

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  
Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047  
**2016**  
Open to Public Inspection

**A For the 2016 calendar year, or tax year beginning 01-01-2016, and ending 12-31-2016**

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

**C** Name of organization  
WSNCHS NORTH INC  
% CHS SERVICES INC  
Doing business as  
ST JOSEPH HOSPITAL  
Number and street (or P O box if mail is not delivered to street address) Room/suite  
4295 HEMPSTEAD TURNPIKE  
City or town, state or province, country, and ZIP or foreign postal code  
BETHPAGE, NY 117145713

**D** Employer identification number  
11-3438973  
**E** Telephone number  
(516) 520-2250  
**G** Gross receipts \$ 120,541,186

**F** Name and address of principal officer  
ALAN D GUERCI MD  
4295 HEMPSTEAD TURNPIKE  
BETHPAGE, NY 117145713

**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 ▶ 0928

**I** Tax-exempt status  501(c)(3)  501(c) ( ) ◀ (insert no )  4947(a)(1) or  527

**J** Website: ▶ [http //stjosephhospital.chslri.org](http://stjosephhospital.chslri.org)

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

**L** Year of formation 1998

**M** State of legal domicile NY

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities  
CHSLI AND ITS MEMBERS, AS A MINISTRY OF THE CATHOLIC CHURCH, CONTINUE CHRIST'S HEALING MISSION, BY PROMOTING EXCELLENCE IN CARE AND COMMITTING ITSELF TO THOSE IN NEED

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	23
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	22
<b>5</b> Total number of individuals employed in calendar year 2016 (Part V, line 2a)	924
<b>6</b> Total number of volunteers (estimate if necessary)	155
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	0
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 34	

	Revenue	
	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	7,657,604	6,191,646
<b>9</b> Program service revenue (Part VIII, line 2g)	102,693,956	113,925,166
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d )	30,860	40,679
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,451,141	302,036
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	111,833,561	120,459,527
Expenses		
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3 )	58,555	372,732
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	65,031,538	68,414,660
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	46,006,280	49,914,622
<b>18</b> Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	111,096,373	118,702,014
<b>19</b> Revenue less expenses Subtract line 18 from line 12	737,188	1,757,513
Net Assets or Fund Balances		
	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	62,029,796	67,952,366
<b>21</b> Total liabilities (Part X, line 26)	57,626,204	61,791,261
<b>22</b> Net assets or fund balances Subtract line 21 from line 20	4,403,592	6,161,105

**Part II Signature Block**

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

**Sign Here**  
Signature of officer \_\_\_\_\_ Date 2017-11-06  
PETER SCAMINACI EXECUTIVE VP, CAO  
Type or print name and title

**Paid Preparer Use Only**  
Print/Type preparer's name LAURA J PARELLO Preparer's signature LAURA J PARELLO Date \_\_\_\_\_  
Check  if self-employed PTIN P01080295  
Firm's name ▶ PricewaterhouseCoopers LLP Firm's EIN ▶ \_\_\_\_\_  
Firm's address ▶ 300 Madison Avenue Phone no (646) 471-3000  
New York, NY 10017

**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

ST JOSEPH HOSPITAL, A MEMBER OF CATHOLIC HEALTH SERVICES OF LONG ISLAND(CHS), AS A MINISTRY OF THE CATHOLIC CHURCH, CONTINUES CHRIST'S HEALING MISSION, PROMOTES EXCELLENCE IN CARE, AND COMMITS ITSELF TO THOSE IN NEED CHS AFFIRMS THE SANCTITY OF LIFE, AND ADVOCATES FOR THE POOR AND UNDERSERVED, AND SERVES THE COMMON GOOD IT CONDUCTS ITS HEALTHCARE PRACTICE, BUSINESS, EDUCATION AND INNOVATION WITH JUSTICE, INTEGRITY AND RESPECT FOR THE DIGNITY OF EACH PERSON

**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 \$ 100,805,212 including grants of \$ 372,732 ) (Revenue \$ 113,957,351 )  
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 ▶ 100,805,212

**Part IV Checklist of Required Schedules**

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

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

		Yes	No
<b>20a</b>	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .	Yes	
<b>b</b>	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	Yes	
<b>21</b>	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . .	Yes	
<b>22</b>	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . .		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> . . . . .	Yes	
<b>24a</b>	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .		No
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .		
<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? . . . . .		
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .		
<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> . . . . .		No
<b>b</b>	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .		No
<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> . . . . .		No
<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> . . . . .		No
<b>28</b>	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)		
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .		No
<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> . . . . .		No
<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> . . . . .	Yes	
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .		No
<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> . . . . .		No
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .		No
<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> . . . . .		No
<b>33</b>	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . .		No
<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> . . . . .	Yes	
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	Yes	
<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> . . . . .	Yes	
<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> . . . . .		No
<b>37</b>	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> . . . . .		No
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited tax shelter transactions, deductible contributions, and 501(c)(7), (12), and (29) organizations.

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 . . . . . [X]

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 (23); 1b Enter the number of voting members included in line 1a, above, who are independent (22); 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? (No); 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? (No); 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?

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (NY); 18 Section 6104 requires an organization to make its Form 1023 (or 1024 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, [X] 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 (CHS SERVICES INC 992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 (516) 705-1926)





**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>	96,607				
	<b>d</b> Related organizations . . . . .	<b>1d</b>	6,000,000				
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>	92,596				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	2,443				
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____						
	<b>h Total.</b> Add lines 1a-1f . . . . .		6,191,646				
<b>Program Service Revenue</b>			Business Code				
	<b>2a</b> NET PATIENT SERVICE REVENUE		621990	113,925,166	113,925,166		
	<b>b</b> _____						
	<b>c</b> _____						
	<b>d</b> _____						
	<b>e</b> _____						
	<b>f</b> All other program service revenue . . . . .						
<b>g Total.</b> Add lines 2a-2f . . . . .		113,925,166					
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			40,679		40,679	
	<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				
			95,115				
		<b>b</b> Less rental expenses					
		<b>c</b> Rental income or (loss)	95,115	0			
	<b>d</b> Net rental income or (loss) . . . . .			95,115		95,115	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		<b>b</b> Less cost or other basis and sales expenses					
		<b>c</b> Gain or (loss)					
	<b>d</b> Net gain or (loss) . . . . .			0			
	<b>8a</b> Gross income from fundraising events (not including \$ 96,607 of contributions reported on line 1c) See Part IV, line 18 . . . . .	<b>a</b>	62,579				
		<b>b</b> Less direct expenses . . . . .	<b>b</b>	81,659			
<b>c</b> Net income or (loss) from fundraising events . . . . .				-19,080		-19,080	
<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .	<b>a</b>	0					
	<b>b</b> Less direct expenses . . . . .	<b>b</b>	0				
	<b>c</b> Net income or (loss) from gaming activities . . . . .			0			
<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> CAFETERIA REVENUE		900099	193,816			193,816	
<b>b</b> OTHER		900099	32,185	32,185			
<b>c</b> _____							
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			226,001				
<b>12 Total revenue.</b> See Instructions . . . . .			120,459,527	113,957,351		310,530	

**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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) 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.	372,732	372,732		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, 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.	399,922	399,922		
<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.	47,693,732	42,216,781	5,476,951	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	4,564,652	4,044,825	519,827	
<b>9</b> Other employee benefits.	12,165,449	10,482,626	1,682,823	
<b>10</b> Payroll taxes.	3,590,905	3,181,969	408,936	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management.	135,150	126,718	8,432	
<b>b</b> Legal.	35,973		35,973	
<b>c</b> Accounting.	3,800		3,800	
<b>d</b> Lobbying.	19,082		19,082	
<b>e</b> Professional fundraising services. See Part IV, line 17.	0			
<b>f</b> Investment management fees.	0			
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	7,180,925	6,094,867	1,086,058	
<b>12</b> Advertising and promotion.	156,719	156,719		
<b>13</b> Office expenses.	1,522,239	1,158,057	364,182	
<b>14</b> Information technology.	0			
<b>15</b> Royalties.	0			
<b>16</b> Occupancy.	1,663,888	1,281,139	382,749	
<b>17</b> Travel.	123,054	102,731	20,323	
<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.	0			
<b>20</b> Interest.	222,060	222,060		
<b>21</b> Payments to affiliates.	2,555,357	2,555,357		
<b>22</b> Depreciation, depletion, and amortization.	3,273,330	2,427,759	845,571	
<b>23</b> Insurance.	4,138,990	4,138,990		
<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> MEDICAL SUPPLIES	12,818,862	12,818,862		
<b>b</b> CHS SERVICES	7,761,613	3,474,428	4,287,185	
<b>c</b> EQUIPMENT SERVICE CONTRACTS	699,697	699,697		
<b>d</b> HOME OFFICE ALLOCATION	1,490,187		1,490,187	
<b>e</b> All other expenses	6,113,696	4,848,973	1,264,723	
<b>25</b> Total functional expenses. Add lines 1 through 24e.	118,702,014	100,805,212	17,896,802	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	7,452,421	<b>1</b>	9,923,585
	<b>2</b> Savings and temporary cash investments . . . . .	301	<b>2</b>	0
	<b>3</b> Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b> Accounts receivable, net . . . . .	11,297,534	<b>4</b>	13,270,801
	<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 . . . . .	1,595,110	<b>8</b>	1,755,025
	<b>9</b> Prepaid expenses and deferred charges . . . . .	2,219,507	<b>9</b>	797,493
	<b>10a</b> Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	<b>10a</b> 51,807,714		
	<b>b</b> Less accumulated depreciation	<b>10b</b> 20,593,021		
		30,229,504	<b>10c</b>	31,214,693
	<b>11</b> Investments—publicly traded securities . . . . .	0	<b>11</b>	0
	<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 . . . . .	0	<b>13</b>	0
	<b>14</b> Intangible assets . . . . .	0	<b>14</b>	0
<b>15</b> Other assets See Part IV, line 11 . . . . .	9,235,419	<b>15</b>	10,990,769	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	62,029,796	<b>16</b>	67,952,366	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	11,787,689	<b>17</b>	12,718,873
	<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 . . . . .	0	<b>20</b>	0
	<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 . . . . .	14,329,167	<b>23</b>	13,379,167
	<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	31,509,348	<b>25</b>	35,693,221
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	57,626,204	<b>26</b>	61,791,261
<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	3,908,468	<b>27</b>	5,721,870
	<b>28</b> Temporarily restricted net assets . . . . .	495,124	<b>28</b>	439,235
	<b>29</b> Permanently restricted net assets	0	<b>29</b>	0
	<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 . . . . .	4,403,592	<b>33</b>	6,161,105	
<b>34</b> Total liabilities and net assets/fund balances . . . . .	62,029,796	<b>34</b>	67,952,366	

**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>	120,459,527
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25) . . . . .	<b>2</b>	118,702,014
<b>3</b>	Revenue less expenses Subtract line 2 from line 1 . . . . .	<b>3</b>	1,757,513
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . .	<b>4</b>	4,403,592
<b>5</b>	Net unrealized gains (losses) on investments . . . . .	<b>5</b>	
<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>	
<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>	6,161,105

**Part XII Financial Statements and Reporting**

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

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-3438973

**Name:** WSNCHS NORTH INC

Form 990 (2016)

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

ST JOSEPH HOSPITAL IS A 203-BED, COMMUNITY HOSPITAL THAT PROVIDES COMPREHENSIVE INPATIENT AND OUTPATIENT MEDICAL, CRITICAL CARE AND SURGICAL SERVICES ITS EMERGENCY DEPARTMENT CARES FOR MORE THAN 34,000 PATIENTS A YEAR OTHER VITAL SERVICES INCLUDE AN AMBULATORY SURGERY UNIT, THE CENTER FOR SLEEP MEDICINE, HYPERBARIC MEDICINE AND WOUND HEALING, A BALANCE CENTER, AN ENDOSCOPY UNIT, A DIABETES EDUCATION CENTER, A FULL SCOPE OF OUTPATIENT RADIOLOGY SERVICES, INCLUDING A CT SCANNER, MRI, AND NUCLEAR CAMERA

