIVE SURGERIES AND DOES NOT PROVIDE EMERGENCY CARE STANISLAUS SURGICAL HOSPITAL PROVIDES FREE CHARITY CARE FOR MEDICALLY NECESSARY PROCEDURES FOR UNINSURED PATIENTS FOR FAMILY INCOMES THAT ARE AT OR BELOW 100% OF FPG PART I, LINE 3B SUTTER VALLEY MEDICAL FOUNDATION IS COMMITTED TO PROVIDING CHARITY CARE TWIN CITIES SURGICAL HOSPITAL PROVIDES FREE CARE AT HIGH PERCENTAGE OF FPG, SO IT DOES NOT PROVIDE DISCOUNTED CARE STANISLAUS SURGICAL HOSPITAL PROVIDES DISCOUNTED CHARITY CARE BASED ON A SLIDING SCALE UP TO 350% OF FPG
SCHEDULE H, PART I, LINE 7	COSTING METHODOLOGY USED COST TO CHARGE RATIO UTILIZING WORKSHEET 2 METHODOLOGY

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7G	FINANCIAL ASSISTANCE/OTHER COMMUNITY BENEFITS AT COST RELATED TO SUBSIDIZED HEALTH SERVICES THE AMOUNT OF COSTS ASSOCIATED WITH PHYSICIAN CLINICS IS \$1,329,886 SCHEDULE H, PART II COMMUNITY BUILDING ACTIVITIES SUTTER VALLEY MEDICAL FOUNDATION (SVMF) DID NOT HAVE ANY COMMUNITY BUILDING ACTIVITIES TO REPORT FOR 2018
SCHEDULE H, PART III, SECTION B - BAD DEBT	AUDIT FOOTNOTE THE ORGANIZATION IS AN AFFILIATE OF SUTTER HEALTH WHICH UNDERWENT A SYSTEM-WIDE AUDIT THE AUDIT REPORT DOES NOT INCLUDE A BAD DEBT EXPENSE FOOTNOTE EFFECTIVE JANUARY 1, 2018, SUTTER ENTITIES IMPLEMENTED THE FINANCIAL ACCOUNTING STANDARDS BOARD (FASB) ACCOUNTING STANDARDS UPDATE (ASU), REVENUE FROM CONTRACTS WITH CUSTOMERS (TOPIC 606) THE ACCOUNTING CHANGE MODIFIED BAD DEBT REPORTING, AND AS A RESULT, BAD DEBT IS ONLY REPORTED IN LIMITED SITUATIONS

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 7	MEDICARE COSTS MEDICARE COST REPORTS THAT THE ORGANIZATION FILES DO NOT INCLUDE ALL OF THE COSTS REQUIRED TO TREAT MEDICARE PATIENTS
SCHEDULE H, PART III, LINE 8	COSTING METHODOLOGY MEDICARE ALLOWABLE COSTS WERE CALCULATED USING A COST TO CHARGE RATIO COMMUNITY BENEFIT MEDICARE SHORTFALL THE IRS COMMUNITY BENEFIT STANDARD INCLUDES THE PROVISION OF CARE TO THE ELDERLY AND MEDICARE PATIENTS CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED AND RELIEVES A GOVERNMENT BURDEN AS THESE PATIENTS TYPICALLY HAVE LOW AND/OR FIXED INCOMES MEDICARE DOES NOT PROVIDE SUFFICIENT REIMBURSEMENT TO COVER THE COST OF PROVIDING CARE FOR THESE PATIENTS FORCING THE HOSPITAL TO USE OTHER FUNDS TO COVER THE DEFICIT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>SCHEDULE H, PART III, LINE 9B</p>	<p>DEBT COLLECTION POLICY COLLECTION PRACTICES ARE CONSISTENT FOR ALL PATIENTS AND COMPLY WITH APPLICABLE PROVISIONS OF FEDERAL AND CALIFORNIA LAW DURING PREADMISSION OR REGISTRATION, THE HOSPITAL PROVIDES ALL PATIENTS WITH INFORMATION REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AN UNINSURED PATIENT WHO INDICATES THE FINANCIAL INABILITY TO PAY A BILL IS EVALUATED FOR FINANCIAL ASSISTANCE AT DISCHARGE PATIENTS WILL BE GIVEN AN APPLICATION WHICH WILL DOCUMENT THE PATIENT'S OVERALL FINANCIAL SITUATION IF AN UNINSURED PATIENT DOES NOT COMPLETE THE APPLICATION FORM WITHIN 30 DAYS OF DELIVERY, THE HOSPITAL WILL NOTIFY THE PATIENT THAT THE APPLICATION HAS NOT BEEN RECEIVED AND WILL PROVIDE THE PATIENT AN ADDITIONAL 210 DAYS TO COMPLETE THE APPLICATION IF A PATIENT HAS APPLIED FOR CHARITY CARE, HAS BEEN APPROVED TO RECEIVE CHARITY CARE, OR IS COOPERATING WITH THE HOSPITAL'S EFFORTS TO SETTLE AN OUTSTANDING BILL WITHIN A REASONABLE TIME PERIOD, THE HOSPITAL WILL NOT PURSUE COLLECTIONS</p>
<p>SCHEDULE H, PART VI, LINE 2</p>	<p>THE ORGANIZATION DOES NOT CONDUCT ANY ADDITIONAL COMMUNITY HEALTH CARE NEEDS ASSESSMENTS OUTSIDE OF THE 2016 2018 COMMUNITY HEALTH NEEDS ASSESSMENT REFERENCED SCHEDULE H, PART VI, LINE 3 PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE SUTTER HOSPITALS FOLLOW A SUTTER HEALTH SYSTEM-WIDE FINANCIAL ASSISTANCE POLICY, WHICH INCLUDES THE FOLLOWING DETAILS OF HOW THE ORGANIZATION INFORMS AND EDUCATES PATIENTS AND PERSONS WHO MAY BE BILLED FOR PATIENT CARE LANGUAGES THE POLICY SHALL BE AVAILABLE IN THE PRIMARY LANGUAGE(S) OF HOSPITAL'S SERVICE AREA IN ADDITION, ALL NOTICES/COMMUNICATIONS PROVIDED IN THIS SECTION SHALL BE AVAILABLE IN PRIMARY LANGUAGE (S) OF HOSPITAL'S SERVICE AREA AND IN A MANNER CONSISTENT WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS INFORMATION PROVIDED TO PATIENTS DURING THE PROVISION OF HOSPITAL SERVICES A DURING PREADMISSION OR REGISTRATION (OR AS SOON THEREAFTER AS PRACTICABLE) HOSPITALS SHALL PROVIDE ALL PATIENTS WITH A COPY OF A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND IDENTIFY THE DEPARTMENT THAT PATIENTS CAN VISIT TO RECEIVE INFORMATION ABOUT, AND ASSISTANCE WITH APPLYING FOR, FINANCIAL ASSISTANCE B FINANCIAL ASSISTANCE COUNSELORS PATIENTS WHO MAY BE UNINSURED PATIENTS SHALL BE ASSIGNED FINANCIAL COUNSELORS, WHO SHALL VISIT WITH THE PATIENTS IN PERSON AT THE HOSPITAL, PROVIDE PATIENTS A FINANCIAL ASSISTANCE APPLICATION, ASSIST WITH THE APPLICATION PROCESS, AND PROVIDE A CONTACT INFORMATION FOR THE PATIENT TO CALL FOR QUESTIONS C EMERGENCY SERVICES IN THE CASE OF EMERGENCY SERVICES, HOSPITALS SHALL PROVIDE ALL PATIENTS A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AS SOON AS PRACTICABLE AFTER STABILIZATION OF THE PATIENT'S EMERGENCY MEDICAL CONDITION OR UPON DISCHARGE D APPLICATIONS PROVIDED AT DISCHARGE AT THE TIME OF DISCHARGE, HOSPITALS SHALL PROVIDE ALL PATIENTS WITH A COPY OF A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY E INFORMATION PROVIDE TO PATIENTS AT OTHER TIMES 1 CONTACT INFORMATION WHICH INCLUDES A PHONE NUMBER AND HOSPITAL DEPARTMENT TO OBTAIN ADDITIONAL INFORMATION ABOUT FINANCIAL ASSISTANCE AND ASSISTANCE WITH THE APPLICATION PROCESS 2 BILLING STATEMENTS BILLING STATEMENTS PROVIDED TO PATIENTS SHALL INCLUDE A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY, A PHONE NUMBER FOR PATIENTS TO CALL WITH QUESTIONS ABOUT FINANCIAL ASSISTANCE, AND THE WEBSITE ADDRESS WHERE PATIENTS CAN OBTAIN ADDITIONAL INFORMATION ABOUT FINANCIAL ASSISTANCE INCLUDING THE FINANCIAL ASSISTANCE POLICY, A PLAIN LANGUAGE SUMMARY OF THE POLICY, AND THE APPLICATION FOR FINANCIAL ASSISTANCE 3 UPON REQUEST HOSPITALS SHALL PROVIDE PATIENTS WITH PAPER COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY UPON REQUEST AND WITHOUT CHARGE F PUBLICITY OF FINANCIAL ASSISTANCE INFORMATION 1 PUBLIC POSTING HOSPITALS SHALL POST COPIES OF THE FINANCIAL ASSISTANCE POLICY, THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IN A PROMINENT LOCATION IN THE EMERGENCY ROOM, ADMISSIONS AREA, AND ANY OTHER LOCATION IN THE HOSPITAL WHERE THERE IS A HIGH VOLUME OF PATIENT TRAFFIC, INCLUDING BUT NOT LIMITED TO THE WAITING ROOMS, BILLING OFFICES, AND HOSPITAL OUTPATIENT SERVICE SETTINGS THESE PUBLIC NOTICES SHALL INCLUDE INFORMATION ABOUT THE RIGHT TO REQUEST AN ESTIMATE OF FINANCIAL RESPONSIBILITY FOR SERVICES 2 WEBSITE THE FINANCIAL ASSISTANCE POLICY, APPLICATION FOR FINANCIAL ASSISTANCE AND PLAIN LANGUAGE SUMMARY SHALL BE AVAILABLE IN A PROMINENT PLACE ON THE SUTTER HEALTH WEBSITE (WWW.SUTTERHEALTH.ORG) AND ON EACH INDIVIDUAL HOSPITAL'S WEBSITE PERSONS SEEKING INFORMATION ABOUT FINANCIAL ASSISTANCE SHALL NOT BE REQUIRED TO CREATE AN ACCOUNT OR PROVIDE ANY PERSONAL INFORMATION BEFORE RECEIVING INFORMATION ABOUT FINANCIAL ASSISTANCE 3 MAIL PATIENTS MAY REQUEST A COPY OF THE FINANCIAL ASSISTANCE POLICY, APPLICATION FOR FINANCIAL ASSISTANCE AND PLAIN LANGUAGE SUMMARY BE SENT BY MAIL, AT NO COST TO THE PATIENT 4 ADVERTISEMENTS/PRESS RELEASES AS NECESSARY AND ON AT LEAST AN ANNUAL BASIS, SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT HOSPITALS IN THE PRINCIPAL NEWSPAPER(S) IN THE COMMUNITIES SERVED BY SUTTER HEALTH, OR WHEN DOING SO IS NOT PRACTICAL, SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THIS INFORMATION, OR USE OTHER MEANS THAT SUTTER HEALTH CONCLUDES WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY TO AFFECTED PATIENTS IN OUR COMMUNITIES 5 COMMUNITY AWARENESS SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY (ESPECIALLY THOSE WHO ARE MOST LIKELY TO REQUIRE FINANCIAL ASSISTANCE) ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 4</p>	<p>COMMUNITY INFORMATION MARYSVILLE IS LOCATED IN YUBA COUNTY