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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*

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**A For the 2017 calendar year, or tax year beginning 01-01-2017 , and ending 12-31-2017**

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

**C** Name of organization
Episcopal Health Services Inc
% EPISCOPAL HEALTH SERVICES
Doing business as

Number and street (or P O box if mail is not delivered to street address) 700 Hicksville Road Suite 210
Room/suite

City or town, state or province, country, and ZIP or foreign postal code
Bethpage, NY 11714

**D Employer identification number**
11-1665825

E Telephone number
(516) 349-4643

**G** Gross receipts $ 223,910,635

**F** Name and address of principal officer
GERARD WALSH
700 Hicksville RD Suite 210
Bethpage, NY 11714

**H(a)** Is this a group return for subordinates? ☐ Yes ☑ No

**H(b)** Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

**H(c)** Group exemption number ▶

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

**J Website:** ▶ WWW EHS ORG

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

**L** Year of formation 1852

**M** State of legal domicile NY

## Part I Summary

**1** Briefly describe the organization's mission or most significant activities
to provide exceptional healthcare and educational programs in an academic setting across the continuum of care and deliver high quality, value based services (see schedule O)

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

| | | | |
|---|---|---|---|
| **3** | Number of voting members of the governing body (Part VI, line 1a) | **3** | 10 |
| **4** | Number of independent voting members of the governing body (Part VI, line 1b) | **4** | 6 |
| **5** | Total number of individuals employed in calendar year 2017 (Part V, line 2a) | **5** | 1,875 |
| **6** | Total number of volunteers (estimate if necessary) | **6** | 101 |
| **7a** | Total unrelated business revenue from Part VIII, column (C), line 12 | **7a** | 0 |
| **b** | Net unrelated business taxable income from Form 990-T, line 34 | **7b** | 0 |

| | | Prior Year | Current Year |
|---|---|---|---|
| **8** | Contributions and grants (Part VIII, line 1h) | 1,629,118 | 2,192,671 |
| **9** | Program service revenue (Part VIII, line 2g) | 166,018,283 | 163,447,935 |
| **10** | Investment income (Part VIII, column (A), lines 3, 4, and 7d ) | 1,932,635 | 977,548 |
| **11** | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 31,060,932 | 56,216,294 |
| **12** | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 200,640,968 | 222,834,448 |
| **13** | Grants and similar amounts paid (Part IX, column (A), lines 1–3 ) | 0 | 0 |
| **14** | Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| **15** | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 137,683,482 | 156,154,719 |
| **16a** | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| **b** | Total fundraising expenses (Part IX, column (D), line 25) ▶0 | | |
| **17** | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 69,500,601 | 66,159,489 |
| **18** | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 207,184,083 | 222,314,208 |
| **19** | Revenue less expenses Subtract line 18 from line 12 | -6,543,115 | 520,240 |

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| **20** | Total assets (Part X, line 16) | 123,710,154 | 122,421,374 |
| **21** | Total liabilities (Part X, line 26) | 122,026,171 | 119,350,321 |
| **22** | Net assets or fund balances Subtract line 21 from line 20 | 1,683,983 | 3,071,053 |

## 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**

****** 2018-11-12
Signature of officer Date

STEVEN GUIDO CFO
Type or print name and title

**Paid Preparer Use Only**

| | | | |
|---|---|---|---|
| Print/Type preparer's name Angelo Pirozzi | Preparer's signature Angelo Pirozzi | Date 2018-11-12 | Check ☐ if self-employed / PTIN P00446022 |
| Firm's name ▶ BDO USA LLP | | | Firm's EIN ▶ |
| Firm's address ▶ 100 PARK AVENUE NEW YORK, NY 100175001 | | | Phone no (212) 885-8000 |

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

## Part III Statement of Program Service Accomplishments

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

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

ST JOHNS EPISCOPAL HOSPITAL IN PARTNERSHIP WITH OUR COMMUNITY PROVIDES EXCEPTIONAL HEALTHCARE AND EDUCATION PROGRAMS IN AN ACADEMIC SETTING ACROSS THE CONTINUUM OF CARE WE DELIVER HIGH QUALITY, VALUE BASED SERVICES WITH CULTURAL SENSITIVITY TO THE FAITHS AND TRADITIONS OF THOSE WE SERVE