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Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SALVATORE SODANO CHAIR	20 00	X		X				0	0	0
BRIAN MCGUIRE VICE CHAIR	20 00	X		X				0	0	0
JOSEPH TANTILLO SECRETARY	20 00	X		X				0	0	0
CHRIS PASCUCCI TREASURER	20 00	X		X				0	0	0
BARBARA ELLEN BLACK TRUSTEE	20 00	X						0	0	0
VIRGINIA EWEN TRUSTEE	20 00	X						0	0	0
FRANK L KURRE TRUSTEE	20 00	X						0	0	0
REV MSGR ROBERT MORRISEY TRUSTEE	20 00	X						0	0	0
DANIEL T ROWE TRUSTEE	20 00	X						0	0	0
JOHN WAGNER TRUSTEE	20 00	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
REV JAMES VLAUN ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
KEVIN J CONWAY ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
PETER D'ANGELO ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
REV PETER DUGANDZIC ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
BRIAN P HEHIR ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
HON ANTHONY MARANO ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
STEPHEN MCLOUGHLIN ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
JEROME POLLER ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
JOHN FRANCFORT MD ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0
ALEXANDER HAZELTON ..... TRUSTEE	2 0 ..... 0 0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors								(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
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)								
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
WILLIAM WARD ..... TRUSTEE	20 ..... 00	X						0	0	0
ROBERT ZUCCARO ..... TRUSTEE	20 ..... 00	X						0	0	0
ALAN D GUERCI MD ..... PRESIDENT & CEO	50 ..... 00	X		X				0	2,595,065	360,447
DANIEL DEBARBA ..... EVP & CFO AS OF 6/6/16	50 ..... 00			X				0	591,354	37,422
RONALD W STEIMEL ..... EXEC VP & CAO	50 ..... 00			X				0	595,784	133,729
WILLIAM C ARMSTRONG ..... SVP FINANCE	50 ..... 00			X				0	1,552,126	188,843
HOWARD SUSSMAN ..... CMO	50 ..... 00				X			343,994	0	55,928
JOHN MORAHAN ..... VP OF FINANCE	50 ..... 00					X		262,907	0	32,776
BARBARA GIBBONS ..... VP PATIENT CARE	50 ..... 00					X		219,937	0	39,949
OREATE BRUNI ..... DIR PHYS COMMUNICATIONS	50 ..... 00					X		199,841	0	49,260

**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			
IHAB IBRAHIM ..... VP PATIENT SAFETY&PROG DEVELOP	50 0 ..... 0 0					X		183,498	0	43,100
JANINE HUGHES ..... PHYSICIAN ASSISTANT	50 0 ..... 0 0					X		177,250	0	39,467

**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.

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
WSNCHS NORTH INC

Employer identification number

11-3438973

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

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

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

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

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**  
 (Complete only if you checked the box on line 5, 7, 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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>7</b>	Amounts from line 4						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b>	Other income (Do not include gain or loss from the sale of capital assets (Explain in Part VI))						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc. (see instructions)					<b>12</b>	
<b>13</b>	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						

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

<b>14</b>	Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	
<b>15</b>	Public support percentage for 2015 Schedule A, Part II, line 14	<b>15</b>	
<b>16a</b>	<b>33 1/3% support test—2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>b</b>	<b>33 1/3% support test—2015.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>17a</b>	<b>10%-facts-and-circumstances test—2016.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>b</b>	<b>10%-facts-and-circumstances test—2015.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
<b>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>		

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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.)						
<b>14</b>	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> <span style="float: right;">► <input type="checkbox"/></span>						

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

<b>15</b>	Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b>	Public support percentage from 2015 Schedule A, Part III, line 15	<b>16</b>	

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

<b>17</b>	Investment income percentage for <b>2016</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2015</b> Schedule A, Part III, line 17	<b>18</b>	
<b>19a</b>	<b>33 1/3% support tests—2016.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span style="float: right;">► <input type="checkbox"/></span>		
<b>b</b>	<b>33 1/3% support tests—2015.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization <span style="float: right;">► <input type="checkbox"/></span>		
<b>20</b>	<b>Private foundation.</b> If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions <span style="float: right;">► <input type="checkbox"/></span>		

**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 (see instructions)		
<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**

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

**Section A - Adjusted Net Income**

	(A) Prior Year	(B) Current Year (optional)
<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 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

	(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 Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e 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 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	

**Section C - Distributable Amount**

		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 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 Part VI) 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 Part VI) See instructions	
<b>9</b> Distributable amount for 2016 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-2016</b>	<b>(iii) Distributable Amount for 2016</b>
<b>1</b> Distributable amount for 2016 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
<b>3</b> Excess distributions carryover, if any, to 2016			
<b>a</b>			
<b>b</b>			
<b>c</b> From 2013. . . . .			
<b>d</b> From 2014. . . . .			
<b>e</b> From 2015. . . . .			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2016 distributable amount			
<b>i</b> Carryover from 2011 not applied (see instructions)			
<b>j</b> Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b> Distributions for 2016 from Section D, line 7			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2016 distributable amount			
<b>c</b> Remainder Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
<b>6</b> Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
<b>7 Excess distributions carryover to 2017.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7			
<b>a</b>			
<b>b</b> Excess from 2013. . . . .			
<b>c</b> Excess from 2014. . . . .			
<b>d</b> Excess from 2015. . . . .			
<b>e</b> Excess from 2016. . . . .			

**Part VI Supplemental Information.**

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

**Facts And Circumstances Test**

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

**Political Campaign and Lobbying Activities**

OMB No 1545-0047

**2016**

**Open to Public Inspection**

**For Organizations Exempt From Income Tax Under section 501(c) and section 527**  
▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**  
▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at**  
**[www.irs.gov/form990](http://www.irs.gov/form990).**

Department of the Treasury  
Internal Revenue Service

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

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

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

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

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

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

Name of the organization WSNCHS NORTH INC	Employer identification number 11-3438973
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**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV
- 2 Political expenditures ▶ \$ \_\_\_\_\_
- 3 Volunteer hours \_\_\_\_\_

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ \_\_\_\_\_
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ \_\_\_\_\_
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year?  Yes  No
- 4a Was a correction made?  Yes  No
- b If "Yes," describe in Part IV

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ \_\_\_\_\_
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ \_\_\_\_\_
- 3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ \$ \_\_\_\_\_
- 4 Did the filing organization file Form 1120-POL for this year?  Yes  No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

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



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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		19,082
<b>j</b>	Total Add lines 1c through 1i			19,082
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV Supplemental Information**

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

Return Reference	Explanation
PART II-B, LINE 1 - OTHER LOBBYING ACTIVITIES	AMOUNT REFLECTS PORTION OF TRADE ASSOCIATION DUES WHICH WERE USED FOR LEGISLATIVE LOBBYING ON THE BEHALF OF THE HEALTHCARE INDUSTRY THOSE TRADE ASSOCIATIONS REPRESENT

**SCHEDULE D**  
(Form 990)

**Supplemental Financial Statements**

OMB No 1545-0047  
**2016**  
**Open to Public Inspection**

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.  
▶ Attach to Form 990.

Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

**Name of the organization**  
WSNCHS NORTH INC

**Employer identification number**  
11-3438973

**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 8/17/06, 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>c</b> Beginning balance             |        |
| <b>d</b> Additions during the year     |        |
| <b>e</b> Distributions during the year |        |
| <b>f</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 . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<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 . . . . .					

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		7,390,000		7,390,000
<b>b</b> Buildings		20,652,832	7,404,723	13,248,109
<b>c</b> Leasehold improvements		400,325	247,954	152,371
<b>d</b> Equipment . . . . .		23,327,923	12,940,344	10,387,579
<b>e</b> Other . . . . .		36,634	0	36,634
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c) ) . . . ▶				31,214,693

**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) INSURANCE CLAIMS RECEIVABLE	10,693,646
(2) SECURITY DEPOSITS	90,123
(3) DUE FROM RELATED PARTY	207,000
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15.)	10,990,769

**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
DUE TO RELATED PARTIES	15,983,712
EST MALPRACTICE LIABILITY	14,011,085
THIRD PARTY PAYOR LIABILITY	3,065,983
457 FUND LIABILITIES	494,476
OTHER SELF INSURED LIABILITIES	2,134,465
DEFERRED REVENUE	3,500
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25.)	35,693,221

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	



## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-3438973

**Name:** WSNCHS NORTH INC

## Supplemental Information

Return Reference	Explanation
PART X, OTHER LIABILITIES - LINE 2, FIN 48 FOOTNOTE	CHS AND MOST OF ITS SUBSIDIARIES ARE EXEMPT FROM FEDERAL INCOME TAXES UNDER SECTION 501(C) (3) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED CHS ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE ACCOUNTING STANDARDS CODIFICATION TOPIC 740, INCOME TAXES MANAGEMENT ANNUALLY REVIEWS ITS TAX POSITIONS AND HAS DETERMINED THAT THERE ARE NO MATERIAL UNCERTAIN TAX POSITIONS THAT REQUIRE RECOGNITION IN THE CONSOLIDATED FINANCIAL STATEMENTS, USING A THRESHOLD OF MORE LIKELY THAN NOT OF BEING SUSTAINED

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

**Supplemental Information Regarding  
Fundraising or Gaming Activities**

OMB No 1545-0047

**2016**

**Open to Public  
Inspection**

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.

Information about Schedule G (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

Name of the organization  
WSNCHS NORTH INC

Employer identification number

11-3438973

**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			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
<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) Total events (add col (a) through col (c))
		<b>GALA</b> (event type)	<b>GOLF</b> (event type)	<b>0</b> (total number)	
<b>1</b>	Gross receipts . . . . .	104,540	54,646		159,186
<b>2</b>	Less Contributions . . . . .	64,361	32,246		96,607
<b>3</b>	Gross income (line 1 minus line 2) . . . . .	40,179	22,400		62,579
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .	635			635
	<b>6</b> Rent/facility costs . . . . .	29,839	27,080		56,919
	<b>7</b> Food and beverages . . . . .				
	<b>8</b> Entertainment . . . . .				
	<b>9</b> Other direct expenses . . . . .	16,205	7,900		24,105
<b>10</b>	Direct expense summary Add lines 4 through 9 in column (d) . . . . . ▶				81,659
<b>11</b>	Net income summary Subtract line 10 from line 3, column (d) . . . . . ▶				-19,080

**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 complete this part to provide any additional information (see instructions).

Return Reference	Explanation
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**SCHEDULE H (Form 990)**  
 Department of the Treasury  
 Internal Revenue Service  
**Name of the organization**  
 WSNCHS NORTH INC

**Hospitals**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**  
 ▶ **Attach to Form 990.**  
 ▶ **Information about Schedule H (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**Employer identification number**  
 11-3438973

OMB No 1545-0047  
**2016**  
**Open to Public Inspection**

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

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

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a) Number of activities or programs (optional)</b>	<b>(b) Persons served (optional)</b>	<b>(c) Total community benefit expense</b>	<b>(d) Direct offsetting revenue</b>	<b>(e) Net community benefit expense</b>	<b>(f) Percent of total expense</b>
<b>a</b> Financial Assistance at cost (from Worksheet 1)			1,630,927	2,420,577	0	0 %
<b>b</b> Medicaid (from Worksheet 3, column a)			12,121,275	8,905,332	3,215,943	2 710 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			412,475	251,571	160,904	0 140 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			14,164,677	11,577,480	3,376,847	2 850 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			61,810		61,810	0 050 %
<b>f</b> Health professions education (from Worksheet 5)			83,311	76,461	6,850	0 010 %
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			96,216		96,216	0 080 %
<b>j Total.</b> Other Benefits			241,337	76,461	164,876	0 140 %
<b>k Total.</b> Add lines 7d and 7j			14,406,014	11,653,941	3,541,723	2 990 %

**Part III 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?	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
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).	38,426,538	
6	Enter Medicare allowable costs of care relating to payments on line 5.	43,424,992	
7	Subtract line 6 from line 5. This is the surplus (or shortfall).	-4,998,454	
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?	Yes
9b	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.	Yes

**Part IV Management Companies and Joint Ventures**

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

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

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

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

**1**

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
 ST JOSEPH 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 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>stjosephhospital CHSLI ORG/</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url) <u>www chsli org</u>		
<b>c</b>	<input 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>WWW CHSLI ORG</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>b</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)**

ST JOSEPH 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	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 % and FPG family income limit for eligibility for discounted care of 400 %		
<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 type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW CHSLI ORG</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW CHSLI ORG</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW CHSLI ORG</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