AND YUBA CITY IS LOCATED IN SUTTER COUNTY SEPARATED BY THE FEATHER RIVER, THE CITIES ARE LOCATED ADJACENT TO ONE ANOTHER AND ARE PART OF THE YUBA CITY METROPOLITAN STATISTICAL AREA AS DESIGNATED BY THE US OFFICE OF MANAGEMENT AND BUDGET THE COMMUNITY SERVED BY BOTH RRCM AND SSHNV, OR THE HOSPITAL SERVICE AREA (HSA), WAS DEFINED BY FIVE ZIP CODES NOTED IN THE TABLE BELOW THIS AREA WAS IDENTIFIED AS THE HSA AS THE MAJORITY OF BOTH RRCM AND SSHNV PATIENTS RESIDED IN THESE ZIP CODES THE HSA WAS HOME TO OVER 146,000 COMMUNITY RESIDENTS, AND WAS RICH IN DIVERSITY ALONG A NUMBER OF DIMENSIONS THERE ARE FOUR HOSPITALS THAT SERVE THE COMMUNITY DATA WERE ANALYZED TO IDENTIFY COMMUNITIES OF CONCERN WITHIN THE HSA THESE ARE DEFINED GEOGRAPHIC AREAS AND POPULATIONS WITHIN THE HSA THAT HAVE THE GREATEST CONCENTRATION OF POOR HEALTH OUTCOMES AND ARE HOME TO MORE MEDICALLY UNDERSERVED, LOW INCOME, AND DIVERSE POPULATIONS AT GREATER RISK FOR POORER HEALTH COMMUNITIES OF CONCERN WERE IMPORTANT TO THE OVERALL CHNA METHODOLOGY BECAUSE, AFTER ASSESSING THE HSA MORE BROADLY, THEY ALLOWED FOR A FOCUS ON THOSE PORTIONS OF THE HSA LIKELY EXPERIENCING THE GREATEST HEALTH DISPARITIES ANALYSIS OF BOTH PRIMARY AND SECONDARY DATA REVEALED FOUR COMMUNITIES THAT MET THE CRITERIA FOR CLASSIFICATION AS A COMMUNITY OF CONCERN THESE COMMUNITIES ARE LINDA, LIVE OAK, OLIVE HURST AND YUBA CITY THE HSA WAS HOME TO OVER 146,000 RESIDENTS MEDIAN AGE VARIED FROM A LOW OF 29.9 YEARS FOR ZIP CODE 95961 TO A HIGH OF 38.8 FOR ZIP CODE 95993 MEDIAN INCOME RANGED FROM \$40,260 FOR ZIP CODE 95901, TO \$64,011 FOR 95993 FURTHER, THE PERCENT MINORITY POPULATION RANGED FROM 44.3% FOR ZIP CODE 95901, TO 62.6% FOR ZIP CODE 95953 THE SSHNV HSA COVERED A RURAL COMMUNITY UNLIKE URBAN COMMUNITIES, THE GEOGRAPHIC AREA INCLUDED IN THE HSA HAD A RELATIVELY LOW POPULATION DENSITY HSA RESIDENTS LIVED IN CONCENTRATED AREAS WITHIN THE ZIP CODES THAT COMPRISED THE HSA FIGURE 2 (IN THE FULL REPORT) DISPLAYS A POPULATION DENSITY MAP (OR PEOPLE PER SQUARE MILE) THAT DEMONSTRATES THE DISTRIBUTION OF POPULATIONS ACROSS THE HSA, AND WITHIN EACH ZIP CODE THE CONCENTRATION OF POPULATIONS RESIDED IN A CLUSTER WITHIN THE CITIES OF LINDA, MARYSVILLE, OLIVEHURST, AND YUBA CITY LIVE OAK, SITUATED DUE NORTH OF YUBA CITY, SITS IN RELATIVE ISOLATION COMPARED TO THE YUBA CITY METROPOLITAN STATISTICAL AREA MUCH OF THE GEOGRAPHIC AREA WITHIN THE ZIP CODE DEFINITIONS OF THE HSA IS FARMLAND, AND NOT INHABITED BY COMMUNITY RESIDENTS THIS FACT BECOMES IMPORTANT WHEN ZIP CODE LEVEL DATA ARE DISCUSSED LATER IN THE REPORT THE HSA WAS RICH IN RACIAL AND ETHNIC DIVERSITY AS WELL FURTHER EXAMINATION OF RACIAL AND ETHNIC DIVERSITY IN THE HSA IS EXAMINED IN FIGURE 3 IN THE FULL REPORT STANISLAUS SURGICAL HOSPITAL STANISLAUS SURGICAL HOSPITAL IS LOCATED IN MODESTO, CALIFORNIA, AND ITS SERVICE AREA INCLUDES THE CITIES OF CERES, HUGHSON, MODESTO, NEWMAN, OAKDALE, PATTERSON, RIVERBANK, TURLOCK AND WATERFORD THE SERVICE AREA INCLUDES ALL OF STANISLAUS COUNTY THERE ARE THREE HOSPITALS THAT SERVE THE COMMUNITY THE DEMOGRAPHICS INCLUDE A TOTAL POPULATION OF 518,321 CITIZENS, WITH 76.51% WHITE (INCLUDING HISPANIC), 2.82% BLACK, 5.28% ASIAN, AND OF THAT POPULATION, 42.5% LATINO THE POPULATION DENSITY IS MUCH HIGHER IN STANISLAUS COUNTY THAN CALIFORNIA AS A WHOLE 44.19% LIVE IN POVERTY, 28.32% CHILDREN LIVE IN POVERTY, 10.4% ARE UNEMPLOYED, 17.84% ARE UNINSURED AND 23.59% HAVE NOT GRADUATED FROM HIGH SCHOOL</p>
<p>SCHEDULE H, PART VI, LINE 5</p>	<p>PROMOTION OF COMMUNITY HEALTH SUTTER HEALTH'S MISSION IS TO "ENHANCE THE WELL-BEING OF THE PEOPLE IN THE COMMUNITIES WE SERVE, THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTH CARE SERVICES " SUTTER HEALTH'S MISSION REACHES BEYOND THE WALLS OF OUR HOSPITALS AND FACILITIES OUR AFFILIATES FURTHER THEIR TAX-EXEMPT PURPOSE BY - BUILDING RELATIONSHIPS OF TRUST BY WORKING COLLABORATIVELY WITH COMMUNITY GROUPS, SCHOOLS AND GOVERNMENT ORGANIZATIONS TO EFFECTIVELY LEVERAGE RESOURCES AND ADDRESS IDENTIFIED COMMUNITY NEEDS, - SUPPORTING NONPROFIT ORGANIZATIONS THAT ARE COMMITTED TO COMMUNITY HEALTH IMPROVEMENT THROUGH FINANCIAL INVESTMENTS, IN-KIND SERVICES AND EMPLOYEE VOLUNTEERISM, AND - PROVIDING GENEROUS CHARITY CARE POLICIES FOR OUR MOST VULNERABLE COMMUNITY MEMBERS TWIN CITIES SURGICAL HOSPITAL THE 2016 - 2018 IMPLEMENTATION STRATEGY FOR TWIN CITIES SURGICAL HOSPITAL DEFINES A VARIETY OF PROGRAMS AND PARTNERSHIPS THAT ADDRESS IDENTIFIED PRIORITY HEALTH NEEDS AND IMPROVE THE OVERALL HEALTH OF THE COMMUNITY IT SERVES A FEW OF THOSE PROGRAMS AND PARTNERSHIPS ARE DESCRIBED BELOW SUTTER SURGICAL HOSPITAL NORTH VALLEY SHADY CREEKS FIT QUEST PROGRAM HAS STUDENTS PARTICIPATE IN 3 ASSEMBLIES AT EACH SCHOOL SITE, LEAD BY NATURALISTS, WITH A FOCUS ON HEALTH, WELLNESS, AND FITNESS EDUCATION, AS WELL AS A WEEK-LONG IMMERSION AT THE OUTDOOR SCHOOL THE GOAL OF FITQUEST IS TO TEACH CHILDREN AND THEIR FAMILIES HEALTHY LESSONS ABOUT FITNESS, PHYSICAL ACTIVITY AND THE IMPORTANCE OF NUTRITIOUS EATING IN 2018, 150 ADULTS AND 2,395 CHILDREN WERE SERVED LIFELONG COMPANIONS WAS A PROGRAM WITHIN OUR HOMELESS SERVICES DEPARTMENT AT OUR LIFE BUILDING CENTER TO HELP KEEP INDIVIDUALS EXPERIENCING HOMELESSNESS WITH THEIR PETS USING KENNELS AND PARTNERSHIPS WITH OTHER ANIMAL SHELTERS AND LOCAL PET BUSINESSES, WE PROVIDED TRAINING AND ANIMAL HANDLING TRAINING FOR THESE STRUGGLING PET OWNERS AND THEIR ANIMALS IN 2018, 959 INDIVIDUALS WERE SERVED WITH 3,351 REFERRALS MADE TO SERVICES SUCH AS PRIMARY HEALTH CARE, BEHAVIORAL HEALTH, DENTAL/VISION AS WELL AS BASIC NEEDS</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 6</p>	<p>AFFILIATED HEALTH CARE SYSTEM THE ORGANIZATION IS AFFILIATED WITH SUTTER HEALTH, A NOT-FOR-PROFIT NETWORK OF HOSPITALS, PHYSICIANS, EMPLOYEES AND VOLUNTEERS WHO CARE FOR MORE THAN 100 NORTHERN CALIFORNIA TOWNS AND CITIES TOGETHER, WE ARE CREATING A MORE INTEGRATED, SEAMLESS AND AFFORDABLE APPROACH TO CARING FOR PATIENTS THE HOSPITALS MISSION IS TO ENHANCE THE WELL-BEING OF PEOPLE IN THE COMMUNITIES WHERE WE SERVE THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTHCARE SERVICES AT SUTTER HEALTH, WE BELIEVE THERE SHOULD BE NO BARRIERS TO RECEIVING TOP-QUALITY MEDICAL CARE WE STRIVE TO PROVIDE ACCESS TO EXCELLENT HEALTHCARE SERVICES FOR NORTHERN CALIFORNIANS, REGARDLESS OF ABILITY TO PAY AS PART OF OUR NOT-FOR-PROFIT MISSION, SUTTER HEALTH INVESTS MILLIONS OF DOLLARS BACK INTO THE COMMUNITIES WE SERVE AND BEYOND THROUGH THESE INVESTMENTS AND COMMUNITY PARTNERSHIPS, WE ARE PROVIDING AND PRESERVING VITAL PROGRAMS AND SERVICES, THEREBY IMPROVING THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE SERVE OVER THE PAST FIVE YEARS, SUTTER HEALTH HAS COMMITTED NEARLY \$4 BILLION TO CARE FOR PATIENTS WHO COULDN'T AFFORD TO PAY, AND TO SUPPORT PROGRAMS THAT IMPROVE COMMUNITY HEALTH OUR 2018 COMMITMENT OF \$734 MILLION INCLUDES UNREIMBURSED COSTS OF PROVIDING CARE TO MEDICAL PATIENTS, TRADITIONAL CHARITY CARE AND INVESTMENTS IN HEALTH EDUCATION AND PUBLIC BENEFIT PROGRAMS FOR EXAMPLE - IN 2018, SUTTER HEALTH INVESTED \$435 MILLION MORE THAN THE STATE PAID TO CARE FOR MEDICAL PATIENTS MEDICAL ACCOUNTED FOR NEARLY 19 PERCENT OF SUTTER HEALTH'S GROSS PATIENT SERVICE REVENUES IN 2018 - THROUGHOUT OUR HEALTHCARE SYSTEM, WE PARTNER WITH AND SUPPORT COMMUNITY HEALTH CENTERS TO ENSURE THAT THOSE IN NEED HAVE ACCESS TO PRIMARY AND SPECIALTY CARE WE ALSO SUPPORT CHILDREN'S HEALTH CENTERS, FOOD BANKS, YOUTH EDUCATION, JOB TRAINING PROGRAMS AND SERVICES THAT PROVIDE COUNSELING TO DOMESTIC VIOLENCE VICTIMS EVERY THREE YEARS, SUTTER HEALTH HOSPITALS PARTICIPATE IN A COMPREHENSIVE AND COLLABORATIVE COMMUNITY HEALTH NEEDS ASSESSMENT, WHICH IDENTIFIES LOCAL HEALTH CARE PRIORITIES AND GUIDES OUR COMMUNITY BENEFIT STRATEGIES THE ASSESSMENTS HELP ENSURE THAT WE INVEST OUR COMMUNITY BENEFIT DOLLARS IN A WAY THAT TARGETS AND ADDRESS REAL COMMUNITY NEEDS FOR MORE FACTS AND INFORMATION VISIT WWW.SUTTERHEALTH.ORG</p>
<p>SCHEDULE H, PART VI, LINE 7</p>	<p>STATE FILING OF COMMUNITY BENEFIT REPORT CALIFORNIA</p>