**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 $ 192,854,029 including grants of $ ) (Revenue $ 217,603,516 )

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** ▶ 192,854,029

**Part IV Checklist of Required Schedules**

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

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

| | | | Yes | No |
|---|---|---|---|---|
| **20a** | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | **20a** | Yes | |
| **b** | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | **20b** | Yes | |
| **21** | Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II* | **21** | | No |
| **22** | Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III* | **22** | | No |
| **23** | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J* | **23** | Yes | |
| **24a** | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a* | **24a** | | No |
| **b** | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | **24b** | | |
| **c** | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | **24c** | | |
| **d** | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | **24d** | | |
| **25a** | **Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I* | **25a** | | No |
| **b** | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I* | **25b** | | No |
| **26** | 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? *If "Yes," complete Schedule L, Part II* | **26** | | No |
| **27** | 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? *If "Yes," complete Schedule L, Part III* | **27** | | No |
| **28** | 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) | | | |
| **a** | A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28a** | | No |
| **b** | A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV* | **28b** | | No |
| **c** | 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? *If "Yes," complete Schedule L, Part IV* | **28c** | | No |
| **29** | Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M* | **29** | | No |
| **30** | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M* | **30** | | No |
| **31** | Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I* | **31** | | No |
| **32** | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II* | **32** | | No |
| **33** | Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I* | **33** | | No |
| **34** | Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1* | **34** | Yes | |
| **35a** | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | **35a** | Yes | |
| **b** | If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* | **35b** | Yes | |
| **36** | **Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2* | **36** | | No |
| **37** | Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI* | **37** | | No |
| **38** | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O | **38** | Yes | |

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

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

| | | | | Yes | No |
|---|---|---|---|---|---|
| **1a** | Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . | **1a** | 211 | | |
| **b** | Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable | **1b** | 0 | | |
| **c** | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . . | **1c** | | Yes | |
| **2a** | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . . | **2a** | 1,875 | | |
| **b** | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions) | **2b** | | Yes | |
| **3a** | Did the organization have unrelated business gross income of $1,000 or more during the year? . . . | **3a** | | | No |
| **b** | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . . | **3b** | | | |
| **4a** | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . | **4a** | | | No |
| **b** | If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR) | | | | |
| **5a** | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . | **5a** | | | No |
| **b** | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | **5b** | | | No |
| **c** | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . . | **5c** | | | |
| **6a** | Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . | **6a** | | | No |
| **b** | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . . | **6b** | | | |
| **7** | **Organizations that may receive deductible contributions under section 170(c).** | | | | |
| **a** | Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor? . . . . . | **7a** | | | No |
| **b** | If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . . | **7b** | | | |
| **c** | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . . | **7c** | | | No |
| **d** | If "Yes," indicate the number of Forms 8282 filed during the year . . . . | **7d** | | | |
| **e** | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | **7e** | | | No |
| **f** | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . | **7f** | | | No |
| **g** | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . . | **7g** | | | |
| **h** | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . . | **7h** | | | |
| **8** | **Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . . | **8** | | | |
| **9a** | Did the sponsoring organization make any taxable distributions under section 4966? . . . | **9a** | | | |
| **b** | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . | **9b** | | | |
| **10** | **Section 501(c)(7) organizations.** Enter | | | | |
| **a** | Initiation fees and capital contributions included on Part VIII, line 12 . . . | **10a** | | | |
| **b** | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | **10b** | | | |
| **11** | **Section 501(c)(12) organizations.** Enter | | | | |
| **a** | Gross income from members or shareholders . . . . . | **11a** | | | |
| **b** | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . . | **11b** | | | |
| **12a** | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | **12a** | | | |
| **b** | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | **12b** | | | |
| **13** | **Section 501(c)(29) qualified nonprofit health insurance issuers.** | | | | |
| **a** | Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O | **13a** | | | |
| **b** | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . | **13b** | | | |
| **c** | Enter the amount of reserves on hand . . . . . | **13c** | | | |
| **14a** | Did the organization receive any payments for indoor tanning services during the tax year? . . . . . | **14a** | | | No |
| **b** | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . . | **14b** | | | |