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

**Policy Relating to Emergency Medical Care**

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

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

ST JOSEPH 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? \_\_\_\_\_

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

**Part VI Supplemental Information**

Provide the following information

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7 - RATIO OF PATIENT CARE COST TO CHARGES WORKSHEET	RATIO OF PATIENT CARE COST TO CHARGES WORKSHEET (WORKSHEET 2 ) AS PRESCRIBED BY THE IRS INSTRUCTIONS TO SCHEDULE H FORM 990 WAS THE METHODOLOGY USED TO CALCULATE THE AMOUNTS REPORTED IN PART I, LINE 7 CHARITY CARE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST LINES 7A, 7B AND 7C AND 7D ALL OTHER LINES INCLUDE COSTS THAT WERE DERIVED BASED ON THE RCC METHODOLOGY OR ACTUAL COSTS FOR THE SERVICES AS TRACKED BY HOSPITAL PERSONNEL UTILIZING DIRECT HOURLY LABOR COSTS, FRINGES AND SUPPLY COSTS
PART I, LINE 7A, COLUMN (D)	DIRECT OFFSETTING REVENUES REPRESENT DISTRIBUTIONS FROM THE NEW YORK STATE (NYS) INDIGENT CARE POOL (ICP) WHICH IS SHOWN NET OF HOSPITAL CONTRIBUTIONS TO THE STATEWIDE POOL THE FORMULA EMPLOYED BY NYS TO DETERMINE DISTRIBUTIONS TO HOSPITALS FROM THE ICP IS COMPLEX AND IS DERIVED FROM A HOSPITAL'S "NEED" CALCULATION THIS CALCULATION CONSIDERS 100% OF A HOSPITAL'S "NEED" BASED ON A "UNITS OF SERVICE" METHODOLOGY FOR UNINSURED PATIENTS THE CALCULATION ALSO MAKES ADJUSTMENTS BASED ON THE PROPORTION OF MEDICAID ELIGIBLE PATIENTS TREATED AT THE FACILITY THE HOSPITAL HAS APPORTIONED THE ICP REVENUE BETWEEN BAD DEBT AND CHARITY CARE FOR REPORTING ON LINE 7A BASED ON THE PROPORTION OF EACH TO THE TOTAL OF ACTUAL BAD DEBT AND CHARITY CARE FOR 2016

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 2,3 - BAD DEBT AS COMMUNITY BENEFIT	AS PART OF ITS TAX EXEMPT PURPOSE THE HOSPITAL PROVIDES ACCESS TO MEDICALLY NECESSARY CARE FOR EMERGENCY AND NON-ELECTIVE PATIENTS REGARDLESS OF AGE, GENDER, GEOGRAPHIC LOCATION, OR CULTURAL BACKGROUND THE HOSPITAL TREATS EMERGENCY AND NON-ELECTIVE PATIENTS REGARDLESS OF WHETHER THEY HAVE THIRD-PARTY COVERAGE OR THE ABILITY TO PAY BY PROVIDING HEALTH CARE TO ALL WHO REQUIRE EMERGENCY OR NON-ELECTIVE CARE IN A NON-DISCRIMINATORY MANNER, THE HOSPITAL IS PROVIDING HEALTH CARE TO THE BROAD COMMUNITY IT SERVES A PATIENT'S PORTION OF A BILL THAT REMAINS UNPAID FOR A CERTAIN STIPULATED TIME PERIOD IS WHOLLY OR PARTIALLY CLASSIFIED AS BAD DEBT BAD DEBTS ASSOCIATED WITH PATIENTS WHO HAVE RECEIVED CARE FROM THE HOSPITAL SHOULD BE CONSIDERED TO BE COMMUNITY BENEFIT SINCE CHARITABLE HOSPITALS EXIST TO PROVIDE SUCH CARE IN PURSUIT OF THEIR TAX EXEMPT PURPOSE, WHICH IS MEETING THE NEED FOR EMERGENCY AND NON-ELECTIVE MEDICAL CARE SERVICES IN THE COMMUNITY
PART III, LINES 2 AND 4 - TEXT OF FOOTNOTE DISCUSSING BAD DEBT	THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS MANAGEMENT PERIODICALLY ASSESSES THE ADEQUACY OF THIS ALLOWANCE BASED UPON HISTORICAL COLLECTION AND WRITE- OFF EXPERIENCE BY PAYOR CATEGORY THE RESULTS OF THESE REVIEWS ARE USED TO MODIFY, AS NECESSARY, THE PROVISION FOR BAD DEBTS AND TO ESTABLISH APPROPRIATE ALLOWANCES FOR UNCOLLECTIBLE PATIENT ACCOUNTS RECEIVABLE AFTER SATISFACTION OF AMOUNTS DUE FROM INSURANCE, CHS FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PATIENT BALANCES WITH COLLECTION AGENCIES, SUBJECT TO CERTAIN RESTRICTIONS ON COLLECTION EFFORTS AS DETERMINED BY CHS POLICY ACCOUNT BALANCES ARE CHARGED OFF AGAINST THE ALLOWANCE AFTER ALL MEANS OF COLLECTION HAVE BEEN EXHAUSTED AND THE POTENTIAL FOR RECOVERY IS CONSIDERED REMOTE CHS DOES NOT HAVE ANY OFF-BALANCE-SHEET CREDIT EXPOSURE RELATED TO ITS PATIENT ACCOUNTS RECEIVABLE

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, SECTION B, LINE 8 - COSTING METHODOLOGY	THE MEDICARE REVENUE AND ALLOWABLE COSTS SHOWN ON PART III SECTION B LINE 5 WERE DERIVED FROM THE AS FILED 2016 CMS-2552 (MEDICARE COST REPORT) MEDICARE REVENUE IS BASED ON THE MEDICARE PROVIDER STATISTICAL AND REIMBURSEMENT REPORT AND MEDICARE COSTS ARE DEVELOPED UTILIZING A RATIO OF MEDICARE ALLOWABLE COSTS TO CHARGES METHODOLOGY AMOUNTS SHOWN FOR TOTAL REVENUE RECEIVED AND MEDICARE ALLOWABLE COSTS ARE NET OF ANY AMOUNTS ALREADY INCLUDED WITHIN PART I, LINE 7, PRIMARILY IN SUBSIDIZED HEALTH SERVICES
PART III, LINE 8 - MEDICARE SHORTFALL AS COMMUNITY BENEFIT	LOSSES ON TREATING MEDICARE BENEFICIARIES SHOULD BE INCLUDED AS A COMMUNITY BENEFIT IN THEIR ENTIRETY THIS REPRESENTS THE AMOUNT BY WHICH COSTS TO DELIVER CARE TO MEDICARE RECIPIENTS EXCEEDS THE LEVEL OF PAYMENT ST JOSEPH BEARS THE BURDEN OF NOT ONLY PROVIDING THE BEST AND MOST ADVANCED MEDICAL CARE POSSIBLE TO THE COMMUNITY BUT ALSO DOING SO WITH NO RECOURSE IN OBTAINING PAYMENT FOR THE COST OF PROVIDING CARE IN EXCESS OF THE MEDICARE PAYMENT AS MEDICARE REVENUE DECLINES AND THE COST TO PROVIDE CUTTING EDGE CARE TO THE COMMUNITY INCREASES, THE HOSPITAL WILL CARRY THE BURDEN AS A PARTICIPATING PROVIDER AND A CHARITABLE ORGANIZATION, MEDICARE PATIENTS, THE MAJORITY OF WHOM ARE ELDERLY AND DISABLED ARE NOT TURNED AWAY, SO ST JOSEPH WILL CONTINUE TO BEAR THE LOSS IN PROVIDING THE BEST CARE POSSIBLE TO THE LOCAL COMMUNITY