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 68-0273974

**Name:** SUTTER VALLEY MEDICAL FOUNDATION

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

<b>Section A. Hospital Facilities</b> (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>2</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	TWIN CITIES SURGICAL HOSPITAL 455 PLUMAS BLVD YUBA CITY, CA 959915074 <a href="https://www.sutterhealth.org/sshnv">https://www.sutterhealth.org/sshnv</a> LICENSE #550000989	X	X							OUTPATIENT SERVICES	
2	STANISLAUS SURGICAL HOSPITAL 1421 OAKDALE ROAD MODESTO, CA 953553356 <a href="http://WWW.STANISLAUSSURGICAL.COM/">WWW.STANISLAUSSURGICAL.COM/</a> LICENSE #030000695	X	X							OUTPATIENT SERVICES	

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

Form and Line Reference	Explanation
<p>REPORTING FACILITY #1, TWIN CITIES SURGICAL HOSPITAL</p>	<p>SCHEDULE H, PART V, SECTION B, LINE 3E TWIN CITIES SURGICAL HOSPITAL (1) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA SCHEDULE H, PART V, SECTION B, LINE 5 TWIN CITIES SURGICAL HOSPITAL (1) CHNA INPUT FROM KEY ADVISORS REPRESENTING BROAD COMMUNITY INTERESTS INPUT FROM THE COMMUNITY WAS COLLECTED THROUGH TWO MAIN MECHANISMS KEY INFORMANT INTERVIEWS WITH COMMUNITY HEALTH EXPERTS AND SERVICE PROVIDERS, AND FOCUS GROUP DISCUSSIONS WITH COMMUNITY MEMBERS INSTRUMENTS USED IN PRIMARY DATA COLLECTION INCLUDED A PARTICIPANT INFORMED CONSENT, AN INTERVIEW QUESTION GUIDE, A PROJECT SUMMARY SHEET, AND A REFLECTION SHEET PRIOR TO THEIR PARTICIPATION ALL PARTICIPANTS WERE GIVEN AN INFORMED CONSENT FORM, WHICH PROVIDED INFORMATION ABOUT THE PROJECT, ASKED FOR PERMISSION TO RECORD THE INTERVIEW, AND LISTED THE POTENTIAL BENEFITS AND RISKS FOR INVOLVEMENT IN THE INTERVIEW (APPENDIX C OF THE CHNA) THE INTERVIEW QUESTION GUIDE WAS USED FOR BOTH THE KEY INFORMANT AND FOCUS GROUP INTERVIEWS THE PROJECT SUMMARY SHEET WAS GIVEN TO PARTICIPANTS TO PROVIDE THEM WITH INFORMATION ABOUT THE PROJECT AND CONTACT INFORMATION FOR CHNA STAFF AFTER THE INTERVIEW OR FOCUS GROUP WAS CONDUCTED, THE FACILITATOR CAPTURED THE MAIN FINDINGS BY COMPLETING A REFLECTION SHEET KEY INFORMANT INTERVIEWS WERE CONDUCTED WITH AREA SERVICE PROVIDERS AND EXPERTS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY WHO WERE FAMILIAR WITH THE POPULATIONS IN THE HSA (FOR A LISTING SEE APPENDIX F OF THE CHNA) PRIMARY DATA COLLECTION BEGAN BY INTERVIEWING AREA-WIDE SERVICE PROVIDERS WITH KNOWLEDGE OF THE HSA, INCLUDING INPUT FROM BOTH SUTTER AND YUBA COUNTY PUBLIC HEALTH DIVISIONS FINDINGS FROM THE AREA-WIDE INFORMANTS WERE COMBINED WITH QUANTITATIVE DATA SHOWING LOCATIONS OF POPULATIONS EXPERIENCING DISPARITIES, TO IDENTIFY AND INTERVIEW KEY INFORMANTS WITH KNOWLEDGE ABOUT THESE SPECIFIC POPULATIONS AND LOCATIONS THESE TARGETED PRIMARY DATA SOURCES WERE SELECTED BASED ON THEIR KNOWLEDGE OF THE NEEDS OF PARTICULAR GEOGRAPHIC LOCATIONS AND/OR SUBGROUPS EXPERIENCING DISPARITIES A TOTAL OF 10 KEY INFORMANT INTERVIEWS WERE COMPLETED WITH 18 COMMUNITY HEALTH EXPERTS AND SERVICE PROVIDERS THE KEY INFORMANT INTERVIEWS WERE USED TO IDENTIFY ADDITIONAL KEY SERVICE PROVIDERS TO INCLUDE IN THE ASSESSMENT, AS WELL AS TO IDENTIFY SPECIFIC POPULATIONS THAT SHOULD BE INCLUDED IN THE FOCUS GROUP INTERVIEWS FOCUS GROUP INTERVIEWS WERE CONDUCTED WITH COMMUNITY MEMBERS LIVING IN GEOGRAPHIC AREAS OF THE HSA IDENTIFIED AS LOCATIONS IN WHICH RESIDENTS EXPERIENCED A DISPARATE AMOUNT OF POOR SOCIO-ECONOMIC CONDITIONS AND POOR HEALTH OUTCOMES RECRUITMENT CONSISTED OF REFERRALS FROM DESIGNATED SERVICE PROVIDERS REPRESENTING VULNERABLE POPULATIONS IN THE HSA, AS WELL AS DIRECT OUTREACH TO ACQUIRE INPUT FOR A SPECIAL POPULATION GROUP SIX FOCUS GROUP DISCUSSIONS WERE CONDUCTED WITH A TOTAL OF 53 COMMUNITY MEMBERS (A LISTING</p>



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

Form and Line Reference	Explanation
REPORTING FACILITY #1, TWIN CITIES SURGICAL HOSPITAL	CAN BE FOUND IN APPENDIX G OF THE CHNA) THE FINDINGS FROM KEY INFORMANT INTERVIEWS AND FOCUS GROUPS IN TWIN CITIES SURGICAL HOSPITAL'S CHNA ARE AVAILABLE AT <a href="http://www.suttersurgicalhospitalnorthvalley.org/about-us/community-needs-assessment.html">HTTP //WWW SUTTERSURGICALHOSPITALNORTHVALLEY ORG/ABOUT-US/COMMUNITY-NEEDS-ASSESSMENT HTML</a> <a href="https://www.sutterhealth.org/sshnv/for-patients/community-health-needs-assessment">https //www sutterhealth org/sshnv/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 6A	TWIN CITIES SURGICAL HOSPITAL (1) CHNA HOSPITAL COLLABORATORS WORKING COLLABORATIVELY, RIDEOUT HEALTH, INCLUDING RIDEOUT REGIONAL MEDICAL CENTER, AND TWIN CITIES SURGICAL HOSPITAL CONTRACTED WITH COMMUNITY HEALTH INSIGHTS TO CONDUCT A CHNA FOR THEIR MUTUAL SERVICE AREAS

**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
SCHEDULE H, PART V, SECTION B, LINES 7A, 7B AND 10A	TWIN CITIES SURGICAL HOSPITAL (1) REPORTING ORG WEBSITE HTTP //WWW SUTTERSURGICALHOSPITALNORTHVALLEY ORG/ABOUT-US/COMMUNITY-NEEDS- ASSESSMENT HTML OTHER WEBSITE HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMEN T

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

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

Form and Line Reference	Explanation
<p>SCHEDULE H, PART V, SECTION B, LINE 11</p>	<p>TWIN CITIES SURGICAL HOSPITAL (1) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT ARE NEEDS THAT TWIN CITIES SURGICAL HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES AND PRESCRIPTION DRUGS 2 ACCESS TO HEALTH EDUCATION AND HEALTH LITERACY 3 ACCESS TO MENTAL, BEHAVIORAL, AND SUBSTANCE ABUSE SERVICES DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI, ALONG WITH ADDITIONAL CRITICAL EFFORTS ON BEHALF OF TWIN CITIES SURGICAL HOSPITAL NO HOSPITAL CAN ADDRESS ALL OF THE HEALTH NEEDS PRESENT IN ITS COMMUNITY TWIN CITIES SURGICAL HOSPITAL IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT 1 ACCESS TO AFFORDABLE, HEALTHY FOOD WHILE THIS IS AN IMPORTANT ISSUE, SSHNV CAN BE MORE EFFECTIVE FOCUSING ITS RESOURCES IN OTHER AREAS, HOWEVER, THROUGH OUR COMMUNITY SPONSORSHIP PROGRAM, ARE ABLE TO PROVIDE SUPPORT FOR ORGANIZATIONS WHO FOCUS WORK IN THIS AREA 2 ACCESS TO SPECIALTY CARE WHILE THIS IS AN IMPORTANT ISSUE, SSHNV IS CURRENTLY FOCUSING ITS RESOURCES IN OTHER AREAS, HOWEVER, WELL CONTINUE TO LOOK FOR OPPORTUNITIES TO INCREASES ACCESS TO SPECIALTY CARE 3 ACCESS TO TRANSPORTATION AND MOBILITY WHILE THIS IS AN IMPORTANT ISSUE, SSHNV IS CURRENTLY FOCUSING ITS RESOURCES IN OTHER AREAS, HOWEVER, WELL CONTINUE TO LOOK FOR OPPORTUNITIES TO INCREASES ACCESS TO TRANSPORTATION 4 COLLABORATION AND COORDINATION AMONG COMMUNITY SERVICES AND PROGRAM INCREASED COLLABORATION IS SOMETHING WE ALWAYS HOPE TO ACHIEVE, IN ALL SUTTER HEALTH SERVICE AREAS WHILE WE DONT HAVE ANY COORDINATED EFFORTS WE CAN HIGHLIGHT IN THIS REPORT, THIS IS AN AREA WILL PLAN TO EXPLORE SCHEDULE H, PART V, LINE 15E TWIN CITIES SURGICAL HOSPITAL (1) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE-OTHER PATIENTS MAY REQUEST ASSISTANCE WITH COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE IN PERSON AT THE HOSPITAL, OVER THE PHONE, THROUGH THE MAIL, OR VIA THE SUTTER HEALTH WEBSITE SCHEDULE H, PART V, LINES 16A, 16B, &amp; 16C TWIN CITIES SURGICAL HOSPITAL (1) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE SUTTER HEALTH WEBSITE AT <a href="https://www.sutterhealth.org/for-patients/financial-assistance">HTTPS //WWW SUTTERHEALTH ORG/FOR-PATIENTS/FINANCIAL-ASSISTANCE</a></p>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16J	TWIN CITIES SURGICAL HOSPITAL (1) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY. THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA. DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND ALSO INFORMATION REGARDING THE RIGHT TO REQUEST AN ESTIMATE OF THEIR FINANCIAL RESPONSIBILITY FOR SERVICES. PATIENTS WHO MAY BE UNINSURED WILL BE ASSIGNED A FINANCIAL COUNSELOR WHO WILL VISIT WITH THE PATIENT IN PERSON AT THE HOSPITAL AND CAN PROVIDE ADDITIONAL INFORMATION ABOUT THE FINANCIAL ASSISTANCE POLICY AND ASSIST WITH THE APPLICATION PROCESS. AT THE TIME OF DISCHARGE ALL PATIENTS WILL BE PROVIDED THE PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY. SUTTER HEALTH WILL PLACE AN ADVERTISEMENT REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE AT THE ORGANIZATION IN THE PRINCIPAL NEWSPAPER IN THE COMMUNITY OR WHEN DOING SO IS NOT PRACTICAL SUTTER WILL ISSUE A PRESS RELEASE CONTAINING THE INFORMATION OR USE OTHER MEANS THAT WILL WIDELY PUBLICIZE THE AVAILABILITY OF THE POLICY. SUTTER HEALTH WILL WORK WITH AFFILIATED ORGANIZATIONS, PHYSICIANS, COMMUNITY CLINICS AND OTHER HEALTH CARE PROVIDERS TO NOTIFY MEMBERS OF THE COMMUNITY ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE. PART V, LINE 22D TWIN CITIES SURGICAL HOSPITAL (1) AMOUNTS CHARGED TO FAP-ELIGIBLE INDIVIDUALS. THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PROVIDES FOR FULL WRITE OFF OF ALL CHARGES FOR AN UNINSURED PATIENT WITH A FAMILY INCOME AT OR BELOW 400% OF THE MOST RECENT FEDERAL POVERTY LEVEL. IN ACCORDANCE WITH INTERNAL REVENUE CODE SECTION 1501(R)-5, THIS ORGANIZATION ADOPTS THE PROSPECTIVE MEDICARE METHOD FOR AMOUNTS GENERALLY BILLED, HOWEVER, PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE ARE NOT FINANCIALLY RESPONSIBLE FOR MORE THAN THE AMOUNTS GENERALLY BILLED BECAUSE ELIGIBLE PATIENTS DO NOT PAY ANY AMOUNT.

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

Form and Line Reference	Explanation
<p>REPORTING FACILITY #2, STANISLAUS SURGICAL HOSPITAL</p>	<p>SCHEDULE H, PART V, SECTION B, LINE 3E STANISLAUS SURGICAL HOSPITAL (2) THE SIGNIFICANT HEALTH NEEDS ARE A PRIORITIZED DESCRIPTION OF THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY AND IDENTIFIED THROUGH THE CHNA PART V, SECTION B, LINE 5 STANISLAUS SURGICAL HOSPITAL (F ACILITY 2) IN CONDUCTING ITS MOST RECENT CHNA, STANISLAUS SURGICAL HOSPITAL (SSH) A FACILITY OF SUTTER VALLEY MEDICAL FOUNDATION, DID TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN THE HOSPITAL'S SERVICE AREA COMMUNITY INPUT WAS PROVIDED BY A BROAD RANGE OF COMMUNITY MEMBERS THROUGH KEY INFORMANT INTERVIEWS AND FOCUS GROUPS INDIVIDUALS WITH THE KNOWLEDGE, INFORMATION, AND EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY WERE CONSULTED THESE INDIVIDUALS INCLUDED REPRESENTATIVES FROM LOCAL PUBLIC HEALTH DEPARTMENTS AS WELL AS LEADERS, REPRESENTATIVES, OR MEMBERS OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS ADDITIONALLY, WHERE APPLICABLE, OTHER INDIVIDUALS WITH EXPERTISE OF LOCAL HEALTH NEEDS WERE CONSULTED THE FOLLOWING QUESTIONS SERVED AT THE INTERVIEW GUIDES FOR BOTH KEY INFORMANT AND FOCUS GROUP INTERVIEWS KEY INFORMANT INTERVIEW QUESTIONS 1 WHAT ARE STANISLAUS COUNTY'S 3 MOST CRITICAL HEALTH ISSUES? WHY ARE THESE THE TOP PRIORITIES? 2 STARTING WITH (HEALTH ISSUE #1), WHAT ARE THE FACTORS THAT CONTRIBUTE TO MAKING THIS A PRIORITY? 3 HOW DO THE HEALTH ISSUES YOUVE IDENTIFIED SPECIFICALLY IMPACT LOW INCOME, UNDERSERVED/UNINSURED POPULATIONS? WHICH POPULATIONS DO THE ISSUES IMPACT MOST? 4 HOW DO THE HEALTH ISSUES YOUVE IDENTIFIED IMPACT ETHNIC/RACIAL SUBPOPULATIONS? WHICH POPULATIONS DO THE ISSUES IMPACT MOST? 5 BASED ON YOUR KNOWLEDGE AND EXPERTISE, WHAT ARE THE SUCCESSFUL STRATEGIES THAT COULD BE IMPLEMENTED TO ADDRESS THE TOP 3 HEALTH ISSUES YOU HAVE IDENTIFIED? WHAT ARE SOME OF THE CHALLENGES TO ADDRESSING THE HEALTH ISSUES? 6 WHAT ASSETS AND SERVICES ARE AVAILABLE IN STANISLAUS COUNTY TO ADDRESS THE TOP HEALTH ISSUES? 7 BEYOND THE 3 TOP HEALTH ISSUES YOUVE IDENTIFIED, ARE THERE ANY OTHER HEALTH ISSUES THAT YOU THINK ARE ALSO IMPORTANT TO ADDRESS? 8 WHAT ARE YOUR SUGGESTIONS FOR WAYS TO ENGAGE COMMUNITY MEMBERS, PARTICULARLY LOW INCOME, UNDERSERVED/UNINSURED POPULATIONS AND ETHNIC/RACIAL SUBPOPULATIONS, IN ADDRESSING THE HEALTH ISSUES? 9 WHAT ROLE CAN KAISER PERMANENTE CENTRAL VALLEY AND SUTTER HEALTH MEMORIAL MEDICAL CENTER PLAY IN ADDRESSING THE HEALTH ISSUES? 10 IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT THE TOP HEALTH ISSUES IN STANISLAUS COUNTY AND HOW TO ADDRESS THE ISSUES? FOCUS GROUP INTERVIEW QUESTIONS 1 PLEASE DESCRIBE FOR ME YOUR IDEA OF WHAT A HEALTHY COMMUNITY LOOKS LIKE 2 NOW THINK ABOUT HOW YOUR COMMUNITY IS RIGHT NOW WHAT IS HEALTHY ABOUT YOUR COMMUNITY? - WHAT MAKES IT EASY TO BE HEALTHY IN YOUR COMMUNITY? - WHAT MAKES IT DIFFICULT TO BE HEALTHY IN YOUR COMMUNITY? 3 IN 2013, WE ASKED COMMUNITY MEMBERS TO DESCRIBE THE TOP HEALTH ISSUES IN THE COMMUNITY ASTHMA, OBES</p>