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

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

## Section A. Governing Body and Management

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1a | Enter the number of voting members of the governing body at the end of the tax year | 1a | 10 | | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O | | | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 1b | 6 | | |
| 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? | 2 | | | 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? | 3 | | | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | | No |
| 6 | Did the organization have members or stockholders? | 6 | | | No |
| 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? | 7a | | | No |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | | | No |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following | | | | |
| a | The governing body? | 8a | | Yes | |
| b | Each committee with authority to act on behalf of the governing body? | 8b | | | No |
| 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* | 9 | | | No |

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

| | | | Yes | No |
|---|---|---|---|---|
| 10a | Did the organization have local chapters, branches, or affiliates? | 10a | | No |
| b | If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? | 10b | | |
| 11a | Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? | 11a | Yes | |
| b | 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* | 12a | Yes | |
| b | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | Yes | |
| c | Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done* | 12c | Yes | |
| 13 | Did the organization have a written whistleblower policy? | 13 | Yes | |
| 14 | Did the organization have a written document retention and destruction policy? | 14 | 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 | 15a | Yes | |
| b | Other officers or key employees of the organization | 15b | 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? | 16a | | No |
| b | If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? | 16b | | |

## Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed ▶

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 ☑ 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
▶EPISCOPAL HEALTH SERVICES 700 HICKSVILLE ROAD - SUITE 210 BETHPAGE, NY 11714 (516) 349-4643

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

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

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

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

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

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

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| See Additional Data Table | | | | | | | | | | |
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| | | | | | | | | | | |
| **1b Sub-Total** ▶ | | | | | | | | | | |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | 7,967,811 | 0 | 982,802 |

**2** Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 283

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

## Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| NSLIJHS LABORATORY,<br>PO BOX 417855<br>BOSTON, MA 11042 | LABORATORY SERVICES | 1,524,262 |
| QUEENS COUNTY MEDICAL SERVICES,<br>5665 NEW NORTHSIDE DR STE 320<br>ATLANTA, GA 30328 | ANESTHESIA SERVICES | 2,538,000 |
| IPC THE HOSPITAL COMPANY INC,<br>THREE BARKER AVE 4TH FL<br>WHITE PLAINS, NY 10601 | PHYSICIAN FEES | 1,689,293 |
| RESTORIX HEALTH INC,<br>PO BOX 71849<br>CHICAGO, IL 60694 | WOUNDCARE/HYPERBARIC | 1,187,556 |
| ST FRANCIS HOSPITAL,<br>992 North Village Ave<br>ROCKVILLE CENTRE, NY 11570 | physician fees | 1,145,262 |

**2** Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 60

**Part VIII Statement of Revenue**

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

| | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|---|---|---|---|---|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns . . | 1a | | | |
| | b Membership dues . . | 1b | | | |
| | c Fundraising events . . | 1c | | | |
| | d Related organizations | 1d | | | |
| | e Government grants (contributions) | 1e | 1,564,244 | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 628,427 | | |
| | g Noncash contributions included in lines 1a-1f $ _____ | | | | |
| | h **Total.** Add lines 1a-1f . . . . . ▶ | | 2,192,671 | | |

| Program Service Revenue | Business Code | | | | |
|---|---|---|---|---|---|
| 2a NET PATIENT SERVICE REV | 621300 | 168,959,871 | 168,959,871 | | |
| b ~~PHYSICIAN BILLING REVENUE~~ | 621110 | -2,168,615 | -2,168,615 | | |
| c ~~PROVISION FOR BAD DEBTS~~ | 621300 | -3,343,321 | -3,343,321 | | |
| d | | | | | |
| e | | | | | |
| f All other program service revenue | | | | | |
| g **Total.** Add lines 2a–2f . . . . ▶ | | 163,447,935 | | | |