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B	THE HOSPITAL'S CHARITY CARE POLICY DESCRIBES THE POLICIES AND PROCEDURES RELATING TO THE PROVISION OF CHARITY CARE TO PERSONS WHO ARE UNABLE TO PAY FOR ALL OR A PORTION OF THEIR BILL. NO INDIVIDUAL WILL BE DENIED MEDICALLY NECESSARY HOSPITAL SERVICES BASED ON A DEMONSTRATED INABILITY TO PAY FOR THOSE SERVICES. IN ADDITION, UPON APPLYING FOR CHARITY CARE, EACH PATIENT AND PATIENT GUARANTOR'S ABILITY TO PAY WILL BE ASSESSED. ELIGIBILITY FOR ASSISTANCE. A REASONABLE REVIEW SHALL BE PERFORMED PRIOR TO TURNING AN ACCOUNT OVER TO A THIRD-PARTY COLLECTION AGENT AND PRIOR TO INSTITUTING ANY LEGAL ACTION FOR NON-PAYMENT, TO ASSURE THAT THE PATIENT AND PATIENT GUARANTOR ARE NOT ELIGIBLE FOR ANY ASSISTANCE PROGRAM (I.E. MEDICAID) AND DO NOT QUALIFY FOR COVERAGE THROUGH THE CHS CHARITY CARE POLICY. AFTER HAVING BEEN TURNED OVER TO A THIRD-PARTY COLLECTION AGENT, ANY ACCOUNT THAT SUBSEQUENTLY IS DETERMINED TO MEET THE CHARITY CARE CRITERIA SHALL BE RETURNED IMMEDIATELY BY THE THIRD-PARTY COLLECTION AGENT FOR APPROPRIATE FOLLOW-UP. THE THIRD-PARTY COLLECTION AGENT SHALL ADVISE THE PATIENT/GUARANTOR OF THE HOSPITAL'S CHARITY CARE POLICY AND RETURN THE ACCOUNT IMMEDIATELY IF IT IS DETERMINED THAT THE QUALIFICATIONS ARE MET.
PART VI, LINE 2 - ASSESSMENT OF COMMUNITY NEEDS AND GOALS	COMMUNITY HEALTH NEEDS ARE ASSESSED ON A CONTINUAL BASIS, DURING MEETINGS OF THE HOSPITAL'S BOARD OF TRUSTEES AND EXECUTIVE LEADERSHIP COUNCIL, COMMUNITY HEALTH AND EDUCATION DEPARTMENT MEETINGS, AT COLLABORATIVE SESSIONS WITH MEMBER HOSPITALS OF CATHOLIC HEALTH SERVICES OF LONG ISLAND (CHS), AND WITH PARTNERS AT COMMUNITY AGENCIES AND ORGANIZATIONS THAT ARE PART OF THE LONG ISLAND HEALTH COLLABORATIVE (LIHC). THE LIHC COMMUNITY HEALTH ASSESSMENT SURVEYS ARE OFFERED YEAR-ROUND AT MULTIPLE OUTREACH SITES IN THE COMMUNITY. BY DISTRIBUTING COMMUNITY NEEDS SURVEYS (AVAILABLE IN ENGLISH, SPANISH, POLISH, AND HAITAIN CREOLE) TO PARTICIPANTS AT SCREENING SITES, EVERY POINT OF CONTACT SERVES AS AN OPPORTUNITY TO REQUEST FEEDBACK ON HOW THE HOSPITAL CAN BETTER MEET THE NEEDS OF THE COMMUNITY. THESE EVENTS ARE PROMOTED IN THE COMMUNITY SURROUNDING THE OUTREACH SITE AND ON CHS'S WEBSITE. ST. JOSEPH CONTINUES TO COLLABORATE WITH OTHER HOSPITALS, LOCAL HEALTH DEPARTMENTS, HEALTH CARE PROVIDERS, PUBLIC HEALTH SPECIALISTS FROM ACADEMIC INSTITUTIONS AND COMMUNITY-BASED ORGANIZATIONS AT LIHC EVENTS. LIHC'S WEBSITE OFFERS COMPREHENSIVE INFORMATION TO PROMOTE GOOD HEALTH AND PREVENT CHRONIC DISEASE. IN ADDITION TO PROVIDING NUMEROUS RESOURCES SUCH AS HEALTH PROGRAM INVENTORIES, HEALTH INSURANCE INFORMATION AND EDUCATIONAL VIDEOS, LIHC AND ITS MEMBERS HAVE ORGANIZED WALKING PROGRAMS, AND DEVELOPED A UNIVERSAL SCREENING TOOL TO HELP MEASURE THE EFFECTIVENESS OF COMMUNITY HEALTH EFFORTS. MORE INFORMATION CAN BE FOUND AT <a href="http://WWW.LIHEALTHCOLLAB.ORG">WWW.LIHEALTHCOLLAB.ORG</a>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3 - COMMUNICATION OF FINANCIAL ASSISTANCE POLICY	<p>1 SINCE IT IS THE DUTY OF THE HOSPITAL TO ENSURE THAT EVERY PATIENT IS MADE AWARE OF THE EXISTENCE OF THE HOSPITALS CHARITY CARE POLICY, ALL EMPLOYEES IN THE SCHEDULING, PATIENT ACCESS, PATIENT FINANCIAL SERVICES AND EMERGENCY DEPARTMENTS HAVE BEEN FULLY VERSED IN THE HOSPITALS CHARITY CARE POLICY, HAVE ACCESS TO THE CHARITY CARE APPLICATION FORMS, AND ARE ABLE TO DIRECT QUESTIONS TO THE APPROPRIATE HOSPITAL REPRESENTATIVES 2 THE HOSPITAL HAS POSTED MULTILINGUAL NOTICES AS TO ANY POLICIES ON CHARITY CARE IN SEVERAL PROMINENT LOCATIONS WITHIN THE HOSPITAL INCLUDING, BUT NOT LIMITED TO, THE EMERGENCY DEPARTMENT, BILLING OFFICE, WAITING ROOMS FOR PURPOSES OF ADMISSIONS, AND THE INPATIENT AND OUTPATIENT REGISTRATION AREA SAID NOTICES ARE PUBLISHED IN ENGLISH AND SPANISH, AND ARE CLEARLY VISIBLE TO THE PUBLIC FROM THE LOCATION AT WHICH THEY ARE POSTED 3 THE HOSPITAL PROVIDES PATIENTS, IN A TIMELY MANNER, A SUMMARY OF ITS CHARITY CARE POLICY UPON REQUEST THE SUMMARY, AT A MINIMUM, PROVIDES SPECIFIC INFORMATION AS TO INCOME LEVELS USED TO DETERMINE ELIGIBILITY AND THE MEANS OF APPLYING FOR ASSISTANCE THIS SUMMARY IS WRITTEN AT OR BELOW A SIXTH GRADE READING LEVEL 4 THE HOSPITAL HAS POSTED ITS CHARITY CARE POLICY SUMMARY ON ITS WEBSITE 5 THE HOSPITAL PROVIDES ALL PATIENTS ACCESS TO INTERPRETERS TO ASSIST THEM IN UNDERSTANDING THE MEDICAL CENTER'S CHARITY CARE PROGRAM IN THE LANGUAGE SPOKEN BY THE PATIENT DURING ANY PRE-ADMISSION, ADMISSION, AND DISCHARGE PROCESS 6 ON ALL BILLS AND STATEMENTS SENT TO PATIENTS, INFORMATION IS INCLUDED REGARDING THE AVAILABILITY OF VARIOUS FINANCIAL ASSISTANCE PROGRAMS, INCLUDING CHARITY CARE, AND A CONTACT NUMBER TO CALL TO OBTAIN FURTHER DETAILS THIS INFORMATION IS AVAILABLE AT OR BELOW A SIXTH GRADE READING LEVEL</p>
PART VI, LINE 4 - COMMUNITY INFORMATION	<p>ST JOSEPH HOSPITAL IS A 203-BED FACILITY LOCATED IN BETHPAGE, NEW YORK, APPROXIMATELY 25 MILES FROM MANHATTAN IN THE SOUTHEASTERN PART OF NASSAU COUNTY THIS NOT-FOR-PROFIT HOSPITAL IS A MEMBER OF CATHOLIC HEALTH SERVICES OF LONG ISLAND (CHS) THE HOSPITAL PRIMARILY SERVES PATIENTS FROM THE SURROUNDING COMMUNITIES OF BETHPAGE, MASSAPEQUA, FARMINGDALE, AMITYVILLE, LEVITTOWN, MASSAPEQUA PARK, WANTAGH, SEAFORD, BELLMORE, EAST MEADOW, LINDENHURST, COPIAGUE, BABYLON, HICKSVILLE, PLAINVIEW AND WOODBURY APPROXIMATELY 90% OF HOSPITAL PATIENTS WHO ARE ADMITTED AND/OR PROVIDED CARE IN THE HOSPITALS EMERGENCY DEPARTMENT RESIDE IN THE AFOREMENTIONED SERVICE AREAS</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	<p>THE HOSPITAL LEADERSHIP IS ENGAGED AND COMMITTED TO LISTENING TO AND ADDRESSING COMMUNITY NEEDS TO FURTHER ST JOSEPH'S MISSION OF PROVIDING HIGH-QUALITY CARE TO OUR PATIENTS AND VERY SUPPORTIVE OF THE NYS PREVENTION AGENDA, AIMED TO IMPROVE POPULATION HEALTH ST JOSEPH HOSPITAL'S COMMUNITY OUTREACH PROGRAMS INCLUDE SUPPORT GROUPS, COMMUNITY HEALTH EDUCATION LECTURES, HEALTH FAIRS AND SCREENINGS, BLOOD DRIVES AND OTHER PATIENT-FOCUSED INITIATIVES ST JOSEPH IS SUPPORTIVE OF EDUCATIONAL INSTITUTIONS AND THEIR RESPECTIVE STUDENTS TO PROVIDE CLINICAL EXPERIENCE AND EDUCATION IN THE HOSPITAL ENVIRONMENT ST JOSEPH HOLDS MULTIPLE AFFILIATION AGREEMENTS WITH EDUCATIONAL FACILITIES SUCH AS LONG ISLAND UNIVERSITY, MOLLOY COLLEGE, TOURO COLLEGE SCHOOL OF HEALTH SCIENCES, ST JOHNS UNIVERSITY, FARMINGDALE STATE COLLEGE AND WESTERN SUFFOLK BOCES FOR ONSITE STUDENT TRAINING/MENTORING IN NURSING, RADIOLOGY TECHNOLOGY, HEALTH ADMINISTRATION AND FOR OTHER HEALTH CARE PROFESSIONS ST JOSEPH IS ALSO A DESIGNATED SITE FOR TRAINING OF DOCTOR OF PHARMACY CANDIDATES THROUGH ST JOHN'S UNIVERSITY ST JOSEPH HOSPITAL IS AN ACTIVE MEMBER OF FARMINGDALE AND BETHPAGE CHAMBERS OF COMMERCE AND PARTICIPATES IN MANY CHAMBERS ACTIVITIES, INCLUDING HEALTH FAIRS, STREET FAIRS AND COMMUNITY FESTIVAL DAYS AT THESE EVENTS THE HOSPITAL PROVIDES FREE EDUCATIONAL HEALTH CARE MATERIAL AND OFTEN OFFERS FREE BLOOD PRESSURE SCREENINGS TO COMMUNITY RESIDENTS ST JOSEPH ALSO HOLDS AN ANNUAL HEALTH FAIR ON ITS PREMISES, INVITING ALL COMMUNITY MEMBERS TO LEARN ABOUT HOSPITAL SERVICES AND SPECIAL PROGRAMS ALSO, IN COLLABORATION WITH THE BETHPAGE LIBRARY, FARMINGDALE LIBRARY AND OTHER COMMUNITY-BASED ORGANIZATIONS, ST JOSEPH HOSPITAL OFFERS FREE LECTURES, HEALTH SCREENINGS AND OTHER OUTREACH PROGRAMS TO RESIDENTS OF NASSAU AND SUFFOLK COUNTIES TARGETING MEDICALLY-UNDERSERVED COMMUNITIES THE HOSPITAL ALSO HOLDS FOUR NEEDS-BASED DRIVES EACH YEAR SCHOOL SUPPLIES COLLECTED IN SEPTEMBER ARE DONATED TO ST MARTIN OF TOURS PARISH OUTREACH, COATS COLLECTED IN OCTOBER ARE DONATED TO THE LONG ISLAND COALITION FOR THE HOMELESS, FOOD COLLECTED IN NOVEMBER AND DECEMBER IS DONATED TO ST MARTIN OF TOURS PARISH OUTREACH, AND TOYS COLLECTED IN DECEMBER ARE DONATED TO USMC TOYS FOR TOTS OTHER IMPORTANT SERVICES PROVIDED BY ST JOSEPH HOSPITAL THAT PROMOTE COMMUNITY HEALTH &amp; WELLNESS ARE - HYPERBARIC AND WOUND HEALING OUTPATIENT CENTER - THE CENTER FOR SLEEP MEDICINE - OUTPATIENT BALANCE/VESTIBULAR TESTING AND PHYSICAL THERAPY - MRI SERVICE - SPEECH SWALLOWING AND VOICE DISORDERS - VASCULAR LAB - MAMMOGRAPHY - ULTRASOUND - OUTPATIENT RADIOLOGY - DIABETES EDUCATION - CARDIAC CT ST JOSEPH HOSPITAL PARTICIPATES IN THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CJR) MODEL THE CJR MODEL AIMS TO SUPPORT BETTER AND MORE EFFICIENT CARE FOR BENEFICIARIES UNDERGOING THE MOST COMMON INPATIENT SURGERIES FOR MEDICARE BENEFICIARIES HIP AND KNEE REPLACEMENTS (ALSO CALLED LOWER EXTREMITY JOINT REPLACEMENTS ON LEJR)</p>
PART VI, LINE 6 - AFFILIATED HEALTHCARE SYSTEM	<p>ALONG WITH THE AFOREMENTIONED COMMUNITY PROGRAMS, ST JOSEPH THROUGH ITS DAILY OPERATIONS, PROVIDES TO THE AREA ACUTE, EMERGENT, AND OUTPATIENT CARE ST JOSEPH IS A MEMBER OF CATHOLIC HEALTH SYSTEM OF LONG ISLAND (D/B/A/ CATHOLIC HEALTH SERVICES OF LONG ISLAND)(CHS), A NEW YORK, NOT-FOR-PROFIT CORPORATION ORGANIZED TO SERVE AS THE COORDINATING BODY OF AN INTEGRATED NETWORK OF PROVIDERS SERVING NASSAU AND SUFFOLK COUNTIES CHS IS SPONSORED BY THE ROMAN CATHOLIC DIOCESE OF ROCKVILLE CENTRE AS OF DECEMBER 31, 2016, CHS COMPRISED SIX HOSPITALS (MERCY MEDICAL CENTER, ST FRANCIS HOSPITAL AND ST JOSEPH HOSPITAL IN NASSAU COUNTY, AND GOOD SAMARITAN HOSPITAL MEDICAL CENTER, ST CHARLES HOSPITAL AND ST CATHERINE OF SIENA MEDICAL CENTER IN SUFFOLK COUNTY), AS WELL AS THREE NURSING HOMES (ST CATHERINE OF SIENA NURSING AND REHABILITATION CARE CENTER, GOOD SAMARITAN NURSING HOME AND OUR LADY OF CONSOLATION NURSING AND REHABILITATIVE CARE CENTER, ALL IN SUFFOLK COUNTY), A REGIONAL HOME CARE AND HOSPICE NETWORK, AND A COMMUNITY-BASED AGENCY FOR PERSONS WITH SPECIAL NEEDS WITH MORE THAN 17,500 EMPLOYEES AND 4,300 MEDICAL STAFF WORKING THROUGHOUT THE SYSTEM, CHS PROVIDES THE REGION'S FINEST HEALTH AND HUMAN SERVICES OUR MISSION STATES CATHOLIC HEALTH SERVICES OF LONG ISLAND (CHS), AS A MINISTRY OF THE CATHOLIC CHURCH, CONTINUES CHRIST'S HEALING MISSION, PROMOTES EXCELLENCE IN CARE AND COMMITS ITSELF TO THOSE IN NEED CHS AFFIRMS THE SANCTITY OF LIFE, ADVOCATES FOR THE POOR AND UNDERSERVED, AND SERVES THE COMMON GOOD IT CONDUCTS ITS HEALTH CARE PRACTICE, BUSINESS, EDUCATION AND INNOVATION WITH JUSTICE, INTEGRITY AND RESPECT FOR THE DIGNITY OF EACH PERSON MEMBER ORGANIZATIONS OF CHS OFFER VIRTUALLY EVERY MEDICAL SPECIALTY AND CLINICAL SERVICE, AND SHARE A DEDICATION TO CONTINUOUSLY UPGRADE THE SCOPE, QUALITY AND ACCESSIBILITY OF CARE ALL OF CHS'S MEMBER ORGANIZATIONS HAVE RETAINED THEIR INDIVIDUAL LINKS TO THEIR HISTORY AND THEIR DISTINCTIVE PERSONALITIES, AS WELL AS THE SERVICE SPECIALTIES WHICH THEY ARE KNOWN FOR, THUS EMBEDDING THE ORGANIZATION IN THE COMMUNITY AND SERVING IT EFFECTIVELY CHS ENTITIES PROVIDE AN ABUNDANCE OF EDUCATION AND SUPPORT GROUPS AS WELL AS FREE HEALTH SCREENINGS THROUGH ITS HEALTHY SUNDAYS PROGRAMS, HEALTH FAIRS, AND OTHER PROGRAMS SINCE 1907, CATHOLIC HEALTH SERVICES HAS BUILT A DISTINGUISHED TRADITION OF OPERATING COMMUNITY-BASED HOSPITALS AND HUMAN SERVICE ORGANIZATIONS WITH THE PRIMARY OBJECTIVE OF IMPROVING THE COMMUNITY'S HEALTH TO FURTHER THE MISSION OF BRINGING CARE TO THE COMMUNITY, CHS AND ITS MEMBER HOSPITALS, TOGETHER WITH A NUMBER OF OTHER HEALTH CARE PROVIDERS ON LONG ISLAND, ENTERED INTO A PARTNERSHIP AGREEMENT WHICH OPERATES AS THE LONG ISLAND HEALTH NETWORK (LIHN) LIHN WAS CREATED TO ESTABLISH A COMPREHENSIVE AND EFFICIENT HOSPITAL NETWORK IN NASSAU AND SUFFOLK COUNTIES WORKING TO, AMONG OTHER THINGS, IMPROVE QUALITY OF CARE, FACILITATE CLINICAL INTEGRATION, BENCHMARK BEST PRACTICES AND REDUCE LENGTH OF STAY AND COSTS MERCY MEDICAL CENTER, A RELATED ORGANIZATION, PROVIDES UNCOMPENSATED CARE THROUGH A BROAD RANGE OF COMMUNITY SERVICE PROGRAMS AND CHARITABLE ACTIVITIES</p>