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

Form and Line Reference	Explanation
<p>REPORTING FACILITY #2, STANISLAUS SURGICAL HOSPITAL</p>	<p>ITY/OVERWEIGHT/DIABETES AND ACCESS TO CARE CAME UP AS TOP HEALTH ISSUES FACING YOUR COMMUNITY HOW IMPORTANT DO YOU THINK THESE ISSUES ARE TODAY? - WHAT OTHER HEALTH ISSUES ARE IMPORTANT? - OF ALL THE HEALTH ISSUES WEVE DISCUSSED WHAT WOULD YOU SAY ARE THREE MOST URGENT ONES? 4 WHAT ARE THE TOP THREE THINGS THAT COULD BE DONE TO MAKE YOUR COMMUNITY HEALTHIER? - FOR EACH OF THESE, WHAT ARE SOME SUCCESSFUL WAYS TO ADDRESS THEM THAT YOUVE SEEN EITHER IN YOUR COMMUNITY OR OTHER COMMUNITIES YOU KNOW ABOUT? - IF YOU HAVENT SEEN OR HEARD ABOUT THINGS THAT HAVE BEEN SUCCESSFUL, DO YOU HAVE ANY IDEAS FOR WAYS TO MAKE YOUR COMMUNITY HEALTHIER? 5 WHAT ARE SOME ORGANIZATIONS, SERVICES OR RESOURCES IN YOUR COMMUNITY THAT HELP PEOPLE TO BE HEALTHY? - HOW DO THESE ORGANIZATIONS, SERVICES OR RESOURCES HELP PEOPLE TO BE HEALTHY? 6 WHAT DOES THE COUNTY/YOUR COMMUNITY NEED IN TERMS OF HEALTH (SERVICES, PROGRAMS, ETC ) THAT DOES NOT CURRENTLY EXIST IN THE COMMUNITY? 7 WHAT DO YOU RECOMMEND AS THE BEST WAYS TO GET PEOPLE IN YOUR COMMUNITY INVOLVED IN MAKING YOUR COMMUNITY HEALTHIER? PLEASE BE SPECIFIC - WHAT ARE THE CHALLENGES TO ENGAGING PEOPLE IN YOUR COMMUNITY? - HOW CAN THESE CHALLENGES BE OVERCOME? 8 WERE JUST ABOUT READY TO WRAP UP IS THERE ANYTHING ELSE YOU FEEL IS IMPORTANT FOR US TO KNOW ABOUT HEALTH IN YOUR COMMUNITY? PART V, SECTION B, LINE 6 STANISLAUS SURGICAL HOSPITAL (FACILITY 2) STANISLAUS SURGICAL HOSPITAL, MEMORIAL MEDICAL CENTER AND KAISER FOUNDATION HOSPITAL - MODESTO COLLABORATED ON THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT PART V, SECTION B, LINE 7A, 7B AND 10A STANISLAUS SURGICAL HOSPITAL (FACILITY 12) <a href="https://www.sutterhealth.org/pdf/for-patients/chna/stanislaus-2018-chna.pdf">HTTPS://WWW.SUTTERHEALTH.ORG/PDF/FOR-PATIENTS/CHNA/STANISLAUS-2018-CHNA.PDF</a> PART V, SECTION B, LINE 11 STANISLAUS SURGICAL HOSPITAL (FACILITY 2) THE FOLLOWING SIGNIFICANT HEALTH NEEDS WERE IDENTIFIED IN THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT AND ARE NEEDS THAT STANISLAUS SURGICAL HOSPITAL INTENDS TO ADDRESS THROUGH ITS IMPLEMENTATION STRATEGY 1 SAFE AND VIOLENCE-FREE ENVIRONMENT 2 ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE ABUSE SERVICES 3 ACTIVE LIVING/HEALTH EATING 4 ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES 5 ACCESS TO BASIC NEEDS, SUCH AS HOUSING AND EMPLOYMENT DESCRIPTIONS OF THE COMMUNITY BENEFIT PROGRAMS THAT ADDRESS THESE SIGNIFICANT HEALTH NEEDS CAN BE FOUND IN PART VI NO HOSPITAL CAN ADDRESS ALL THE HEALTH NEEDS IN THE COMMUNITY STANISLAUS SURGICAL HOSPITAL IS COMMITTED TO SERVING THE COMMUNITY BY ADHERING TO ITS MISSION, USING ITS SKILLS AND CAPABILITIES, AND REMAINING A STRONG ORGANIZATION SO THAT IT CAN CONTINUE TO PROVIDE A WIDE RANGE OF COMMUNITY BENEFITS THE HOSPITAL DOES NOT PLAN TO ADDRESS THE FOLLOWING SIGNIFICANT HEALTH NEEDS THAT WERE IDENTIFIED IN THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT 1 INJURY AND DISEASE PREVENTION MANAGEMENT THIS IS AN IDENTIFIED LOW PRIORITY HEALTH NEED THAT SSH IS NOT ADDRESSING THE RATIONALE FOR THIS IS THERE ARE RESOURCES AVAILABLE THROUGH OUR SISTER AFFILIATE, SUTTER</p>

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

Form and Line Reference	Explanation
REPORTING FACILITY #2, STANISLAUS SURGICAL HOSPITAL	GOULD MEDICAL CENTER AND SUTTER TRACY COMMUNITY HOSPITAL THEY OFFER DIABETES MANAGEMENT THROUGH COMMUNITY MEDICAL CENTERS 2 ACCESS TO FUNCTIONAL NEEDS TRANSPORTATION AND DISABILITY THAT PREVENT ACCESS THROUGH MOVEMENT THIS IS ALSO IDENTIFIED AS A LOW PRIORITY HEALTH NEED THAT SSH IS NOT ADDRESSING MANY HEALTH PLANS OFFER TRANSPORTATION THROUGH THEIR MEDICAL PLANS AND WE WILL PARTNER WITH THEM TO PROVIDE THIS AS NEEDED IN ADDITION, OUR HOSPITAL PROVIDES TAXI VOUCHERS AND OTHER TRANSPORTATION OPTIONS ON A CASE BY CASE BASIS ACCESS TO SPECIALTY CARE ALSO IDENTIFIED AS A LOW PRIORITY HEALTH NEED THAT SSH IS NOT ADDRESSING OUR FOCUS IS ON ESTABLISHING PATIENTS WITH PRIMARY CARE AND MENTAL HEALTH CARE AS THOSE WERE BOTH IDENTIFIED AS HIGHER PRIORITY AREAS



**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
SCHEDULE H, PART V, SECTION B, LINE 15E	STANISLAUS SURGICAL HOSPITAL (2) METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE-OTHER PATIENTS MAY SUBMIT CHARITY CARE APPLICATION TO THE COLLECTIONS SUPERVISOR SCHEDULE H, PART V, SECTION B, LINES 16A, 16B, & 16C STANISLAUS SURGICAL HOSPITAL (2) THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE ON THE SUTTER HEALTH WEBSITE AT <a href="https://stanislaussurgical.com/financial-assistance">HTTPS //STANISLAUSSURGICAL COM/FINANCIAL-ASSISTANCE</a>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 16J	STANISLAUS SURGICAL HOSPITAL (2) MEASURES USED TO PUBLICIZE THE FACILITY'S FINANCIAL ASSISTANCE POLICY THE FINANCIAL ASSISTANCE POLICY IS AVAILABLE IN THE PRIMARY LANGUAGES OF THE HOSPITAL'S SERVICE AREA (ENGLISH & SPANISH) DURING PREADMISSION OR REGISTRATION ALL PATIENTS WILL BE PROVIDED THE FINANCIAL ASSISTANCE POLICY IS POSTED IN SEVERAL PROMINENT LOCATIONS WITHIN THE HOSPITAL, INCLUDING, BUT NOT LIMITED TO THE BILLING OFFICE, ADMISSIONS OFFICE, AND PATIENT WAITING AREA HOSPITAL PROVIDES PATIENTS, IN A TIMELY MANNER, A COPY OF THE FINANCIAL ASSISTANCE POLICY UPON REQUEST

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

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
<b>1</b> SUTTER MED CARE CT & AMBULATORY SURG CT 460 Plumas Yuba City, CA 95991	OUTPATIENT SERVICES/SURGERY CENTER
<b>1</b> URGENT CARE 600 COFFEE ROAD MODESTO, CA 95355	Urgent Care
<b>2</b> STOCKTON MEDICAL PLAZA 2545 WEST HAMMER LANE STOCKTON, CA 95209	Urgent Care/Surgery Center/ Outpatient Services
<b>3</b> STOCKTON SURGERY CENTER 8011 DON AVENUE STOCKTON, CA 95209	SURGERY CENTER
<b>4</b> PATTERSON CARE CENTER 801 E STREET PATTERSON, CA 95363	Lab/Outpatient Services
<b>5</b> TURLOCK CARE CENTER 3100 W CHRISTOFFERSEN PARKWAY TURLOCK, CA 95382	Urgent Care/Radiology/ Laboratory
<b>6</b> SUTTER IMAGING SACRAMENTO 3161 L STREET SACRAMENTO, CA 95816	Imaging
<b>7</b> SUTTER ROSEVILLE CANCER CENTER 8 MEDICAL PLAZA DRIVE ROSEVILLE, CA 95661	Outpatient Services
<b>8</b> ROSEVILLE PATIENT SERVICE CENTERS 3 MEDICAL PLAZA DRIVE ROSEVILLE, CA 95661	Outpatient Services
<b>9</b> SUTTER IMAGING ROSEVILLE PARKWAY 1640 EAST ROSEVILLE PARKWAY ROSEVILLE, CA 95661	Imaging
<b>10</b> SUTTER IMAGING ROSEVILLE II 2 MEDICAL PLAZA DRIVE ROSEVILLE, CA 95661	Imaging
<b>11</b> SUTTER MEDICAL PLAZA - SUTTER PLACE 2020 SUTTER PLACE DAVIS, CA 95616	OUTPATIENT SERVICES
<b>12</b> SUTTER CANCER CENTER SACRAMENTO 2800 L ST SACRAMENTO, CA 95816	Outpatient Services
<b>13</b> SUTTER URGENT CARE FAIRFIELD 2702 LOW COURT FAIRFIELD, CA 94534	Outpatient Services
<b>14</b> SUTTER YUBA CITY MEDICAL CENTER 480 PLUMAS YUBA CITY, CA 95991	Outpatient Services

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
<b>16</b> VACAVILLE CARE CENTER 770 MASON STREET VACAVILLE, CA 95687	Outpatient Services
<b>1</b> VALLEJO CARE CENTER 100 HOSPITAL DRIVE VALLEJO, CA 94589	Outpatient Services
<b>2</b> SUTTER AMADOR SURGERY CENTER 223 CLINTON ROAD JACKSON, CA 95642	Outpatient Services
<b>3</b> SUTTER FAIRFIELD SURGERY CENTER 2700 LOW COURT FAIRFIELD, CA 94534	SURGERY CENTER
<b>4</b> AUBURN AMC FAMILY PRACTICE & ORTHOPEDICS 3133 PROFESSIONAL DRIVE AUBURN, CA 95603	Family Practice & Orthopedics
<b>5</b> URGENT CARE/LAB/RADIOLOGY/CARDIOLOGY 440 PLUMAS YUBA CITY, CA 95991	Urgent Care/Lab/Radiology/ CARDIOLOGY
<b>6</b> AUBURN GASTROENTEROLOGY & NEUROLOGY 11795 EDUCATION STREET AUBURN, CA 95602	Gastroenterology & Neurology
<b>7</b> ROSEVILLE FAMILY PRACTICE & PHYS THERAPY 568 N SUNRISE AVE ROSEVILLE, CA 95661	Outpatient Services & PHYSICAL THERAPY
<b>8</b> ELK GROVE - PHYSICAL THERAPY 9280 W STOCKTON BLVD ELK GROVE, CA 95758	PHYSICAL THERAPY
<b>9</b> GRASS VALLEY FAMILY PRACTICE & PHYS THRP 10058 WOLF ROAD GRASS VALLEY, CA 95949	Outpatient Services & PHYSICAL THERAPY
<b>10</b> DAVIS - PHYSICAL THERAPY 11930 HERITAGE OAK PLACE AUBURN, CA 95616	PHYSICAL THERAPY
<b>11</b> PHYSICAL THERAPY 420 B ST YUBA CITY, CA 95991	Physical Therapy
<b>12</b> SUTTER FAIRFIELD DIAGNOSTIC IMAGING CTR 2700 LOW COURT FAIRFIELD, CA 94534	Diagnostic Imaging Center
<b>13</b> SUTTER IMAGING CAMPUS COMMONS 2 SCRIPPS DRIVE SACRAMENTO, CA 95825	Diagnostic Imaging Center
<b>14</b> SUTTER IMAGING SOUTH 8118 TIMBERLAKE WAY SACRAMENTO, CA 95823	Diagnostic Imaging Center