| Other Revenue | | | | | |
|---|---|---|---|---|---|
| 3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶ | | 842,741 | | | 842,741 |
| 4 Income from investment of tax-exempt bond proceeds ▶ | | 0 | | | |
| 5 Royalties . . . . . ▶ | | 0 | | | |
| | (i) Real / (ii) Personal | | | | |
| 6a Gross rents | 60,885 | | | | |
| b Less rental expenses | | | | | |
| c Rental income or (loss) | 60,885 / 0 | | | | |
| d Net rental income or (loss) . . . . . ▶ | | 60,885 | | | 60,885 |
| | (i) Securities / (ii) Other | | | | |
| 7a Gross amount from sales of assets other than inventory | 1,210,994 | | | | |
| b Less cost or other basis and sales expenses | 1,076,187 | | | | |
| c Gain or (loss) | 134,807 | | | | |
| d Net gain or (loss) . . . . . ▶ | | 134,807 | | | 134,807 |
| 8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . a | 0 | | | | |
| b Less direct expenses . . . b | 0 | | | | |
| c Net income or (loss) from fundraising events . . ▶ | | 0 | | | |
| 9a Gross income from gaming activities See Part IV, line 19 . . . a | 0 | | | | |
| b Less direct expenses . . . b | 0 | | | | |
| c Net income or (loss) from gaming activities . . ▶ | | 0 | | | |
| 10a Gross sales of inventory, less returns and allowances . . a | 0 | | | | |
| b Less cost of goods sold . . b | 0 | | | | |
| c Net income or (loss) from sales of inventory . . ▶ | | 0 | | | |
| Miscellaneous Revenue | Business Code | | | | |
| 11a NYS IAAF FUNDS | 900099 | 46,892,729 | 46,892,729 | | |
| b I&R AND NON I&R ROTATION INCOME | 900099 | 3,329,646 | 3,329,646 | | |
| c HEALTH FIRST RISK POOL INCOME | 900099 | 1,937,400 | 1,937,400 | | |
| d All other revenue . . . . | | 3,995,634 | 1,995,806 | | 1,999,828 |
| e **Total.** Add lines 11a–11d . . . . . ▶ | | 56,155,409 | | | |
| 12 **Total revenue.** See Instructions . . . . . ▶ | | 222,834,448 | 217,603,516 | | 3,038,261 |

## Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraisingexpenses |
|---|---|---|---|---|
| 1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21 | 0 | | | |
| 2 Grants and other assistance to domestic individuals See Part IV, line 22 | 0 | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16 | 0 | | | |
| 4 Benefits paid to or for members | 0 | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 6,304,466 | | 6,304,466 | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 Other salaries and wages | 110,118,354 | 103,120,284 | 6,998,070 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 7,682,748 | 6,940,474 | 742,274 | |
| 9 Other employee benefits | 23,611,209 | 20,856,333 | 2,754,876 | |
| 10 Payroll taxes | 8,437,942 | 7,319,819 | 1,118,123 | |
| 11 Fees for services (non-employees) | | | | |
| a Management | 0 | | | |
| b Legal | 660,768 | | 660,768 | |
| c Accounting | 184,996 | | 184,996 | |
| d Lobbying | 0 | | | |
| e Professional fundraising services See Part IV, line 17 | 0 | | | |
| f Investment management fees | 0 | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 23,524,106 | 17,388,716 | 6,135,390 | 0 |
| 12 Advertising and promotion | 307,505 | | 307,505 | |
| 13 Office expenses | 2,973,922 | 2,524,525 | 449,397 | |
| 14 Information technology | 3,304,031 | 2,866,209 | 437,822 | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 3,991,686 | 2,620,458 | 1,371,228 | |
| 17 Travel | 48,542 | 12,561 | 35,981 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 Conferences, conventions, and meetings | 137,282 | 98,067 | 39,215 | |
| 20 Interest | 322,794 | 321,309 | 1,485 | |
| 21 Payments to affiliates | 0 | | | |
| 22 Depreciation, depletion, and amortization | 4,777,748 | 4,144,642 | 633,106 | |
| 23 Insurance | 3,057,236 | 2,576,627 | 480,609 | |
| 24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O ) | | | | |
| a MEDICAL SUPPLIES | 10,200,561 | 10,200,561 | | |
| b OTHER MATERIALS & EXPENSES | 7,052,768 | 6,247,900 | 804,868 | |
| c DRUGS | 5,615,544 | 5,615,544 | | |
| d | | | | |
| e All other expenses | | | | |
| 25 **Total functional expenses.** Add lines 1 through 24e | 222,314,208 | 192,854,029 | 29,460,179 | 0 |
| 26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) | | | | |