**Additional Data****Software ID:****Software Version:****EIN:** 11-3438973**Name:** WSNCHS NORTH INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>											
Name, address, primary website address, and state license number											
1	ST JOSEPH HOSPITAL 4295 HEMPSTEAD TURNPIKE BETHPAGE, NY 117145713 WWW STJOSEPHHOSPITAL CHSLI ORG 2952006H	X	X					X			

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5	ST JOSEPH HOSPITAL CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN ASSOCIATION WITH LONG ISLAND HEALTH COLLABORATIVE (LIHC) MEMBERS THE LIHC IS A PARTNERSHIP OF LONG ISLAND'S HOSPITALS, COUNTY HEALTH DEPARTMENTS, HEALTH PROVIDERS, COMMUNITY-BASED SOCIAL AND HUMAN SERVICE ORGANIZATIONS, ACADEMIC INSTITUTIONS, HEALTH PLANS, LOCAL GOVERNMENT, AND THE BUSINESS SECTOR, ALL ENGAGED IN IMPROVING THE HEALTH OF LONG ISLANDERS THE LIHC IS THE MAIN WORKING GROUP ASSOCIATED WITH CARRYING OUT THE GOALS OF THE LONG ISLAND POPULATION HEALTH IMPROVEMENT PROGRAM IN 2016, MEMBERS OF LIHC REVIEWED EXTENSIVE DATA SETS SELECTED FROM BOTH PRIMARY AND SECONDARY DATA SOURCES TO IDENTIFY AND CONFIRM PREVENTION AGENDA PRIORITIES FOR THE 2016-2018 COMMUNITY HEALTH NEEDS ASSESSMENT CYCLE PRIMARY DATA SOURCES COLLECTED AND ANALYZED INCLUDE THE LIHC COMMUNITY HEALTH ASSESSMENT SURVEY, QUALITATIVE DATA FROM COMMUNITY BASED ORGANIZATION SUMMIT EVENTS, AND THE LIHC WELLNESS SURVEY THE BROAD COMMUNITY WAS ENGAGED IN ASSESSMENT EFFORTS THROUGH THE DISTRIBUTION AND COMPLETION OF THE PREVENTION AGENDA COMMUNITY MEMBER SURVEYS THIS TOOL WAS DEVELOPED IN COLLABORATION WITH COMMUNITY PARTNERS FROM THE LIHC DATA FROM THIS SURVEY WERE COLLECTED AUGUST 1, 2015 THROUGH APRIL 30, 2016 THROUGH DISTRIBUTION AND PROMOTION OF THIS SURVEY THROUGHOUT A WIDE RANGE OF SOCIAL SERVICE LOCATIONS, INCLUDING ST JOSEPH HOSPITAL, DOCTORS OFFICES, HEALTH DEPARTMENTS, LIBRARIES, SCHOOLS, INSURANCE ENROLLMENT SITES AND COMMUNITY-BASED ORGANIZATIONS THIS INCLUDES THE MEDICALLY UNDERSERVED INDIVIDUALS LIVING IN THE COMMUNITIES OF FARMINGDALE, AMITYVILLE, LINDENHURST AND COPIAGUE ST JOSEPH HOSPITAL PROMOTES THE SURVEY THROUGH SOCIAL MEDIA LINKS, ON ITS WEBSITE, AND BY DISTRIBUTING SURVEYS AT HEALTH FAIRS AND OTHER CONSUMER-ORIENTED EVENTS DISTRIBUTING SURVEYS AT HEALTH FAIRS AND OTHER CONSUMER-ORIENTED EVENTS

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 6A	ST JOSEPH HOSPITAL, MERCY MEDICAL CENTER, GLEN COVE HOSPITAL, NORTHWELL HEALTH SYSTEM (LONG ISLAND JEWISH VALLEY STREAM, NORTH SHORE UNIVERSITY HOSPITAL, PLAINVIEW HOSPITAL, SOUTH OAKS HOSPITAL, SYOSSET HOSPITAL), NASSAU UNIVERSITY MEDICAL CENTER, SOUTH NASSAU COMMUNITIES HOSPITAL, AND WINTHROP UNIVERSITY HOSPITAL

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 6B	THE HOSPITALS CHNA WAS ALSO CONDUCTED WITH NASSAU AND SUFFOLK HEALTH DEPARTMENTS, STONY BROOK UNIVERSITY AND MORE THAN 40 COMMUNITY-BASED ORGANIZATIONS, COLLECTIVELY KNOWN AS THE LONG ISLAND HEALTH COLLABORATIVE (LIHC)