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

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
<b>31</b> FOLSOM PATIENT SERV CENTERSURGENT CARE 2575 E BIDWELL ST FOLSOM, CA 95630	Outpatient Services/Urgent Care
<b>1</b> SACRAMENTO AREA PATIENT SERVICE CENTERS 1625 STOCKTON BLVD SACRAMENTO, CA 95816	Outpatient Services
<b>2</b> FORT SUTTER PATIENT SERVICE CENTERS 2801 K ST SACRAMENTO, CA 95816	Outpatient Services
<b>3</b> NORTHEAST SAC PATIENT SERVICE CENTERS 3100 DOUGLAS BLVD ROSEVILLE, CA 95661	Outpatient Services
<b>4</b> SACRAMENTO AREA PATIENT SERVICE CENTERS 1201 ALHAMBRA BLVD SACRAMENTO, CA 95816	Outpatient Services
<b>5</b> SACRAMENTO AREA PATIENT SERVICE CENTERS 2725 CAPITOL AVE SACRAMENTO, CA 95816	Outpatient Services
<b>6</b> YOLO AREA PATIENT SERVICE CENTERS 635 ANDERSON RD DAVIS, CA 95616	Outpatient Services
<b>7</b> SUTTER MEDICAL PLAZA ELK GROVE 8170 LAGUNA BLVD ELK GROVE, CA 95758	Outpatient Services
<b>8</b> SMF SURGERY CENTER 8200 LAGUNA BLVD ELK GROVE, CA 95758	Ambulatory Surgery Center
<b>9</b> YOLO AREA PATIENT SERVICE CENTERS 2210 DEL PASO RD SACRAMENTO, CA 95831	Outpatient Services
<b>10</b> PLACER AREA PATIENT SERVICE CENTERS 685 TWELVE BRIDGES DR LINCOLN, CA 95648	Outpatient Services
<b>11</b> SUTTER IMAGING FOLSOM I 1655 CREEKSIDE DRIVE FOLSOM, CA 95630	Diagnostic Imaging Center
<b>12</b> SUTTER IMAGING FOLSOM II 1661 CREEKSIDE DRIVE FOLSOM, CA 95630	Diagnostic Imaging Center
<b>13</b> WOODLAND PATIENT SERVICES CENTER 475 PIONEER AVE WOODLAND, CA 95776	Outpatient Services
<b>14</b> YOLO AREA PATIENT SERVICE CENTERS 125 N LINCOLN ST DIXON, CA 95620	Outpatient Services

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

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
<b>46</b> BELL ROAD MEDICAL OFFICES 3288 BELL RD AUBURN, CA 95603	Outpatient Services
<b>1</b> NORTHEAST SAC PATIENT SERVICE CENTERS 5767 GREENBACK LANE SACRAMENTO, CA 95825	Outpatient Services
<b>2</b> YOLO AREA PATIENT SERVICE CENTERS 7420 GREENHAVEN DR SACRAMENTO, CA 95831	Outpatient Services
<b>3</b> AUBURN PARKHILL FAMILY PRACTICE 404 AUBURN-FOLSOM ROAD AUBURN, CA 95603	Family Practice
<b>4</b> SUTTER IMAGING AUBURN 3123 PROFESSIONAL DRIVE AUBURN, CA 95603	Diagnostic Imaging Center
<b>5</b> CARDIOLOGY 2575 E BIDWELL ST FOLSOM, CA 95630	Cardiology
<b>6</b> SUTTER IMAGING CARMICHAEL 6620 COYLE AVENUE CARMICHAEL, CA 95608	Diagnostic Imaging Center
<b>7</b> PROCEDURE CENTER 550 B ST YUBA CITY, CA 95991	Procedure Center
<b>8</b> HOME HEALTHHOSPICE 400 PLUMAS YUBA CITY, CA 95991	Home Health/Hospice
<b>9</b> DAVIS INTERNAL MED & GASTROENTEROLOGY 2068 JOHN JONES WAY DAVIS, CA 95616	Internal Medicine & Gastroenterology
<b>10</b> L STREET MEDICAL NEUROLOGY 2800 L STREET SACRAMENTO, CA 95819	Neurology
<b>11</b> ORTHOPEDICS 470 PLUMAS YUBA CITY, CA 95991	Orthopedics
<b>12</b> SUTTER OBSTETRICS AND GYNECOLOGY 969 PLUMAS YUBA CITY, CA 95991	Obstetrics
<b>13</b> SUTTER ADVANCED DERMATOLOGY & LASER CTR 350 Del Norte Yuba City, CA 95991	Dermatology
<b>14</b> ROSEVILLE EXPRESS CLINIC 4010 FOOTHILLS BOULEVARD ROSEVILLE, CA 95747	Outpatient Services

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

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

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

Name and address	Type of Facility (describe)
<b>61</b> EXPRESS CLINIC - EL DORADO HILLS 3919 PARK DRIVE EL DORADO HILLS, CA 95762	Outpatient Services
<b>1</b> EXPRESS CLINIC - ELK GROVE 4810 ELK GROVE BOULEVARD ELK GROVE, CA 95758	Outpatient Services
<b>2</b> CITRUS HEIGHTS WALK-IN CARE 5406 SUNRISE BOULEVARD CITRUS HEIGHTS, CA 95610	Outpatient Services
<b>3</b> SUTTER GOULD CARDIOLOGY STOCKTON 1801 EAST MARCH LANE STOCKTON, CA 95210	Cardiology
<b>4</b> RADIATION ONCOLOGY SERVICES-VACAVILLE 200 BELLA VISTA ROAD VACAVILLE, CA 95687	Outpatient Services
<b>5</b> Rancho Cordova Walk-In Care 4040 Sunrise Boulevard Rancho Cordova, CA 95742	Outpatient Services
<b>6</b> Roseville Walk-In Care 781 Pleasant Grove Boulevard Roseville, CA 95678	OUTPATIENT SERVICES
<b>7</b> Oakdale Road Care Center 1501 Oakdale Road Suite 218 Modesto, CA 95355	SURGERY CENTER
<b>8</b> Tracy Care Center 445 W Eaton Ave Tracy, CA 95376	OUTPATIENT SERVICES
<b>9</b> Laboratory 100 Mission Blvd JACKSON, CA 95642	LABORATORY

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

Schedule I (Form 990)

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

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number 68-0273974

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?
2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000 Part II can be duplicated if additional space is needed

Table with 7 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section (if applicable), (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation (book, FMV, appraisal, other), (g) Description of noncash assistance, (h) Purpose of grant or assistance. Includes rows for SUTTER VALLEY HOSPITALS and MARCH OF DIMES.

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



**Part III Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22  
 Part III can be duplicated if additional space is needed

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

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

Return Reference	Explanation
SCHEDULE I, PART I, LINE 2	IN ORDER TO CLOSELY MONITOR EFFICIENCY AND EFFECTIVENESS, THE COMMUNITY BENEFIT FUNCTION OUTLINES MEASURABLE REPORTING (QUARTERLY, SIX-MONTH AND/OR YEAR-END), PROGRAM AND FUNDING REQUIREMENTS IN A MEMORANDUM OF UNDERSTANDING (MOU), BUSINESS SERVICES AGREEMENT (BSA), OR JOINT VENTURE AGREEMENT FOR EACH INVESTMENT MADE WITH A COMMUNITY PARTNER WHERE IT IS DETERMINED NECESSARY, ADDITIONAL EFFORTS ARE MADE TO MONITOR EFFECTIVENESS AND EFFICIENCY OF INVESTMENTS, WHICH COULD INCLUDE - QUARTERLY MEETINGS WITH COMMUNITY PARTNERS - E-MAIL AND TELEPHONIC COMMUNICATIONS WITH COMMUNITY PARTNERS - CONTINUED DIALOGUE WITH INVOLVED HOSPITAL STAFF AND COMMUNITY PARTNERS THROUGHOUT DURATION OF PROGRAM - SITE VISITS WITH COMMUNITY PARTNERS - BI-ANNUAL "OUTCOMES" SURVEY (6-MONTH AND YEAR-END OUTCOMES) - REVIEW OF HOSPITAL USAGE AND PATIENT LEVEL DATA - COLLECTION OF PATIENT STORIES AND NARRATIVES - COLLABORATIVE DISCUSSIONS AROUND AD-HOC SUCCESSES AND CHALLENGES THAT ARISE - REPORTING TO INCLUDE YEAR-END FINANCIAL SUMMARY THAT COMPARES ACTUAL EXPENDITURES TO THE FUNDED PROJECTS BUDGET, INDICATING ANY UNUSED AMOUNT OF GRANT FUNDS AT THE END OF EACH YEAR/REPORTING PERIOD, COMMUNITY BENEFIT ANALYZES FULL-YEAR DATA TO ENSURE COMMUNITY PARTNERS MET THE OBJECTIVES OUTLINED IN THE MOU OR BSA IF THE COMMUNITY PARTNERS DID NOT REACH THE ANTICIPATED OUTCOMES, COMMUNITY BENEFIT WORKS TO UNDERSTAND WHAT CIRCUMSTANCES PREVENTED THE ORGANIZATION FROM MEETING THE GOALS TO HELP IDENTIFY WAYS TO IMPROVE OR PERHAPS RE-EVALUATE WHAT SUCCESS OF THIS PROGRAM LOOKS LIKE, AND MAKES THE DETERMINATION TO CONTINUE OR TERMINATE FUNDING

**Schedule J**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

## Compensation Information

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

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

OMB No 1545-0047

# 2018

**Open to Public Inspection**

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number  
68-0273974

**Part I Questions Regarding Compensation**

		Yes	No		
<p><b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> First-class or charter travel  <input type="checkbox"/> Travel for companions  <input type="checkbox"/> Tax indemnification and gross-up payments  <input type="checkbox"/> Discretionary spending account                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing allowance or residence for personal use  <input type="checkbox"/> Payments for business use of personal residence  <input type="checkbox"/> Health or social club dues or initiation fees  <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)                 </td> </tr> </table>	<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)				
<p><b>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain</p>	<b>1b</b>				
<p><b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p>	<b>2</b>				
<p><b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Compensation committee  <input checked="" type="checkbox"/> Independent compensation consultant  <input type="checkbox"/> Form 990 of other organizations                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Written employment contract  <input checked="" type="checkbox"/> Compensation survey or study  <input checked="" type="checkbox"/> Approval by the board or compensation committee                 </td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee			
<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee				
<p><b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization</p>					
<p><b>a</b> Receive a severance payment or change-of-control payment?</p>	<b>4a</b>		No		
<p><b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	<b>4b</b>	Yes			
<p><b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p>	<b>4c</b>		No		
<p><b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b></p>					
<p><b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</p>					
<p><b>a</b> The organization?</p>	<b>5a</b>		No		
<p><b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III</p>	<b>5b</b>		No		
<p><b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</p>					
<p><b>a</b> The organization?</p>	<b>6a</b>		No		
<p><b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III</p>	<b>6b</b>		No		
<p><b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p>	<b>7</b>	Yes			
<p><b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III</p>	<b>8</b>		No		
<p><b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	<b>9</b>				



**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 J, PART I, LINE 3	<p>SUPPLEMENTAL COMPENSATION INFORMATION. THE CEO OF THIS ORGANIZATION IS AN EMPLOYEE OF SUTTER HEALTH, A RELATED TAX-EXEMPT ORGANIZATION. THE COMPENSATION COMMITTEE OF THE SUTTER HEALTH BOARD OF DIRECTORS RETAINS ULTIMATE DISCRETIONARY AUTHORITY OVER ALL ELEMENTS OF COMPENSATION TO ASSURE THAT ORGANIZATIONAL PURPOSES ARE APPROPRIATELY BEING SERVED. THE COMPENSATION COMMITTEE USES CREDIBLE DATA SOURCES AND MAINTAINS AN OBJECTIVE "ARM'S LENGTH" DECISION-MAKING PROCESS, ENSURING THE INTEGRITY OF SUTTER'S EXECUTIVE PROGRAMS AND CONSISTENCY WITH THE ORGANIZATION'S OVERALL MISSION. SEE SCHEDULE O NARRATIVE FOR PART VI, LINE 15 FOR A FULL DESCRIPTION OF THE COMPENSATION APPROVAL PROCESS COMPLETED BY SUTTER HEALTH.</p>