## Part X Balance Sheet

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

| | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|
| Assets | 1 | Cash–non-interest-bearing | 4,109,428 | 1 | 2,602,711 |
| | 2 | Savings and temporary cash investments | 131,358 | 2 | 3,329,921 |
| | 3 | Pledges and grants receivable, net | 204,487 | 3 | 10,295 |
| | 4 | Accounts receivable, net | 13,810,331 | 4 | 12,837,825 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | 0 | 5 | 0 |
| | 6 | 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 | 6 | 0 |
| | 7 | Notes and loans receivable, net | 0 | 7 | 0 |
| | 8 | Inventories for sale or use | 1,849,906 | 8 | 1,886,850 |
| | 9 | Prepaid expenses and deferred charges | 4,692,691 | 9 | 3,647,206 |
| | 10a | Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 181,958,906 | | | |
| | b | Less accumulated depreciation — 10b: 143,151,342 | 38,087,009 | 10c | 38,807,564 |
| | 11 | Investments—publicly traded securities | 0 | 11 | 0 |
| | 12 | Investments—other securities See Part IV, line 11 | 0 | 12 | 0 |
| | 13 | Investments—program-related See Part IV, line 11 | 0 | 13 | 0 |
| | 14 | Intangible assets | 0 | 14 | 0 |
| | 15 | Other assets See Part IV, line 11 | 60,824,944 | 15 | 59,299,002 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | 123,710,154 | 16 | 122,421,374 |
| Liabilities | 17 | Accounts payable and accrued expenses | 43,265,870 | 17 | 45,990,779 |
| | 18 | Grants payable | 0 | 18 | 0 |
| | 19 | Deferred revenue | 5,338,271 | 19 | 5,338,387 |
| | 20 | Tax-exempt bond liabilities | 0 | 20 | 0 |
| | 21 | Escrow or custodial account liability Complete Part IV of Schedule D | 0 | 21 | 0 |
| | 22 | 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 | 22 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | 2,458,894 | 23 | 7,009,118 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | 0 | 24 | 0 |
| | 25 | Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | 70,963,136 | 25 | 61,012,037 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | 122,026,171 | 26 | 119,350,321 |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.** | | | |
| | 27 | Unrestricted net assets | -11,760 | 27 | 803,113 |
| | 28 | Temporarily restricted net assets | 699,402 | 28 | 1,271,599 |
| | 29 | Permanently restricted net assets | 996,341 | 29 | 996,341 |
| | | **Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.** | | | |
| | 30 | Capital stock or trust principal, or current funds | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 | Total net assets or fund balances | 1,683,983 | 33 | 3,071,053 |
| | 34 | Total liabilities and net assets/fund balances | 123,710,154 | 34 | 122,421,374 |

## Part XI Reconcilliation of Net Assets

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

| | | | |
|---|---|---|---|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 222,834,448 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 222,314,208 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | 520,240 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 1,683,983 |
| 5 | Net unrealized gains (losses) on investments | 5 | -403,102 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 1,269,932 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 3,071,053 |

## Part XII Financial Statements and Reporting

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

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | | |
| 2a | Were the organization's financial statements compiled or reviewed by an independent accountant? | 2a | | No |
| | If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis | | | |
| b | Were the organization's financial statements audited by an independent accountant? | 2b | Yes | |
| | If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis | | | |
| c | If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? | 2c | Yes | |
| | If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O | | | |
| 3a | As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | 3a | | No |
| 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 | 3b | | |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-1665825

**Name:** Episcopal Health Services Inc

Form 990 (2017)

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

ST JOHN'S EPISCOPAL HOSPITAL PROVIDED THE FOLLOWING SERVICES TO RESIDENTS OF ITS LOCAL COMMUNITY IN 2017 8,449 DISCHARGES 42,450 ADULT AND PEDIATRIC MEDICAL AND SURGICAL DAYS OF CARE TO 6,913 PATIENTS 12,041 DAYS OF BEHAVIORAL HEALTHCARE TO 866 PATIENTS 670 BABIES WERE DELIVERED 36,417 PATIENTS WERE TREATED AND RELEASED FROM THE 24 HR EMERGENCY ROOM 14,917 TO THE CHRONIC DIALYSIS SERVICE 54,328 VISITS TO THE AMBULATORY AND BEHAVIORAL HEALTH CLINICS