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	<p>ST JOSEPH HOSPITAL AND LIHC COMMUNITY PARTNERS SELECTED CHRONIC DISEASE AS THE PRIORITY A REA WITH A FOCUS ON (1) OBESITY AND (2) PREVENTIVE CARE AND MANAGEMENT FOR THE 2016-2018 CYCLE MENTAL HEALTH WILL BE HIGHLIGHTED WITHIN ALL INTERVENTION STRATEGIES PRIORITY 1 OB ESITY ST JOSEPH WORKED TO REDUCE OBESITY IN ADULTS THROUGH COMMUNITY-BASED AWARENESS INIT IATIVES SUCH AS FREE COMMUNITY LECTURES AND BMI SCREENINGS ST JOSEPH HOSPITAL OFFERED A WEIGHT WATCHERS PROGRAM FOR STAFF AND COMMUNITY MEMBERS A GROUP OF 18 MET FOR 15 WEEKS FR OM SEPTEMBER TO DECEMBER 2016 AND LOST A TOTAL OF 181 POUNDS WHILE LEARNING ABOUT PROPER N UTRITION, THE IMPORTANCE OF INCREASED ACTIVITY, AND LIFESTYLE CHANGES ST JOSEPH HOSPITAL STAFF VOLUNTEER AT HEALTHY SUNDAY EVENTS PROVIDING HEALTH AND NUTRITION EDUCATION MATERIA L AND SCREENINGS IN MEDICALLY-UNDERSERVED COMMUNITIES BMI SCREENINGS ARE OFFERED AT HEALT HY SUNDAYS EVENTS, GIVING PROGRAM PARTICIPANTS A TOOL TO BENCHMARK WEIGHT LOSS/CONTROL ST JOSEPH HOSPITAL ACTIVELY PROMOTED THE LONG ISLAND HEALTH COLLABORATIVE'S WALKING PROGRAM , DISTRIBUTING PROMOTIONAL MATERIALS AT COMMUNITY EVENTS AND THROUGH SOCIAL MEDIA ALSO, S T JOSEPH HOSPITAL SHARED PROGRAM INFORMATION WITH CHS-AFFILIATED PHYSICIANS AND MID-LEVEL PRACTITIONERS TO ENCOURAGE MORE PEOPLE TO WALK AND CHOOSE A HEALTHIER LIFESTYLE ST JOSE PH ALSO PROMOTED THE LONG ISLAND HEALTH COLLABORATIVE'S WALKING PROGRAM AT ITS DIABETES ED UCATION PROGRAMS, WEIGHT WATCHERS MEETINGS, AND PROGRAM MATERIAL IS DISPLAYED THROUGHOUT T HE HOSPITAL INFORMATION HAS BEEN POSTED ON SOCIAL MEDIA AND IS DISTRIBUTED AT ALL COMMUNI TY EVENTS CHS WAS THE MEDAL OF HONOR TITLE SPONSOR FOR THE SECOND CONSECUTIVE YEAR SERVIN G AGAIN AS THE OFFICIAL RACE MEDICINE PROVIDER FOR THE 2016 CHS SUFFOLK COUNTY MARATHON AN D FREEDOM FEST THE NET PROCEEDS FROM THE ANNUAL EVENT BENEFITS LOCAL VETERANS SERVICES OR GANIZATIONS THERE WERE 5 ST JOSEPH EMPLOYEES WHO WORKED IN THE RACE MEDICINE TENT P RIOR ITY 2 PREVENTIVE CARE AND MANAGEMENT ST JOSEPH WORKED TO INCREASE ACCESS TO HIGH-QUALITY DISEASE PREVENTIVE CARE AND MANAGEMENT FOR DIABETES IN CLINICAL AND COMMUNITY SETTINGS S T JOSEPH HOSPITAL OFFERS FREE PROGRAMS FOR THE COMMUNITY, PROVIDING EDUCATION ON HOW TO B ETTER MANAGE HEALTH THE PROGRAMS ARE PRESENTED BY CERTIFIED DIABETES EDUCATORS, SUPPORT A LL AREAS OF DIABETES CARE, MANAGEMENT AND EDUCATION IN VARIOUS LOCATIONS, AND TARGET HIGH- RISK POPULATIONS AND UNDERSERVED COMMUNITIES IN 2016, THERE WERE 13 FREE DIABETES EDUCATI ON LECTURES WITH A MORE THAN 120 TOTAL ATTENDEES, AVERAGING 9 ATTENDEES PER LECTURE TOPIC S INCLUDED NUTRITION AND GOOD HEALTH, DINING OUT TIPS AND TIDBITS, DIABETES PREVENTION WH AT YOU NEED TO KNOW, DIABETES AND SLEEP, AND MANY MORE ST JOSEPH HOSPITAL OFFERS THE CEN TERS FOR DISEASE CONTROL (CDC) DIABETES PREVENTION RECOGNIZED PROGRAM (DPRP) A TRAINED FA CILITATOR HELPS PARTICIPANTS MAKE LIFESTYLE CHANGES SUCH AS EATING HEALTHIER, REDUCING STR ESS, AND GETTING MORE PHYSICAL</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	<p>ACTIVITY THE HOSPITAL BEEN AWARDED FULL RECOGNITION BY THE CDC FOR THE DIABETES PREVENTI ON PROGRAM THE PROGRAM USES AN APPROVED CURRICULUM THAT MEETS THE DURATION, INTENSITY AND REPORTING REQUIREMENTS DESCRIBED IN THE DPRP STANDARDS FULL RECOGNITION MEANS THE PROGRA M HAS DEMONSTRATED EFFECTIVENESS IN ACHIEVING ALL OF THE PERFORMANCE CRITERIA DETAILED IN THE STANDARDS PARTICIPANTS RECEIVE INFORMATION REGARDING THE SKILLS NEEDED TO LOSE WEIGHT , BE MORE PHYSICALLY ACTIVE, AND MANAGE STRESS THERE ARE 16 WEEKLY SESSIONS (CORE GROUP), AND 6 MONTHLY FOLLOW UP SESSIONS (POST- CORE GROUP) TO HELP MAINTAIN THE HEALTHY LIFESTYL E CHANGES ONE GROUP CONCLUDED IN ITS POST-CORE SESSION IN AUGUST 2016 AND WITH FIVE PARTI CIPANTS IN JULY 2016, A NEW CORE GROUP BEGAN WITH FOUR PARTICIPANTS ST JOSEPH HOSPITAL STAFF VOLUNTEER AT CHS HEALTHY SUNDAYS COMMUNITY OUTREACH EVENTS HELD AT CHURCHES IN UNDER SERVED COMMUNITIES, OFFERING FREE HEALTH SCREENINGS AND PROVIDING EDUCATIONAL MATERIALS ON NUTRITION, HEALTHY EATING AND PREVENTIVE HEALTH IN 2016, ST JOSEPH PARTICIPATED IN 5 HE ALTHY SUNDAY EVENTS, PROVIDING FREE BLOOD PRESSURE AND BMI SCREENINGS TO 145 INDIVIDUALS, 97 FLU VACCINATIONS, AND ALL ATTENDEES WERE OFFERED HEALTH EDUCATION MATERIAL ST JOSEPHS PODIATRY AND WOUND CARE DEPARTMENTS CONTINUE TO WORK TOGETHER TO IMPACT THE TREATMENT OF PATIENTS WITH DIABETES ON APRIL 28, 2016 THE WOUND CARE DEPARTMENT HOSTED A FREE FOOT SCR EENING AND BALANCE SEMINAR TWELVE MEMBERS OF THE COMMUNITY RECEIVED SCREENINGS AND INFORM ATION ON BALANCE ISSUES ST JOSEPH HOSPITAL PARTICIPATED IN THE COMMUNITY HEALTH SUMMIT C OUNCIL AT FARMINGDALE HIGH SCHOOL MARCH 30, 2016 COMMUNITY OUTREACH STAFF OFFERED FREE ED UCATION MATERIAL ABOUT DIABETES SELF-MANAGEMENT AND COMPLICATIONS OF DIABETES, HEART DISEA SE/HIGH BLOOD PRESSURE AND STROKE, AND THE POSSIBLE CORRELATION OF OBESITY TO CHRONIC DISE ASE ST JOSEPH PROVIDED NINE FREE BLOOD PRESSURE SCREENINGS THROUGHOUT THE CALENDAR YEAR AT THE MASSAPEQUA LIBRARY, MASSAPEQUA SENIOR CENTER, AND ST MARKS CHURCH IN WOODBURY THR EE FREE COMMUNITY LECTURES/SCREENINGS WERE OFFERED AT THE SONS OF ITALY, FARMINGDALE (CARD IAC CT), ST WILLIAM THE ABO TT, SEAFORD (STROKE), AND MASSAPEQUA SENIOR CENTER (CARDIAC CT ) ST JOSEPH PRESENTED THREE FREE LECTURES TO EMS PERSONNEL ON TOPICS SUCH AS ARRHYTHMIA, CARDIAC CT, STROKE, AND OVERDOSE AND DRUG ADDICTION ON 9/22/16, ST JOSEPH HOSTED A FREE "COMMUNITY FALLS PREVENTION DAY", DISTRIBUTING INFORMATION ON WAYS TO "FALL-PROOF YOUR EN VIRONMENT" ST JOSEPH HOSPITAL PARTICIPATES IN THE AMERICAN HEART ASSOCIATION HEART WALK, THE LONG ISLAND MARCUM WORKPLACE CHALLENGE - A 3 5-MILE RUN-WALK FOR CHARITY - AND THE AM ERICAN CANCER SOCIETY'S MAKING STRIDES AGAINST BREAST CANCER WALK THESE EVENTS ENCOURAGE WALKING FOR PHYSICAL ACTIVITY AND GOOD HEALTH FOR EMPLOYEES AND THE COMMUNITY EDUCATIONAL MATERIALS ARE OFFERED TO PARTICIPANTS AT EACH EVENT ST JOSEPH HOSPITAL PARTICIPATED IN MANY ADDITIONAL COMMUNITY EVEN</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	<p>TS THROUGHOUT 2016, OFFERING FREE PREVENTIVE CARE AND MANAGEMENT EDUCATION MATERIAL EVENT S INCLUDED THE MONTHLY NASSAU COUNTY SENIOR LUNCHEON, BETHPAGE FIREMANS PARADE, MASSAPEQUA COMMUNITY FAIR, SOUTH FARMINGDALE FAMILY DAY, SENATOR KEMP HANNON FREE HEALTH FAIR IN GAR DEN CITY, SUFFOLK COUNTY MARATHON AND THE FARMINGDALE HEALTH SUMMIT ST JOSEPH HOSPITAL O FFERED THE FREE, SEVEN-WEEK STEPPING-ON PROGRAM DESIGNED TO PROMOTE IMPROVED BALANCE, STRE NGTH, HOME AND COMMUNITY SAFETY, VISION, THE IMPORTANCE OF SAFE FOOTWEAR, AND MEDICATION R EVIEW FALL PREVENTION MATERIALS WERE DISTRIBUTED AND FREE NIGHT LIGHTS WERE GIVEN COURTES Y OF THE SUFFOLK COUNTY DEPARTMENT OF HEALTH THE CLASS WAS HELD 5/10/16-6/28/16 AT THE OA KS ADULT COMMUNITY CENTER IN MASSAPEQUA WITH 10 ATTENDEES PRIORITY 3 MENTAL HEALTH ST J OSEPH HOSPITAL OFFERS TWO BEREAVEMENT GROUPS ON A REGULAR BASIS THE INITIAL BEREAVEMENT G ROUP AND NEXT STEPS GROUP RAN BETWEEN SIX TO EIGHT WEEKS, DEPENDING UPON THE NEEDS OF THE GROUP A TOTAL OF 83 PEOPLE BENEFITED FROM THE BEREAVEMENT GROUPS ST JOSEPH HOSPITAL PAR TICIPATED IN THE BI-COUNTY EMPOWERMENT CONFERENCE IN AUGUST 2016 INFORMATION ON EATING HE ALTHY, REDUCING STRESS, THE IMPORTANCE OF PHYSICAL ACTIVITY, AND THE LONG ISLAND HEALTH CO LLABORATIVES WALKING PROGRAM WAS DISTRIBUTED INFORMATIONAL PACKETS ON FREE DIABETES EDUCA TION PROGRAMS OFFERED AT THE HOSPITAL WERE ALSO AVAILABLE IN NOVEMBER 2016, TWO STAFF MEM BERS FROM ST JOSEPH HOSPITAL PARTICIPATED IN THE MENTAL HEALTH FIRST AID TRAINING PRESENT ED BY THE MENTAL HEALTH ASSOCIATION OF NASSAU COUNTY AND OFFERED AT ST FRANCIS HOSPITAL THIS FREE, EIGHT-HOUR TRAINING IS FOR CAREGIVERS OF THOSE WHO LIVE WITH CHRONIC DISEASE AS WELL AS HOSPITAL STAFF WHO WORK WITH CAREGIVERS OR RUN HOSPITAL SUPPORT GROUPS THE FREE CHS MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GUIDE IS AVAILABLE THROUGHOUT THE HOSPITAL AND AT ALL COMMUNITY OUTREACH EVENTS</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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Form and Line Reference	Explanation
PART V, SECTION B, LINE 20E	ST JOSEPH HAS POSTED MULTILINGUAL NOTICES ABOUT ITS CHARITY CARE POLICIES IN SEVERAL PROMINENT LOCATIONS WITHIN ST JOSEPH INCLUDING, BUT NOT LIMITED TO, THE EMERGENCY DEPARTMENT, BILLING OFFICE, WAITING ROOMS FOR PURPOSES OF ADMISSIONS, AND THE INPATIENT AND OUTPATIENT REGISTRATION AREA SAID NOTICES ARE PUBLISHED IN ENGLISH AND SPANISH AND ARE CLEARLY VISIBLE TO THE PUBLIC ST JOSEPH HAS POSTED ITS CHARITY CARE POLICY SUMMARY ON ITS WEBSITE

Schedule I (Form 990)

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

OMB No 1545-0047

2016

Open to Public Inspection

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

Attach to Form 990.

Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury Internal Revenue Service Name of the organization WSNCHS NORTH INC

Employer identification number 11-3438973

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 8 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section if applicable, (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation, (g) Description of non-cash assistance, (h) Purpose of grant or assistance. Row 1: CATHOLIC HEALTH SERVICES OF LONG ISLAND, 11-3403968, 501(C)(3), 372,732, NONE, NONE, OUTPATIENT CENTERS.

- 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 non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash 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
PART I, LINE 2 - PROCEDURE FOR MONITORING GRANT FUND USE	CHS SERVICES, A RELATED ENTITY, MAINTAINS THE BOOKS AND RECORDS FOR ST JOSEPH HOSPITAL AND CATHOLIC HEALTH SERVICES OF LONG ISLAND AND IS THEREFORE ABLE TO MONITOR THAT CATHOLIC HEALTH SERVICES OF LONG ISLAND USES THE GRANT FUNDS FOR MISSION SPONSORSHIP, OUTPATIENT CENTERS, GRANTS TO UNDERSERVED COMMUNITIES AND CAPITAL SUPPORT
PART II, LINE 1, COLUMN (H)	NAME OF ORGANIZATION OR GOVERNMENT CATHOLIC HEALTH SYSTEM OF LONG ISLAND (H) PURPOSE OF GRANT 1) SUPPORT TO CATHOLIC HEALTH SYSTEM OF LONG ISLAND AS A PASS THROUGH TO PROVIDE GENERAL SUPPORT TO THE CATHOLIC MINISTRIES OF THE DIOCESE OF ROCKVILLE CENTRE IN CONNECTION WITH THE FORMATION OF YOUTH AND ADULTS IN THE FAITH, PROMOTION OF THE DIGNITY OF LIFE, PROMOTION OF QUALITY EDUCATION FOR YOUNG PEOPLE, AND FOSTERING OF VOCATIONS FOR THE PRIESTHOOD, 2) PROVIDE SUPPORT TO CATHOLIC HEALTH SYSTEM OF LONG ISLAND TO FUND OUTPATIENT CENTERS THAT PROVIDE CHARITY CARE TO THOSE CENTERS COMMUNITIES, AND 3) TO FUND SUPPORT PROVIDED THROUGH THE CATHOLIC HEALTH SERVICES OF LONG ISLAND CAREGIVERS FUND THE CATHOLIC HEALTH SERVICES OF LONG ISLAND CAREGIVERS FUND WAS FORMED WITH THE MISSION TO ASSIST OUR FELLOW CAREGIVERS ON THE FRONT LINES, HERE AND ABROAD, WHO STRUGGLE JUST TO OBTAIN BASIC RESOURCES TO PROVIDE CARE TO THOSE DESPERATELY IN NEED

**Schedule J**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

OMB No 1545-0047

**For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**  
 ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**  
 ▶ **Attach to Form 990.**

**2015**  
**Open to Public Inspection**

▶ **Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

Name of the organization WSNCHS NORTH INC	Employer identification number 11-3438973
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**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 border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p><b>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 border="0"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee									
<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 non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.</p>	<b>7</b>	No								
<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 II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

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

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

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

**Part III Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 4B - SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN	THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN. THE AMOUNTS BELOW ARE INCLUDED ON SCHEDULE J, PART II, COLUMN C: ALAN D. GUERCI, MD \$306,000 PARTICIPATION IN PLAN; WILLIAM ARMSTRONG \$137,000 PARTICIPATION IN PLAN; RONALD STEIMEL \$82,000 PARTICIPATION IN PLAN. THE DEFERRED COMPENSATION AMOUNT IN COLUMN C FOR THESE INDIVIDUALS INCLUDES BOTH QUALIFIED AND NON-QUALIFIED RETIREMENT PLANS. THE FOLLOWING INDIVIDUALS VESTED IN THE SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN. THE AMOUNTS BELOW ARE INCLUDED ON SCHEDULE J, PART II, COLUMN B(III): THESE AMOUNTS INCLUDE A GROSS TAX UP: ALAN GUERCI \$767,223 VESTED IN PLAN; WILLIAM ARMSTRONG \$664,661 VESTED IN PLAN. THE AMOUNTS OUTLINED HEREIN WERE INCLUDED IN EACH INDIVIDUAL'S 2016 FORM W-2, BOX 5 AS TAXABLE WAGES BECAUSE THEY ARE VESTED, BUT ARE NOT DISTRIBUTED UNTIL RETIREMENT.
PART II, REPORTING OF TOP FINANCIAL OFFICIAL	WILLIAM ARMSTRONG WAS REPORTED AS AN OFFICER IN 2015 AS THE TOP FINANCIAL OFFICIAL IN HIS ROLE AS INTERIM CFO. EFFECTIVE 6/6/16, DANIEL DEBARBA BECAME THE TOP FINANCIAL OFFICER AS CFO, AND WILLIAM ARMSTRONG RESUMED HIS ROLE AS SVP OF FINANCE.