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE J, PART I, LINE 4B	NONQUALIFIED RETIREMENT PLAN THE PURPOSE OF THE NONQUALIFIED RETIREMENT PLAN IS TO PROVIDE SUTTER HEALTH EXECUTIVES WITH A COMPETITIVE RETIREMENT BENEFIT CONSISTENT WITH SUTTER HEALTHS OVERALL COMPENSATION PHILOSOPHY FOR ALL EMPLOYEES CONTRIBUTIONS ARE DESIGNED TAKING INTO CONSIDERATION LOST RETIREMENT BENEFITS THAT WOULD OTHERWISE BE OBTAINED THROUGH THE QUALIFIED PENSION PLAN SUTTERS PLANS ARE DESIGNED CONSISTENT WITH COMPETITIVE INDUSTRY PRACTICES THE RETIREMENT PLAN FOR SUTTER HEALTH EMPLOYEES IS A COMBINATION OF 403(B) EMPLOYER MATCH CONTRIBUTIONS AND QUALIFIED PENSION PLAN BENEFITS SUTTER HEALTH EXECUTIVES ARE GENERALLY INELIGIBLE FOR EMPLOYER MATCH CONTRIBUTIONS TO ENSURE A COMPETITIVE RETIREMENT BENEFIT, SUTTER HEALTH MAKES AN ANNUAL CONTRIBUTION TO A NON-QUALIFIED 457(F) PLAN FOR ITS EXECUTIVES THE FORMULA PROVIDES 6% TO 12% OF BASE SALARY PLUS ANNUAL INCENTIVE PLAN AWARD (COMMENSURATE WITH MANAGEMENT LEVEL) CONTRIBUTIONS ARE ALSO MADE FOR A SMALL GROUP OF SENIOR LEVEL EXECUTIVES WHOSE ESTIMATED RETIREMENT BENEFIT (SOCIAL SECURITY PLUS QUALIFIED PLAN BENEFITS PLUS 457(F)) FALLS BELOW 50% - 65% OF FINAL 4-YEAR AVERAGE BASE SALARY WHEN RETIRING AT AGE 65 WITH 22.5 YEARS OF SERVICE TARGET BENEFIT LEVELS ARE DISCOUNTED FOR YEARS OF SERVICE LESS THAN 22.5 AT AGE 65 UNLIKE SUTTER HEALTHS QUALIFIED PENSION PLAN WHERE EMPLOYEE BENEFITS ARE GUARANTEED (I.E., A DEFINED BENEFIT), SUTTERS NON-QUALIFIED PLAN BENEFITS ARE NOT GUARANTEED BY SUTTER HEALTH INVESTMENT RISK IS BORNE BY PARTICIPANTS AND BENEFITS ARE NOT PROTECTED SHOULD SUTTER HEALTH BECOME INSOLVENT

Return Reference	Explanation
SCHEDULE J, PART I, LINE 7	<p>NON-FIXED PAYMENTS SPOT AWARDS ARE INFREQUENTLY USED TO REWARD EMPLOYEES THERE ARE NO SPECIFIC GUIDELINES FOR THE AMOUNT OF THE SPOT AWARD BUT THE AMOUNT TENDS TO NOT EXCEED 5% TO 10% OF GROSS ANNUAL SALARY ANNUAL INCENTIVE PLAN (AIP) THE PURPOSE OF THE PLAN IS TO FOCUS EXECUTIVES ON SPECIFIC, SHORTER-TERM GOALS THAT ARE CRITICAL TO THE ACHIEVEMENT OF AFFILIATE, OPERATING UNIT AND SYSTEM-WIDE OBJECTIVES THAT DRIVE OVERALL ORGANIZATION PERFORMANCE LONG TERM PERFORMANCE PLANS SUTTER HEALTH ALSO EMPLOYS LONG TERM PERFORMANCE PLANS WHICH ARE DESIGNED TO FOCUS ON LONGER TERM STRATEGIC OBJECTIVES OF THE ORGANIZATION SUTTERS LONG TERM PERFORMANCE PLAN APPROACH IS A COMBINATION OF BOTH LONGER TERM MEASURES OF ORGANIZATION SUCCESS AND KEY ORGANIZATION STRATEGIES WHICH REQUIRE THE COMBINED EFFORT OF ALL LEADERSHIP TO ACHIEVE SUCCESS SUTTER USES A COMMON FATE APPROACH IN THAT ALL LONG TERM PERFORMANCE PLAN PARTICIPANTS ARE MEASURED AGAINST THE SAME, ORGANIZATION-WIDE CRITERIA VS INDIVIDUAL EFFORTS THIS FOSTERS A COMMON PURPOSE ACROSS LEADERSHIP AND A SHARED SENSE OF ACCOUNTABILITY FOR THE OVERALL SUCCESS OF SUTTER HEALTH TO ENSURE THAT EXTRAORDINARY EFFORTS BY INDIVIDUALS CAN BE RECOGNIZED AND THAT ACTIONS OF LEADERSHIP ARE CONSISTENT WITH SUPPORTING SUTTER HEALTHS OVERALL MISSION, VISION, AND VALUES, SUTTERS LONG TERM INCENTIVE PLAN APPROACH ALSO INCORPORATES A COMBINATION OF CEO AND SUTTER HEALTH COMPENSATION COMMITTEE DISCRETION IN SOME CASES, THE SUTTER HEALTH COMPENSATION COMMITTEE HAS DELEGATED AUTHORITY TO THE PRESIDENT &amp; CEO TO MODIFY INDIVIDUAL AWARDS WITHIN LIMITS THAT HAVE BEEN PRE-APPROVED BY THE SUTTER HEALTH COMPENSATION COMMITTEE THIS INCLUDES BOTH THE REDUCTION AND INCREASE OF AWARD AMOUNTS SUCH MODIFICATIONS GENERALLY DO NOT EXCEED +/- 20% AND ARE EMPLOYED JUDICIOUSLY IN ALL CASES, THE COMPENSATION COMMITTEE OF THE BOARD DETERMINES ACHIEVEMENT OF ORGANIZATION GOALS AND MAKES FINAL AWARD DETERMINATION WHICH MAY RESULT IN A REDUCTION OF AWARD IF APPROPRIATE ALL SENIOR EXECUTIVE AWARDS ARE REVIEWED FOR COMPENSATION REASONABLENESS AND APPROVED BY THE COMPENSATION COMMITTEE PRIOR TO PAYMENT</p>



**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 68-0273974  
**Name:** SUTTER VALLEY MEDICAL FOUNDATION

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
JAMES CONFORTI DIRECTOR/SH SVP/COO	(i)	0	0	0	0	0	0	0
	(ii)	882,157	310,854	130,789	460,359	22,245	1,806,404	113,665
PETER HULL MD DIRECTOR/CME SVH	(i)	0	0	0	0	0	0	0
	(ii)	343,916	54,013	5,621	34,105	18,379	456,034	0
SARAH KREVANS DIRECTOR/PRESIDENT & CEO, SH	(i)	0	0	0	0	0	0	0
	(ii)	1,678,673	842,240	329,388	1,909,372	26,449	4,786,122	300,989
THERESA FREI CEO, SVMF	(i)	0	0	0	0	0	0	0
	(ii)	496,702	74,870	116,349	104,331	21,730	813,982	105,702
PAIGE TERRA CFO, SH VALLEY AREA	(i)	0	0	0	0	0	0	0
	(ii)	512,533	147,915	52,107	81,501	19,848	813,904	43,475
PENNY WESTFALL CHIEF LEGAL OFFICER, SH VALLEY	(i)	0	0	0	0	0	0	0
	(ii)	404,767	112,151	53,835	67,268	9,154	647,175	43,042
JEFF SZCZESNY VP, HR SH VALLEY AREA	(i)	0	0	0	0	0	0	0
	(ii)	382,993	121,505	46,686	59,561	19,515	630,260	39,482
GARY ZUFELT CEO, SUTTER GOULD MED FDN	(i)	0	0	0	0	0	0	0
	(ii)	423,689	132,789	57,831	97,811	23,180	735,300	41,505
JONATHAN K BARENG DIR, RADIATION PHYSICS	(i)	268,857	13,191	3,285	13,792	17,657	316,782	0
	(ii)	0	0	0	0	0	0	0
VIRGINIA JOYCE MED DIR, QUAL & PATIENT SAFETY	(i)	249,343	13,965	5,417	12,791	16,187	297,703	0
	(ii)	0	0	0	0	0	0	0
ERIC RASMUSSEN DIR FND GROWTH & MED GRP STRT	(i)	207,726	10,274	3,345	10,656	22,694	254,695	0
	(ii)	0	0	0	0	0	0	0
ZULFIQAR A SANDHU DIR SERVICE AREA	(i)	232,814	10,943	1,523	11,943	22,831	280,054	0
	(ii)	0	0	0	0	0	0	0
STANLEY SKUBIC LEAD PHYSICIST - pd	(i)	237,714	0	2,721	12,195	15,408	268,038	0
	(ii)	0	0	0	0	0	0	0
PAMELA ADDY REG DIR OUTPATIENT IMAGING	(i)	195,197	9,378	5,557	10,014	16,514	236,660	0
	(ii)	0	0	0	0	0	0	0
THOMAS BLINN FRMR CEO, VALLEY AREA FNDTN	(i)	0	0	0	0	0	0	0
	(ii)	0	0	291,377	0	0	291,377	0
GLENN GROVES REGIONAL ADMIN DIRECTOR	(i)	103,491	9,055	2,448	5,309	814	121,117	0
	(ii)	0	0	4,919	0	0	4,919	0
SUHEIR HADDAD CFO, SH VALLEY AREA FDN	(i)	0	0	0	0	0	0	0
	(ii)	372,323	103,469	18,372	56,289	19,446	569,899	12,295
KATHERINE T MANUEL COO, SGMF	(i)	0	0	0	0	0	0	0
	(ii)	309,370	68,365	64,244	33,905	13,370	489,254	55,701
MICHAEL MARINO VP, HR FOUNDATIONS, SH VALLEY	(i)	0	0	0	0	0	0	0
	(ii)	227,058	57,252	10,730	27,949	12,288	335,277	7,137
CHARLES SANDERS III CFO FNDTN - SGMF/NORTH	(i)	0	0	0	0	0	0	0
	(ii)	252,424	57,558	18,757	27,978	14,233	370,950	10,050



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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
JEFF SPRAGUE SH SVP & CFO	(i)	0	0	0	0	0	0	
	(ii)	749,362	269,485	186,017	503,648	15,462	1,723,974	

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

**Schedule K (Form 990)**

**Supplemental Information on Tax-Exempt Bonds**

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

▶ Attach to Form 990.

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

OMB No 1545-0047

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number

68-0273974

**Part I Bond Issues**

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A CHFFA 2008A	52-1643828	13033F2L3	05-14-2008	329,041,638	REFUNDING 5/1/07, 04, & 02		X		X		X
B CHFFA 2015A	52-1643828	13032UAR9	11-12-2015	204,061,105	REFUND 2005A & 1995 CERTIFICATES		X		X		X
C CHFFA 2016B	52-1643828	13032UDW5	08-17-2016	901,627,093	REFUND 2005BC & 2003AB & 2007A	X			X		X
D CHFFA 2017A	52-1643828	13032UNY0	07-06-2017	496,319,743	REFUND 2004CD, 2008A (PT), 2008BC	X			X		X

**Part II Proceeds**

		A		B		C		D	
1	Amount of bonds retired . . . . .	158,610,000	0	0	0	0	0	0	0
2	Amount of bonds legally defeased . . . . .	118,730,000	0	0	0	0	0	0	0
3	Total proceeds of issue . . . . .	329,041,638	204,061,105	902,923,938	496,319,743				
4	Gross proceeds in reserve funds . . . . .	0	0	0	0				
5	Capitalized interest from proceeds . . . . .	0	0	0	0				
6	Proceeds in refunding escrows . . . . .	0	0	0	0				
7	Issuance costs from proceeds . . . . .	0	0	0	0				
8	Credit enhancement from proceeds . . . . .	0	0	0	0				
9	Working capital expenditures from proceeds . . . . .	0	0	0	0				
10	Capital expenditures from proceeds . . . . .	0	0	0	0				
11	Other spent proceeds . . . . .	329,041,638	204,061,105	902,923,938	496,319,743				
12	Other unspent proceeds . . . . .	0	0	0	0				
13	Year of substantial completion . . . . .								
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue? . . . . .	X		X			X		X
15	Were the bonds issued as part of an advance refunding issue? . . . . .		X		X	X		X	
16	Has the final allocation of proceeds been made? . . . . .	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X		X		X	

**Part III Private Business Use**

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

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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X		X		X		X	
<b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .	X		X		X		X	
<b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X		X		X	
<b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government . . . . . ▶	2 300 %		0 120 %		0 240 %		1 360 %	
<b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government . . . . . ▶	0 160 %		0 %		0 020 %		0 030 %	
<b>6</b> Total of lines 4 and 5 . . . . .	2 460 %		0 120 %		0 260 %		1 390 %	
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X		X		X
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X		X		X
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .								
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2? . . . . .		X		X		X		X
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2? . . . . .	X		X		X		X	