**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.**

▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
WSNCHS NORTH INC

**Employer identification number**

11-3438973

**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	102,750	PHYSICIAN SERVICES		No
(2) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	265,137	NOCTURNIST SERVICES		No
(3) SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIBUTOR	2,106,000	RADIOLOGY SERVICES		No

**Part V Supplemental Information**

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

Return Reference	Explanation

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

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

OMB No 1545-0047

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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
WSNCHS NORTH INC

Employer identification number

11-3438973

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, LINE 6 - MEMBERS OF THE ORGANIZATION	THE SOLE MEMBER OF ST JOSEPH HOSPITAL IS CATHOLIC HEALTH SYSTEM OF LONG ISLAND (D/B/A/ CATHOLIC HEALTH SERVICES OF LONG ISLAND) (CHS) CHS IS A NEW YORK NOT-FOR-PROFIT CORPORATION ORGANIZED TO SERVE AS THE COORDINATING BODY OF AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS CHS IS SPONSORED BY THE ROMAN CATHOLIC DIOCESE OF ROCKVILLE CENTER (DIOCESE)

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM, PART VI, LINE 7A - ELECTION OF THE GOVERNING BODY	CHS IS THE SOLE MEMBER AND ESTABLISHED CO-OPERATOR OF ST JOSEPH HOSPITAL AND AS SUCH, HAS THE RIGHT TO APPOINT THE GOVERNING BODY OF ST JOSEPH HOSPITAL

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM, PART VI, LINE 7B - DECISIONS OF THE GOVERNING BODY	AS THE SOLE MEMBER OF ST JOSEPH HOSPITAL, CHS IS REQUIRED TO APPROVE CERTAIN DECISIONS MADE BY THE GOVERNING BODY OF ST JOSEPH HOSPITAL THE GOVERNING BODY OF ST JOSEPH HOSPITAL IS THE SAME AS THAT OF CHS

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 11B - REVIEW PROCESS FOR FORM 990	THE FORM 990 AND RELATED SCHEDULES ARE COMPLETED BY OUTSIDE TAX ADVISORS AND REVIEWED INTERNALLY BY MANAGEMENT. THE FINAL DRAFT OF THE FORM 990 IS THEN PROVIDED TO ALL VOTING MEMBERS OF THE BOARD, AND PRESENTED TO THE COMPLIANCE AND AUDIT COMMITTEE (THE COMMITTEE) OF THE BOARD OF DIRECTORS OF CHS, WHICH HAS BEEN DELEGATED THE FORM 990 REVIEW FUNCTION BY THE BOARD. UPON REVIEW AND RECOMMENDATION OF THE COMMITTEE, THE FORM 990 IS THEN SENT TO THE BOARD FOR APPROVAL. UPON BOARD APPROVAL, THE FORM 990 IS SUBMITTED TO THE INTERNAL REVENUE SERVICE.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM, PART VI, LINE 12 - CONFLICT OF INTEREST POLICY	DISCLOSURE IN ACCORDANCE WITH THE CONFLICT OF INTEREST POLICY (THE POLICY) BY BOARD AND BOARD COMMITTEE MEMBERS, EMPLOYEES AND OTHERS THAT SATISFY THE CRITERIA TO BE CONSIDERED AN INTERESTED PERSON IS SUBMITTED UPON HIRE OR APPOINTMENT AND ANNUALLY THEREAFTER SUCH INDIVIDUALS HAVE A CONTINUING OBLIGATION TO UPDATE THE INFORMATION PROVIDED DURING THE COURSE OF THE YEAR A SUMMARY OF DISCLOSURES IS PROVIDED TO THE CHS COMPLIANCE AND AUDIT COMMITTEE BY CHS' COMPLIANCE OFFICER ALL DISCLOSURES ARE INVESTIGATED AND INFORMATION RELATED TO THE DISCLOSURE IS GATHERED AND SUMMARIZED AND INCLUDED WITH THE SUMMARY OF DISCLOSURES UPON REVIEW OF THE SUMMARY OF DISCLOSURES, THE CHS COMPLIANCE AND AUDIT COMMITTEE SHALL REPORT ITS FINDINGS TO THE CHS BOARD OF DIRECTORS THE BOARD SHALL DETERMINE WHETHER A CONFLICT OF INTEREST EXISTS BASED ON THE CRITERIA CONTAINED IN THE POLICY IF A CONFLICT OF INTEREST IS IDENTIFIED AND A MAJORITY OF THE BOARD OR BOARD COMMITTEE AGREES THAT THE TRANSACTION OR ARRANGEMENT IS IN THE BEST INTEREST OF CHS AND WISHES TO GO FORWARD WITH IT, THE CHAIR OF THE BOARD OF DIRECTORS SHALL PROVIDE A WRITTEN REQUEST TO THE CHAIR OF THE CHS COMPLIANCE AND AUDIT COMMITTEE, DELINEATING THE TRANSACTION AND CONFLICT AND PROVIDING REASONS WHY THE BOARD AGREES THAT THE TRANSACTION OR ARRANGEMENT IS IN THE BEST INTEREST OF CHS, CERTIFIES THAT CHS CANNOT SECURE SIMILAR SERVICES FROM AN ORGANIZATION WITHOUT A CONFLICT, AND WISHES TO GO FORWARD WITH IT THE PERSON DETERMINED TO HAVE A CONFLICT OF INTEREST MUST RECUSE HIM/HERSELF FROM ANY DECISION MAKING OR VOTING ON THE INTEREST THAT GAVE RISE TO THE CONFLICT

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
<p>FORM 990, PART VI, LINE 15 COMPENSATION POLICY</p>	<p>THE CHIEF ADMINISTRATIVE OFFICER SUBMITS FOR APPROVAL TO THE SYSTEM CEO RECOMMENDATIONS FOR BASE SALARY ADJUSTMENTS AND INCENTIVE AWARDS FOR "DISQUALIFIED PERSONS" AS DEFINED IN THE CHS EXECUTIVE COMPENSATION POLICY (COMPENSATION POLICY) THE COMPENSATION POLICY DEFINES A "DISQUALIFIED PERSON" AS A PERSON IN A POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER THE AFFAIRS OF CHS OR AN OPERATING ENTITY, AND IS EITHER A) A VOTING MEMBER OF THE BOARD OF DIRECTORS OR BOARD OF TRUSTEES, B) THE ENTITY'S PRESIDENT, CHIEF EXECUTIVE OFFICER (CEO), AND CHIEF OPERATING OFFICERS (COO) OR PERSONS HOLDING EQUIVALENT POSITIONS, C) THE ENTITY'S TREASURERS AND CHIEF FINANCIAL OFFICERS (CFO), D) THE PERSON'S COMPENSATION IS PRIMARILY BASED ON REVENUES DERIVED FROM ACTIVITIES OF CHS OR AN OPERATING ENTITY, OR OF A PARTICULAR DEPARTMENT OR FUNCTION OF CHS OR AN OPERATING ENTITY, THAT THE PERSON CONTROLS, E) THE PERSON HAS OR SHARES AUTHORITY TO CONTROL OR DETERMINE A SUBSTANTIAL PORTION OF CHS OR AN OPERATING ENTITY'S CAPITAL EXPENDITURES, OPERATING BUDGET, OR COMPENSATION FOR OTHER EMPLOYEES, F) THE PERSON MANAGES A DEPARTMENT OR ACTIVITY OF CHS OR AN OPERATING ENTITY THAT REPRESENTS A SUBSTANTIAL PORTION OF THE ACTIVITIES, ASSETS, INCOME, OR EXPENSES OF CHS OR AN OPERATING ENTITY, COMPARED TO THE ORGANIZATION AS A WHOLE, OR G) FAMILY MEMBERS OF ANY OF THOSE DESCRIBED IN THE PRECEDING D, E, OR F ONCE APPROVED BY THE CHS CEO, THESE RECOMMENDATIONS ARE SENT TO THE EXECUTIVE COMPENSATION COMMITTEE OF THE CHS BOARD OF DIRECTORS FOR REVIEW THE EXECUTIVE COMPENSATION COMMITTEE, WITH AN INDEPENDENT COMPENSATION CONSULTANT ENGAGED BY THE BOARD, WILL REVIEW PROPOSED SALARY ADJUSTMENTS AND INCENTIVE AWARDS TO ENSURE REASONABLENESS BY REVIEWING COMPARABLE TOTAL COMPENSATION DATA (INCLUDING INCENTIVES) PAID TO SIMILARLY SITUATED EXECUTIVES AT THE MEDIAN OF THE DEFINED MARKETPLACE WITH POSSIBLE ADJUSTMENT MADE FOR SPECIAL SKILL, EXPERIENCE, COMPETENCE AND PERFORMANCE, INCLUDING CONTRIBUTION TO THE SYSTEM AS A WHOLE REVIEWS ARE PERFORMED ANNUALLY BY AN INDEPENDENT CONSULTANT THE COMPENSATION COMMITTEE SETS STANDARDS TO ENSURE THAT THE CRITERIA USED TO DETERMINE INCENTIVE COMPENSATION ARE SPECIFIC, OBJECTIVE, MEASURABLE AND RELATED TO INDICATORS OF PERFORMANCE BASED ON THE INFORMATION PROVIDED, THE COMMITTEE WILL THEN MAKE ITS RECOMMENDATION TO THE CHS BOARD OF DIRECTORS</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 19 - DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION	GOVERNING DOCUMENTS - CERTIFICATE OF INCORPORATION FILED WITH THE NYS DEPARTMENT OF STATE, CONFLICT OF INTEREST POLICY IS NOT PUBLICLY AVAILABLE, FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM, PART VII, SECTION A - LINE 1A	<p>HOURS FOR TRUSTEES ARE THE ESTIMATED WEEKLY HOURS (2 0) TRUSTEES CONTRIBUTE TO THIS AND ALL OTHER RELATED ORGANIZATIONS, NOT NECESSARILY EQUALLY BUT IN THE PROPORTION NECESSARY, FOR WHICH THEY RECEIVE NO COMPENSATION ALAN D GUERCI, MD, PRESIDENT &amp; CEO - THE TOTAL HOURS WORKED REPORTED REFLECTS TIME WORKED AS AN OFFICER FOR ALL OF THE FOLLOWING RELATED ENTITIES CHS SERVICES, INC (11-3555766), RVC INSURANCE COMPANY, INC (20-8067039), CATHOLIC HEALTH SYSTEMS OF LONG ISLAND (11-3403968), ST FRANCIS HOSPITAL (11-2050523), ST FRANCIS HOSPITAL RESEARCH &amp; EDUCATION CORPORATION, INC (11-3090867), ST FRANCIS HOSPITAL FOUNDATION (11-2916033), MERCY MEDICAL CENTER (11-1635088), WSNCHS NORTH, INC (11-3438973), GOOD SAMARITAN HOSPITAL MEDICAL CENTER (11-1888924), ST CATHERINE OF SIENA MEDICAL CENTER (06-1562701), SIENA VILLAGE, INC (06-1569129), ST CHARLES HOSPITAL (11-1871039) AND GOOD SAMARITAN SELF INSURANCE AGAINST MALPRACTICE (11-2537396) RONALD W STEIMEL EXECUTIVE VICE PRESIDENT &amp; CHIEF ADMINISTRATIVE OFFICER - THE TOTAL HOURS WORKED REPORTED REFLECTS TIME WORKED AS AN OFFICER FOR ALL OF THE FOLLOWING RELATED ENTITIES MERCY MEDICAL CENTER (11-1888924) AND WSNCHS NORTH, INC (11-3438973) WILLIAM ARMSTRONG, SR VP FINANCE - THE TOTAL HOURS WORKED REPORTED REFLECTS TIME WORKED AS AN OFFICER OR HIGHEST PAID EMPLOYEE FOR ALL OF THE FOLLOWING RELATED ENTITIES CHS SERVICES, INC (11-3555766), ST FRANCIS HOSPITAL (11-2050523), ST FRANCIS HOSPITAL RESEARCH &amp; EDUCATION CORPORATION, INC (11-3090867), ST FRANCIS HOSPITAL FOUNDATION (11-2916033), MERCY MEDICAL CENTER (11-1635088), WSNCHS NORTH, INC (11-3438973), GOOD SAMARITAN HOSPITAL MEDICAL CENTER (11-1888924), ST CATHERINE OF SIENA MEDICAL CENTER (06-1562701), ST CHARLES HOSPITAL (11-1871039), ST CHARLES HOSPITAL FOUNDATION (41-2076312), SIENA VILLAGE, INC (06-1569129), GOOD SAMARITAN SELF INSURANCE AGAINST MALPRACTICE (11-2537396) AND GOOD SAMARITAN HOSPITAL FOUNDATION (77-0611240) DANIEL DE BARBA, EVP &amp; CFO - THE TOTAL HOURS WORKED REPORTED REFLECTS TIME WORKED AS AN OFFICER OR HIGHEST PAID EMPLOYEE FOR ALL OF THE FOLLOWING RELATED ENTITIES CHS SERVICES, INC (11-3555766), ST FRANCIS HOSPITAL (11-2050523), ST FRANCIS HOSPITAL RESEARCH &amp; EDUCATION CORPORATION, INC (11-3090867), ST FRANCIS HOSPITAL FOUNDATION (11-2916033), MERCY MEDICAL CENTER (11-1635088), WSNCHS NORTH, INC (11-3438973), GOOD SAMARITAN HOSPITAL MEDICAL CENTER (11-1888924), ST CATHERINE OF SIENA MEDICAL CENTER (06-1562701), ST CHARLES HOSPITAL (11-1871039), ST CHARLES HOSPITAL FOUNDATION (41-2076312), SIENA VILLAGE, INC (06-1569129), GOOD SAMARITAN SELF INSURANCE AGAINST MALPRACTICE (11-2537396), GOOD SAMARITAN HOSPITAL FOUNDATION (77-0611240), ST CATHERINE OF SIENA MEDICAL CENTER FOUNDATION (27-1459941), CATHOLIC HEALTH SYSTEM OF LONG ISLAND (11-3403968) AND RVC INSURANCE COMPANY INC (20-8067039)</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART X, LINE 20 - TAX- EXEMPT BOND LIABILITIES	THE TAX-EXEMPT BOND ISSUANCES REFLECTED ON PART X, LINE 20 ARE ISSUED ON BEHALF OF THE CATHOLIC HEALTH SERVICES OF LONG ISLAND OBLIGATED GROUP PROJECT WHICH INCLUDES THE FILING ENTITY AND RELATED ENTITIES ONE BOND ISSUED TO THE OBLIGATED GROUP, NASSAU COUNTY LOCAL ECONOMIC ASSISTANCE CORPORATION (SERIES 2014B BONDS) WAS ALLOCATED TO WSNCHS NORTH, INC THE BOND IS REPORTED ON SCHEDULE K OF THE PARENT ORGANIZATION, CATHOLIC HEALTH SERVICES OF LONG ISLAND