**Part IV Arbitrage**

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

**Part IV Arbitrage** (Continued)

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

**Part V Procedures To Undertake Corrective Action**

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

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

Return Reference	Explanation
SCHEDULE K	THE ORGANIZATIONS SOLE CORPORATE MEMBER IS A CONDUIT BORROWER OF TAX-EXEMPT BOND ISSUES THAT ALLOCATES PORTIONS OF EACH ISSUE TO CERTAIN SUBSIDIARY ORGANIZATIONS, INCLUDING THE ORGANIZATION THE OUTSTANDING BOND LIABILITY ALLOCATED TO THIS ORGANIZATION IS REPORTED ON FORM 990, PART X, BALANCE SHEET, AND PART VI HEREIN WITH THE EXCEPTION OF THIS PORTION OF PART VI, THE SCHEDULE K FOR THIS ORGANIZATION IS REPORTING INFORMATION FOR THE ENTIRE BOND ISSUE SCHEDULE K, PART I-1, LINE A, COLUMN (E) THE FILING ORGANIZATION RECEIVED BOND PROCEEDS IN THE AMOUNTS OF \$15,965,401 FROM THE 2008A ISSUE, \$19,966,327 FROM THE 2015A ISSUE, \$53,216,412 FROM THE 2016B ISSUE, AND \$117,119,861 FROM THE 2017A ISSUE SCHEDULE K, PART I, CHFFA 2008A, COLUMN (F) THE REFUNDING OCCURRED VIA THE REPAYMENT OF A DRAW ON A TAXABLE LINE OF CREDIT, DRAWN IN SEVERAL INSTALLMENTS BETWEEN APRIL 7 AND APRIL 11, 2008, USED TO REFUND THE 2002, 2004 AND 2007 ISSUES THE REFUNDED BONDS ISSUED IN 2007 WERE USED TO REFUND BONDS ISSUED IN 1991 AND 1995 AND TO REFUND BONDS ISSUED IN 1996 THAT WERE USED TO REFUND BONDS ISSUED IN 1985, 1989, 1990, 1991, 1992, AND 1995 THE REFUNDED BONDS ISSUED IN 2004 WERE USED FOR EXPANSION THE REFUNDED BONDS ISSUED IN 2002 WERE USED TO REFUND BONDS ISSUED IN 1992, WHICH WERE USED TO REFUND BONDS ISSUED IN 1985, 1986 AND 1987 SCHEDULE K, PART II, LINE 7 ISSUANCE COSTS FROM PROCEEDS ISSUANCE COSTS WERE FUNDED THROUGH EQUITY CONTRIBUTIONS SCHEDULE K, PART IV, LINE 2C THE REBATE COMPUTATION WAS PERFORMED FOR BONDS CHFFA 2008A ON 6/20/2018

## Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 68-0273974  
**Name:** SUTTER VALLEY MEDICAL FOUNDATION

Return Reference	Explanation
SCHEDULE K	THE ORGANIZATIONS SOLE CORPORATE MEMBER IS A CONDUIT BORROWER OF TAX-EXEMPT BOND ISSUES THAT ALLOCATES PORTIONS OF EACH ISSUE TO CERTAIN SUBSIDIARY ORGANIZATIONS, INCLUDING THE ORGANIZATION THE OUTSTANDING BOND LIABILITY ALLOCATED TO THIS ORGANIZATION IS REPORTED ON FORM 990, PART X, BALANCE SHEET, AND PART VI HEREIN WITH THE EXCEPTION OF THIS PORTION OF PART VI, THE SCHEDULE K FOR THIS ORGANIZATION IS REPORTING INFORMATION FOR THE ENTIRE BOND ISSUE SCHEDULE K, PART I-1, LINE A, COLUMN (E) THE FILING ORGANIZATION RECEIVED BOND PROCEEDS IN THE AMOUNTS OF \$15,965,401 FROM THE 2008A ISSUE, \$19,966,327 FROM THE 2015A ISSUE, \$53,216,412 FROM THE 2016B ISSUE, AND \$117,119,861 FROM THE 2017A ISSUE SCHEDULE K, PART I, CHFFA 2008A, COLUMN (F) THE REFUNDING OCCURRED VIA THE REPAYMENT OF A DRAW ON A TAXABLE LINE OF CREDIT, DRAWN IN SEVERAL INSTALLMENTS BETWEEN APRIL 7 AND APRIL 11, 2008, USED TO REFUND THE 2002, 2004 AND 2007 ISSUES THE REFUNDED BONDS ISSUED IN 2007 WERE USED TO REFUND BONDS ISSUED IN 1991 AND 1995 AND TO REFUND BONDS ISSUED IN 1996 THAT WERE USED TO REFUND BONDS ISSUED IN 1985, 1989, 1990, 1991, 1992, AND 1995 THE REFUNDED BONDS ISSUED IN 2004 WERE USED FOR EXPANSION THE REFUNDED BONDS ISSUED IN 2002 WERE USED TO REFUND BONDS ISSUED IN 1992, WHICH WERE USED TO REFUND BONDS ISSUED IN 1985, 1986 AND 1987 SCHEDULE K, PART II, LINE 7 ISSUANCE COSTS FROM PROCEEDS ISSUANCE COSTS WERE FUNDED THROUGH EQUITY CONTRIBUTIONS SCHEDULE K, PART IV, LINE 2C THE REBATE COMPUTATION WAS PERFORMED FOR BONDS CHFFA 2008A ON 6/20/2018

**Schedule L**  
(Form 990 or 990-EZ)

**Transactions with Interested Persons**

OMB No 1545-0047

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

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number  
68-0273974

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 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

1	(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 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

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

**Part III Grants or Assistance Benefiting Interested Persons.**  
 Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(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) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	854,745	TRADE VENDOR LINEN/UNIFORMS		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

**2018**

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

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number  
68-0273974

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . . .				
2 Art—Historical treasures . . . . .				
3 Art—Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities—Publicly traded . . . . .	X	920	300,357	FMV
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .				
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ ( _____ )				
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

<b>29</b>	
-----------	--

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

	Yes	No
<b>30a</b>		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?

<b>31</b>	Yes	
-----------	-----	--

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

<b>32a</b>		No
------------	--	----

b If "Yes," describe in Part II

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



**Part II Supplemental Information.**

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

Return Reference	Explanation
SCHEDULE M, PART I, COLUMN B	COLUMN (B) REPRESENTS THE NUMBER OF ITEMS RECEIVED

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

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

▶ Attach to Form 990 or 990-EZ.

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

**Open to Public Inspection**

Department of the Treasury

Name of the organization

SUTTER VALLEY MEDICAL FOUNDATION

Employer identification number

68-0273974

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART I, LINE 1 & PART III, LINE 1	MISSION STATEMENT WE ENHANCE THE HEALTH AND WELL-BEING OF PEOPLE IN THE COMMUNITIES WE SERVE THROUGH A NOT-FOR-PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTH CARE SERVICES

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 4A	<p>PROGRAM SERVICE ACCOMPLISHMENTS SUTTER VALLEY MEDICAL FOUNDATION (SVMF) IS A COMMUNITY BASED, NOT-FOR-PROFIT MEDICAL ORGANIZATION SERVING CENTRAL AND NORTHERN CALIFORNIA COMMUNITIES AND SUPPORTING THE SUTTER HEALTH-AFFILIATED HOSPITALS SVMF HAS CARE CENTERS LOCATED IN AMADOR, PLACER, SACRAMENTO, SAN JOAQUIN, SOLANO, STANISLAUS, SUTTER, YOLO AND YUBA COUNTIES OUR MISSION IS TO ENHANCE THE HEALTH AND WELL-BEING OF PEOPLE IN THE COMMUNITIES WE SERVE THROUGH NOT FOR PROFIT COMMITMENT TO COMPASSION AND EXCELLENCE IN HEALTH CARE WE VALUE EXCELLENCE AND QUALITY, CARING AND COMPASSION, HONESTY AND INTEGRITY, TEAMWORK AND COMMUNITY SUTTER VALLEY MEDICAL FOUNDATION IS ALIGNED WITH PHYSICIAN AND MID-LEVEL PROVIDERS OF GOULD MEDICAL GROUP, SUTTER MEDICAL GROUP AND SUTTER NORTH MEDICAL GROUP WE OFFER A FULL RANGE OF PRIMARY CARE AND SPECIALTY CARE MEDICAL SERVICES, INCLUDING AMBULATORY SURGERY, URGENT AND WALK-IN CARE CLINICS AND STATE OF THE ART IMAGING, LAB AND CARDIOLOGY TECHNOLOGY IN ADDITION, WE OPERATE THE TWIN CITIES SURGICAL HOSPITAL IN YUBA COUNTY, AS WELL AS RURAL HEALTH CLINICS IN AMADOR AND YUBA COUNTIES AND THE MAINO COMMUNITY HEALTH LIBRARY IN STANISLAUS COUNTY IN 2015, SUTTER MEDICAL FOUNDATION CHANGED ITS NAME TO SUTTER VALLEY MEDICAL FOUNDATION AND IN 2016, SUTTER GOULD MEDICAL FOUNDATION MERGED INTO SUTTER VALLEY MEDICAL FOUNDATION IN 2018, THE FOUNDATION PROVIDED MORE THAN \$62 MILLION IN CHARITY CARE AND COMMUNITY BENEFITS AND PROVIDED PATIENT SERVICES OF ALMOST 5.9 MILLION PATIENT VISITS THE FOUNDATION ALSO PROVIDES COMMUNITY SUPPORT THROUGH DONATIONS AND PARTICIPATION IN VARIOUS NOT-FOR PROFIT COMMUNITY PROGRAMS INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING - AMERICAN CANCER SOCIETY - AMERICAN HEART ASSOCIATION - FITQUEST PROGRAM SUPPORTING STUDENT WELLNESS THOUGHT SCHOOLS IN SUTTER, YUBA, SACRAMENTO AND PLACER COUNTIES - GIRLS ON THE RUN - HEALTH CAREERS ACADEMY PROGRAM FOR HIGH SCHOOL STUDENTS - KIWANIS - LOOK GOOD FEEL BETTER PROGRAM SUPPORTING WOMEN RECEIVING CANCER TREATMENT - MARCH OF DIMES - NATIONAL DIABETES SOCIETY - ROTARY - SALVATION ARMY</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 1A	THE AFFAIRS AND MANAGEMENT OF SUTTER VALLEY MEDICAL FOUNDATION (SVMF) ARE SUPERVISED BY THE EXECUTIVE COMMITTEE WHICH HAS POWER TO TRANSACT ALL REGULAR BUSINESS OF SVMF DURING THE PERIOD BETWEEN MEETINGS OF THE BOARD OF DIRECTORS THE EXECUTIVE COMMITTEE CONSISTS OF AT LEAST FIVE BOARD MEMBERS INCLUDING SVMF'S CHAIR WHO SHALL SERVE AS CHAIR OF THE COMMITTEE, THE CHAIR OF THE FINANCE AND PLANNING COMMITTEE, AN ADDITIONAL DIRECTOR AND THE PRESIDENT OF SVMF AT LEAST ONE COMMITTEE MEMBER IS A PHYSICIAN DIRECTOR FORM 990, PART VI, LINE 4 SIGNIFICANT CHANGES MADE TO THE ORGANIZATION'S GOVERNING DOCUMENTS PREVIOUSLY DESIGNATED DIRECTORS INCLUDED THE CHIEF OPERATING OFFICER OF THE GENERAL MEMBER AND ONE INDIVIDUAL DESIGNATED BY THE PRESIDENT AND CEO OF THE GENERAL MEMBER CURRENTLY DESIGNATED DIRECTORS INCLUDE THE CHIEF OPERATING OFFICER OF THE GENERAL MEMBER AND 2 INDIVIDUALS DESIGNATED BY THE PRESIDENT AND CEO OF THE GENERAL MEMBER

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 6 & 7A	CLASSES OF PERSONS AND THE NATURE OF THEIR RIGHTS THIS CORPORATION IS AN AFFILIATE OF SUTTER HEALTH, A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION SUTTER HEALTH IS THE SOLE MEMBER WITH THE RIGHT TO ELECT AT LEAST A MAJORITY OF THE MEMBERS OF THE BOARD OF DIRECTORS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 7B	<p>CLASSES OF PERSONS, DECISIONS REQUIRING APPROVAL &amp; TYPE OF VOTING RIGHTS SUTTER HEALTH AS THE SOLE MEMBER OF THE ORGANIZATION IS ENTITLED TO EXERCISE FULLY ALL RIGHTS AND PRIVILEGES OF MEMBERS OF NONPROFIT CORPORATIONS UNDER THE CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION LAW, AND ALL OTHER APPLICABLE LAWS THE MEMBER HAS THE RIGHTS AND POWERS TO APPOINT (AND REMOVE) MEMBERS OF THE CORPORATION'S BOARD OF DIRECTORS, SUBJECT TO THE PROVISIONS OF THE BYLAWS IN ADDITION, THE MEMBER HAS THE RIGHT TO APPROVE THE FOLLOWING ACTIONS OF THE CORPORATION'S BOARD OF DIRECTORS A MERGER, CONSOLIDATION, REORGANIZATION, OR DISSOLUTION OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, B AMENDMENT OR RESTATEMENT OF THE ARTICLES OF INCORPORATION OR THE BYLAWS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, C ADOPTION OF OPERATING BUDGETS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, INCLUDING CONSOLIDATED OR COMBINED BUDGETS OF THE CORPORATION AND ALL SUBSIDIARY ORGANIZATIONS OF THE CORPORATION, D ADOPTION OF CAPITAL BUDGETS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, E AGGREGATE OPERATING OR CAPITAL EXPENDITURES ON AN ANNUAL BASIS THAT EXCEED APPROVED OPERATING OR CAPITAL BUDGETS BY A SPECIFIED DOLLAR AMOUNT TO BE DETERMINED FROM TIME TO TIME BY THE GENERAL MEMBER, F LONG-TERM OR MATERIAL AGREEMENTS INCLUDING, BUT NOT LIMITED TO, BORROWINGS, EQUITY FINANCINGS, CAPITALIZED LEASES AND INSTALLMENT CONTRACTS, AND PURCHASE, SALE, LEASE, DISPOSITION, HYPOTHECATION, EXCHANGE, GIFT, PLEDGE, OR ENCUMBRANCE OF ANY ASSET, REAL OR PERSONAL, WITH A FAIR MARKET VALUE IN EXCESS OF A DOLLAR AMOUNT TO BE DETERMINED FROM TIME TO TIME BY THE DIRECTORS OF THE GENERAL MEMBER, WHICH SHALL NOT BE LESS THAN 10% OF THE TOTAL ANNUAL CAPITAL BUDGET OF THE CORPORATION, G APPOINTMENT OF AN INDEPENDENT AUDITOR AND HIRING OF INDEPENDENT COUNSEL EXCEPT IN CONFLICT SITUATIONS BETWEEN THE GENERAL MEMBER AND THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, H THE CREATION OR ACQUISITION OF ANY SUBSIDIARY OR AFFILIATE ENTITY, I CONTRACTING WITH AN UNRELATED THIRD PARTY FOR ALL OR SUBSTANTIALLY ALL OF THE MANAGEMENT OF THE ASSETS OR OPERATIONS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, J APPROVAL OF MAJOR NEW PROGRAMS AND CLINICAL SERVICES OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY THE GENERAL MEMBER SHALL FROM TIME TO TIME DEFINE THE TERM "MAJOR" IN THIS CONTEXT, K APPROVAL OF STRATEGIC PLANS OF THE CORPORATION OR ANY SUBSIDIARY OR AFFILIATE ENTITY, L ADOPTION OF QUALITY ASSURANCE POLICIES NOT IN CONFORMITY WITH POLICIES ESTABLISHED BY THE GENERAL MEMBER, M ANY TRANSACTION BETWEEN THE CORPORATION, A SUBSIDIARY OR AFFILIATE AND A DIRECTOR OF THE CORPORATION OR AN AFFILIATE OF SUCH DIRECTOR IN ADDITION, THE GENERAL MEMBER SHALL HAVE THE AUTHORITY (BY A VOTE OF NOT LESS THAN TWO-THIRDS (2/3) OF ITS BOARD), TO DECLARE A MAJOR ACTIVITY REQUIRING APPROVAL</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 11B	PROCESS USED BY MANAGEMENT &/OR GOVERNING BODY TO REVIEW FORM 990 SUTTER HEALTH HAS A CENTRALIZED TAX DEPARTMENT RESPONSIBLE FOR THE PREPARATION OF THE FORM 990 ANNUALLY THE TAX DEPARTMENT RECEIVES AND PROVIDES TRAINING AND EDUCATION TO APPROPRIATE PERSONNEL WHO ASSIST THE TAX DEPARTMENT IN COLLECTING AND REVIEWING DATA TO BE REPORTED ON THE FORM 990 THE PREPARATION MATERIAL IS REVIEWED BY VARIOUS DEPARTMENTS INCLUDING TAX, FINANCE, LEGAL, AND HUMAN RESOURCES A NATIONAL ACCOUNTING FIRM PREPARES AND REVIEWS THE RETURN A COMPLETED RETURN IS THEN REVIEWED BY THE TAX DEPARTMENT, LEGAL DEPARTMENT, FINANCE, AND THE CFO BEFORE THE RETURN IS FILED