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No 1545-0047

**2016**

**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. ▶ Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

Name of the organization  
WSNCHS NORTH INC

**Employer identification number**

11-3438973

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

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

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

See Additional Data Table

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> BIPO HOLDINGS LLC 1600 STEWART AVE WESTBURY NY WESTBURY, NY 11590 46-4763720	PHYSICIAN ASSN	NY	NA	N/A								
<b>(2)</b> IDHC LLC 2500 YORK RD JAMISONPA 18929 JAMISON, PA 18929 45-2411095	HEALTH SERVICES	PA	NA	N/A								
<b>(3)</b> BEACON HEALTH PTNRS 1600 STEWART AVE WESTBURY NY 1159 WESTBURY, NY 11590 45-4229842	HEALTHCARE	NY	NA	N/A								
<b>(4)</b> WISDOM GARDENS LP 51 TERRYVILLE RD PORT JEFFERSON, NY 11776 11-3567947	SR HOUSING	NY	NA	N/A								

**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.

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) 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

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)CHS SERVICES INC	LMPR	337,750	COST
(2)GOOD SAMARITAN HOSPITAL MEDICAL CENTER	LM	547,991	COST
(3)MERCY MEDICAL CENTER	LM	317,664	COST
(4)ST FRANCIS HOSPITAL	LM	118,525	COST
(5)ST CATHERINE OF SIENA MEDICAL CENTER	LM	100,681	COST
(6)ST CHARLES HOSPITAL	LM	64,356	COST



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

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

Return Reference	Explanation
SCHEDULE R, PART IV	FOR ALL PROFESSIONAL CORPORATIONS REPORTED ON SCHEDULE R, PART IV, THE PHYSICIAN IS THE SOLE SHAREHOLDER OF THE ENTITY AND THE DIRECT CONTROLLING ENTITY REPORTED IN COLUMN (D) IS THE BENEFICIAL OWNER THIS STRUCTURE IS CONSISTENT WITH THE NEW YORK CORPORATE PRACTICE OF MEDICINE

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 11-3438973  
**Name:** WSNCHS NORTH INC

**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
(1) 992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 11-3403968	SUPPORT ORG	NY	501(C)(3)	12A-I	NA		No
(1) 992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 11-3555766	SUPPORT ORG	NY	501(C)(3)	12B-II	CHSLI	Yes	
(2) 992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 14-1801961	DORMANT	NY	501(C)(3)	3	CHSLI		No
(3) 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 11-1888924	HOSPITAL	NY	501(C)(3)	3	CHSLI	Yes	
(4) MALPRACTICE 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 11-2537396	SELF INSURANC	NY	501(C)(3)	12A-I	GOOD SAMARTN	Yes	
(5) 51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-3434776	TRANSPORTATIO	NY	501(C)(3)	12A-I	MARYHAVENCTR		No
(6) 51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-2861698	Prgm-disabled	NY	501(C)(3)	10	CHSLI		No
(7) 51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-2861690	Schl-disabled	NY	501(C)(3)	2	MARYHAVENCTR		No
(8) 51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-3638367	SUPPORT ORG	NY	501(C)(3)	12A-I	MARYHAVENCTR		No
(9) 1000 NORTH VILLAGE AVENUE ROCKVILLE CTR, NY 11570 11-1635088	HOSPITAL	NY	501(C)(3)	3	CHSLI	Yes	
(10) 110 Bi-County Blvd Suite 114 FARMINGDALE, NY 11735 11-2126736	HOME CARE	NY	501(C)(3)	10	CHSLI		No
(11) 111 BEACH DRIVE WEST ISLIP, NY 11795 11-3284066	LT NURSE CARE	NY	501(C)(3)	10	CHSLI		No
(12) 51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-2499790	RENTING	NY	501(C)(2)		MARYHAVENCTR		No
(13) 2000 BISHOPS ROAD SMITHTOWN, NY 11787 06-1569129	SR HOUSING	NY	501(C)(3)	10	STCATHERINE	Yes	
(14) 50 ROUTE 25A SMITHTOWN, NY 11787 06-1562701	HOSPITAL	NY	501(C)(3)	3	CHSLI	Yes	
(15) 200 BELLE TERRE ROAD PORT JEFFERSN ST, NY 11777 11-1871039	HOSPITAL	NY	501(C)(3)	3	CHSLI	Yes	
(16) 15 POWER DRIVE HAUPPAGE, NY 11788 11-3594561	RESP THERAPY	NY	501(C)(3)	10	CATHHOMECARE		No
(17) 100 PORT WASHINGTON BLVD ROSLYN, NY 11576 11-2050523	HOSPITAL	NY	501(C)(3)	3	CHSLI	Yes	
(18) 100 PORT WASHINGTON BLVD ROSLYN, NY 11576 11-2916033	SUPPORT ORG	NY	501(C)(3)	12A-I	ST FRANCIS		No
(19) 100 PORT WASHINGTON BLVD ROSLYN, NY 11576 11-3090867	RESEARCH ORG	NY	501(C)(3)	12A-I	ST FRANCIS	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
(21)  200 BELLE TERRE ROAD PORT JEFFERSN ST, NY 11777 11-2983148	SUPPORT ORG	NY	501(C)(3)	12A-I	CHSLI		No
(1)  992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 11-2716640	SUPPORT ORG	NY	501(C)(3)	12A-I	CHSLI		No
(2)  51 TERRYVILLE ROAD PORT JEFFERSN ST, NY 11776 11-3559713	SR HOUSING	NY	501(C)(3)	10	MARYHAVENCTR		No
(3)  110 Bi-County Blvd Suite 114 FARMINGDALE, NY 11735 11-2958438	HOSPICE SVC	NY	501(C)(3)	10	CHSLI		No
(4)  200 BELLE TERRE ROAD PORT JEFFERSON, NY 11777 41-2076312	SUPPORT ORG	NY	501(C)(3)	12A-I	ST CHARLES		No
(5)  1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 77-0611240	SUPPORT ORG	NY	501(C)(3)	12A-I	GOOD SAMARTN		No
(6)  1000 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 55-0813603	SUPPORT ORG	NY	501(C)(3)	12A-I	MERCY MEDCTR		No
(7)  50 ROUTE 25A SMITHTOWN, NY 11787 27-1459941	SUPPORT ORG	NY	501(C)(3)	12A-I	STCATHERINE		No
(8)  110 Bi-County Blvd Suite 114 FARMINGDALE, NY 11735 45-2907761	SUPPORT ORG	NY	501(C)(3)	12A-I	CATHHOMECARE		No
(9)  110 Bi-County Blvd Suite 114 FARMINGDALE, NY 11735 26-3169427	SUPPORT ORG	NY	501(C)(3)	12A-I	GOODSHEPHERD		No
(10)  111 BEACH DRIVE WEST ISLIP, NY 11795 45-0517566	SUPPORT ORG	NY	501(C)(3)	12A-I	OURLADYOFC		No
(11)  992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 27-1531084	REAL ESTATE	NY	501(C)(3)	12A-I	CHSLI		No
(12)  100 PORT WASHINGTON BLVD ROSLYN, NY 11576 11-3613997	HEALTHCARESVC	NY	501(C)(3)	12A-I	ST FRANCIS		No
(13)  992 NORTH VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 20-8067039	CAPTIVE INS	NY	501(C)(3)	12B-II	CHSLI		No
(14)  1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 20-8243412	HEALTHCARESVC	NY	501(C)(4)		GOOD SAMARTN		No
(15)  992 N VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 47-2353387	SUPPORT ORG	NY	501(C)(3)	12A-1	WSNCHS NORTH	Yes	

**Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust**

(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
(1) RADIOLOGY CONSULTING OF LONG ISLANDPLLC 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 42-1646134	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(1) SAMARITAN PEDIATRIC SERVICES PC 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 20-8180263	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(2) SAMARITAN MEDICAL SERVICES PC 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 20-8088453	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(3) SOUTHWEST SUFFOLK MEDICAL PC 580 UNION BOULEVARD WEST ISLIP, NY 11795 06-1603195	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(4) CARDIAC EKG INTERPRETATION PC 992 N VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 11-2924518	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(5) LI REGIONAL ARTHRITIS & OSTEOPOROSIS CAR 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 20-8964140	HEALTHCARE SVC	NY	GOOD SAMARITAN	C-CORP					No
(6) SAMARITAN MANAGEMENT SERVICES 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 11-2838185	HEALTHCARE SVC	NY	CHSLI	C-CORP					No
(7) ADVANCED REHABILITATION MEDICINE PLLC 200 BELLE TERRE ROAD PORT JEFFERSON, NY 11777 11-3640709	HEALTHCARE SVC	NY	STCHARLES HOSP	C-CORP					No
(8) ST FRANCIS CARDIAC PREVENTION SERVICES 100 PORT WASHINGTON BLVD ROSLYN, NY 11576 11-3224885	HEALTHCARE SVC	NY	STFRANCIS HOSP	C-CORP					No
(9) SOUTH SHORE PRACTICE MANAGEMENT 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 11-3307977	HEALTHCARE SVC	NY	SAMARITAN MGMT	C-CORP					No
(10) SAMARITAN HOME CARE AMERICA 1000 MONTAUK HIGHWAY WEST ISLIP, NY 11795 11-3319259	HEALTHCARE SVC	NY	SAMARITAN MGMT	C-CORP					No
(11) MERCY INTERNAL MEDICINE PC 992 N VILLAGE AVENUE ROCKVILLE CENTRE, NY 11570 51-0639649	HEALTHCARE SVC	NY	MERCY MED CTR	C-CORP					No
(12) LONG ISLAND EMERGENCY CARE PC 1000 N VILLAGE AVE ROCKVILLE, NY 11571 11-3633515	PHYSICIAN SVC	NY	MERCY MED CTR	S-CORP					No

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

<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
<b>(1)</b> CHS SERVICES INC	LMPR	337,750	COST
<b>(1)</b> GOOD SAMARITAN HOSPITAL MEDICAL CENTER	LM	547,991	COST
<b>(2)</b> MERCY MEDICAL CENTER	LM	317,664	COST
<b>(3)</b> ST FRANCIS HOSPITAL	LM	118,525	COST
<b>(4)</b> ST CATHERINE OF SIENA MEDICAL CENTER	LM	100,681	COST
<b>(5)</b> ST CHARLES HOSPITAL	LM	64,356	COST