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 12	<p>PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST EMPLOYEES ARE EDUCATED ON THE CONFLICT OF INTEREST POLICY AND THE NEED TO MAKE DISCLOSURE AS PART OF ANNUAL COMPLIANCE EDUCATION IN ADDITION, ANNUALLY A DISCLOSURE STATEMENT IS COMPLETED BY ALL DIRECTORS, OFFICERS AND KEY EMPLOYEES ON THIS STATEMENT THE INDIVIDUAL WILL LIST A WIDE RANGE OF INFORMATION WHICH INCLUDES BUSINESS RELATIONSHIPS, EMPLOYMENT RELATIONSHIPS, PROPERTY INTERESTS, AND THOSE OF RELATED PARTIES IF THERE IS A POTENTIAL CONFLICT OF INTEREST RELATED TO A PARTICULAR TRANSACTION, THE INTERESTED INDIVIDUAL MUST DISCLOSE THE EXISTENCE AND NATURE OF THE RELATIONSHIP THE BOARD CHAIR MAY APPOINT A DISINTERESTED PERSON OR COMMITTEE TO INVESTIGATE THE CONFLICT THE BOARD MAY CONSULT WITH THE OFFICE OF THE GENERAL COUNSEL AS NECESSARY UNTIL THE POTENTIAL CONFLICT IS RESOLVED, THE BOARD CHAIR (OR COMMITTEE CHAIR AS APPLICABLE) MAY REQUEST THE INDIVIDUAL TO NOT PARTICIPATE DURING RELATED PRESENTATIONS AND DISCUSSIONS IN ALL CIRCUMSTANCES INVOLVING AN ACTUAL CONFLICT, THE INTERESTED INDIVIDUAL SHALL LEAVE THE ROOM PRIOR TO THE BOARDS FINAL DISCUSSION AND VOTE</p>



**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINES 15A & 15B	PROCESS FOR DETERMINING COMPENSATION THE COMPENSATION COMMITTEE OF THE SUTTER HEALTH BOARD OF DIRECTORS RETAINS ULTIMATE DISCRETIONARY AUTHORITY OVER ALL ELEMENTS OF COMPENSATION TO ASSURE THAT ORGANIZATIONAL PURPOSES ARE APPROPRIATELY BEING SERVED THE COMPENSATION COMMITTEE USES CREDIBLE DATA SOURCES AND MAINTAINS AN OBJECTIVE "ARMS LENGTH" DECISION-MAKING PROCESS, ENSURING THE INTEGRITY OF SUTTERS EXECUTIVE PROGRAMS AND CONSISTENCY WITH THE ORGANIZATIONS OVERALL MISSION IN ORDER TO ENSURE EXTERNAL COMPETITIVENESS, NATIONAL, CALIFORNIA AND LOCAL MARKET AREA COMPENSATION DATA COMPARISONS ARE REVIEWED COMPETITIVE ANALYSIS INCLUDES (A) BASE SALARY, (B) TOTAL CASH (BASE SALARY + ANNUAL INCENTIVE), (C) TOTAL DIRECT CASH (BASE SALARY + ANNUAL INCENTIVE + LONG TERM INCENTIVE) AND (D) TOTAL REMUNERATION (BASE SALARY + ANNUAL INCENTIVE + BENEFITS AND LONG TERM INCENTIVE) THIS ANALYSIS INCLUDES COMPARABLE ORGANIZATIONS AND GEOGRAPHIC CONSIDERATIONS FOR THE MOST SENIOR EXECUTIVE POSITIONS, NATIONAL COMPARISONS FOR ORGANIZATIONS SIMILAR IN SIZE, SCOPE AND COMPLEXITY AS SUTTER HEALTH ARE MOST APPROPRIATE SINCE IT IS A NATIONAL MARKETPLACE IN WHICH SUTTER COMPETES FOR EXECUTIVE TALENT ON THE OTHER HAND, BECAUSE CALIFORNIA'S UNDERLYING COMPENSATION STRUCTURE IS HIGHER THAN NATIONAL DATA (ESPECIALLY IN THE BAY AREA), REGIONAL PAY ADJUSTMENTS MAY BE MADE OFFICERS AND KEY EMPLOYEES OF THIS ORGANIZATION UNDERGO A REVIEW AND COMPENSATION COMMITTEE APPROVAL ANNUALLY, AND SUCH APPROVAL IS RECORDED IN THE MINUTES THE 2018 EXECUTIVE COMPENSATION APPROVAL WAS COMPLETED IN DECEMBER 2017

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 19	AVAILABILITY OF GOVERNING DOCUMENTS, COI POLICY & FINANCIAL STATEMENTS THE SUTTER HEALTH SYSTEM POSTS ITS CURRENT AND PAST AUDITED FINANCIAL STATEMENTS AT SUTTERHEALTH.ORG OTHER DOCUMENTS ARE ALSO LOCATED AT THIS WEBSITE INCLUDING THE ANNUAL REPORT, MISSION STATEMENT, HISTORY, AND LINKS TO AFFILIATE WEBSITES THE GOVERNING DOCUMENTS ARE NOT AVAILABLE TO THE PUBLIC AT THIS TIME FORM 990, PART VII, SECTION A COMPENSATION OF BOARD MEMBERS THE FOLLOWING BOARD MEMBERS OF THE ORGANIZATION ARE FULL-TIME EMPLOYEES (40 HOURS PER WEEK) OF SUTTER HEALTH AND THEIR SUTTER HEALTH SALARIES ARE REPORTED HEREIN THESE INDIVIDUALS RECEIVE NO COMPENSATION FOR THEIR SERVICE AS BOARD MEMBERS OF THIS ORGANIZATION - SARAH KREVANS - JAMES CONFORTI - PETER HULL INDIVIDUALS LISTED AS OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION THAT ARE PAID FULL-TIME BY A RELATED ORGANIZATION ARE COMMON LAW EMPLOYEES OF SUTTER HEALTH, A SEPARATE LEGAL ENTITY IT IS THE INTENTION OF SUTTER HEALTH AND THE FILING ORGANIZATION TO MAKE INFORMATION ACCESSIBLE AND TRANSPARENT, REPORTING THOSE SUTTER HEALTH EMPLOYEES WHO HAVE OFFICER AND KEY EMPLOYEE RESPONSIBILITIES TO THE FILING ORGANIZATION

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART XI, LINE 9	OTHER CHANGES IN FUND BALANCE GAIN/(LOSS) ON HEALTH CARE INVESTMENTS \$ 11,065,215 HEALTHC ARE RELATED JV INCOME (12,648,419) GUARANTEED PAYMENT JV INCOME (623,958) EQUITY TRANSFERS (NET) (4,099,475) OTHER CHANGES IN FUND BALANCE 7,381 ----- TOTAL \$ (6,299,256)

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION MEDICAL GROUP COMPENSATION TOTAL FEES 586842919

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION PROFESSIONAL FEE - PHYSICAN TOTAL FEES 7950049

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION NON-PHYSICIAN MEDICAL TOTAL FEES 14396

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION THERAPISTS/OTHER MEDICAL TOTAL FEES 656905

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION NURSE REGISTRY FEES TOTAL FEES 444379



**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2018**

**Open to Public Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
SUTTER VALLEY MEDICAL FOUNDATION

**Employer identification number**

68-0273974

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
<b>(1)</b> TWIN CITIES SURGICAL HOSPITAL LLC 2200 RIVER PLAZA DRIVE SACRAMENTO, CA 95833 35-2182617	SURGERY	CA	26,230,069	13,341,927	SUTTER VMF

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

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
<b>(1)</b> SUTTER HEALTH DEFERRED COMP PLANS' TRUST 2200 RIVER PLAZA DRIVE SACRAMENTO, CA 95833 27-6851989	RABBI TRUST	CA	NA	TRUST				Yes	
<b>(2)</b> NORTHWOOD EUROPE TE FEEDER LP 1819 WAZEE ST 2ND FLOOR DENVER, CO 90202 98-1272216	HOLDING COMPANY	CJ	NA	C CORP				Yes	

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

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

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

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

See Additional Data Table

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



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

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

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

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 68-0273974  
**Name:** SUTTER VALLEY MEDICAL FOUNDATION

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 51-0160184	FUNDRAISING	CA	501(C)(3)	7	SUTTER BH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2728423	FUNDRAISING	CA	501(C)(3)	7	SUTTER BH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 51-0172285	HEALTHCARE	CA	501(C)(3)	3	SUTTER BH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2290244	FUNDRAISING	CA	501(C)(3)	12A - I	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 23-7288765	FUNDRAISING	CA	501(C)(3)	7	SUTTER BH	Yes	
450 30TH STREET STE 2840 OAKLAND, CA 94609 94-2992642	UNIVERSITY	CA	501(C)(3)	2	SUTTER BH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2594966	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-0562680	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1156581	HEALTHCARE	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2988520	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0217870	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1196176	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
2200 RIVER PLAZA DRIVE SACRAMENTO, CA 95833 94-2788907	SUPPORTING OR	CA	501(C)(3)	12C III-FI	NA		No
91-2301 FT WEAVER RD EWA BEACH, HI 96706 99-0298651	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 46-1183948	HEALTH PLAN	CA	501(C)(4)	N/A	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2788906	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0040113	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-2668262	FUNDRAISING	CA	501(C)(3)	7	SUTTER VH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-1156621	HOSPITAL	CA	501(C)(3)	3	SUTTER HLTH	Yes	
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 94-6068843	HEALTHCARE	CA	501(C)(3)	10	SUTTER HLTH	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
C/O SH TAX 2200 RIVER PLAZA DR SACRAMENTO, CA 95833 68-0318845	FUNDRAISING	CA	501(C)(3)	12A - I	SUTTER VH	Yes	
745 FORT STREET SUITE 1100 HONOLULU, HI 96813 99-0289310	INSURANCE SER	HI	501(C)(3)	12C III-FI	SUTTER HLTH	Yes	







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

	<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
<b>(1)</b>	SUTTER VALLEY HOSPITALS	B	777,891	
<b>(1)</b>	SUTTER VALLEY HOSPITALS	K	9,744,976	
<b>(2)</b>	SUTTER VALLEY HOSPITALS	Q	1,419,661	
<b>(3)</b>	SUTTER VALLEY HOSPITALS	S	3,221,043	
<b>(4)</b>	SUTTER VALLEY HOSPITALS	J	361,374	
<b>(5)</b>	SUTTER INSURANCE SERVICES CORPORATION	P	2,343,681	
<b>(6)</b>	SUTTER ROSEVILLE MEDICAL CENTER FOUNDATION	P	86,370	
<b>(7)</b>	SUTTER FAIRFIELD SURGERY CENTER LLC	P	351,284	
<b>(8)</b>	SUTTER FAIRFIELD SURGERY CENTER LLC	J	684,244	
<b>(9)</b>	SUTTER HEALTH PLAN	S	78,334,493	