**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 LAURENCE C PROVENZANO<br>PRESIDENT & CHAIRMAN | 10 0<br>1 0 | X | | X | | | | 120,000 | 0 | 0 |
| MARGARET O CARPENTER<br>SECOND VP | 1 0<br>0 0 | X | | X | | | | 0 | 0 | 0 |
| RONALD O COLE<br>TREASURER, THRU OCT 2017 | 2 0<br>0 0 | X | | X | | | | 18,500 | 0 | 0 |
| PATRICK GUY<br>SECRETARY | 1 0<br>0 0 | X | | X | | | | 0 | 0 | 0 |
| GERARD WALSH<br>CHIEF EXECUTIVE OFFICER | 34 5<br>3 0 | X | | X | | | | 635,621 | 0 | 45,212 |
| DANIEL A KASLE<br>TREASURER, as of OCT 2017 | 1 0<br>0 0 | X | | X | | | | 0 | 0 | 0 |
| REV DR NORMAN WHITMIRE JR<br>BOARD MEMBER | 1 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| REV T DIANE BRITT<br>BOARD MEMBER | 1 0<br>0 0 | X | | | | | | 0 | 0 | 0 |
| DR ALBERT STROjan<br>Chief Acad Off/Board Member | 40 0<br>0 0 | X | | | | | | 411,081 | 0 | 0 |
| REV SARAH KOOPERKAMP<br>BOARD MEMBER | 1 0<br>0 0 | X | | | | | | 0 | 0 | 0 |

**Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W- 2/1099-MISC) | (E) Reportable compensation from related organizations (W- 2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| CHRISTOPHER PARKER<br>CHIEF OPERATING OFFICER | 38 0<br>0 0 | | | X | | | | 476,843 | 0 | 63,315 |
| STEVEN GUIDO<br>CHIEF FINANCIAL OFFICER | 34 5<br>3 0 | | | X | | | | 458,339 | 0 | 72,592 |
| JAMES HENRY<br>CHIEF OF ORTHOPEDICS | 30 0<br>0 0 | | | | X | | | 343,402 | 0 | 33,500 |
| RAYMOND PASTORE<br>CHIEF MEDICAL OFFICER | 32 0<br>8 0 | | | | X | | | 440,194 | 0 | 7,000 |
| SHELDON MARKOWITZ<br>CHAIR - DEPT OF MEDICINE | 35 0<br>0 0 | | | | X | | | 255,738 | 0 | 72,492 |
| NATALIE SCHWARTZ<br>VP, REGULATORY AFFAIRS | 40 0<br>0 0 | | | | X | | | 281,395 | 0 | 76,390 |
| FRANCINE NIGRELLO thru 117<br>CHIEF COMPLIANCE OFFICER | 37 5<br>0 0 | | | | X | | | 153,031 | 0 | 2,496 |
| GWENDOLYN SEYMORE-PINCKNEY<br>CHIEF NURSING OFFICER | 37 5<br>0 0 | | | | X | | | 234,367 | 0 | 78,992 |
| SHARIKA GORDON<br>VP, HUMAN RESOURCES | 37 5<br>0 0 | | | | X | | | 191,856 | 0 | 29,758 |
| JOHN ROCCO<br>VP, OPERATIONS | 37 5<br>0 0 | | | | X | | | 221,228 | 0 | 60,838 |

**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 | | | |
| DELBURT JOINER<br>CHIEF QUALITY OFFICER | 37 5<br>0 0 | | | | X | | | 247,832 | 0 | 26,317 |
| ANNCY THOMAS<br>CHIEF MEDICAL INFO OFFICER | 37 5<br>0 0 | | | | X | | | 211,945 | 0 | 22,600 |
| WILLIAM FEDORICH LLM<br>Chief Corporate General Counci | 37 5<br>0 0 | | | | X | | | 283,898 | 0 | 29,516 |
| THOMAS LUBESKI as of 0117<br>medical director | 37 5<br>0 0 | | | | X | | | 306,429 | 0 | 59,216 |
| EILEEN VAN REUSEN as of 0217<br>vp, medical group | 37 5<br>0 0 | | | | X | | | 162,641 | 0 | 27,273 |
| KEVIN SHIPPY<br>Chief Innovation Officer | 37 5<br>0 0 | | | | X | | | 152,115 | 0 | 0 |
| JAVIER ANDRADE MD<br>PHYSICIAN | 37 5<br>0 0 | | | | | X | | 521,533 | 0 | 54,032 |
| DONALD MORRISH MD<br>PHYSICIAN | 37 5<br>0 0 | | | | | X | | 482,438 | 0 | 70,392 |
| NEYSA VALENTIN MD<br>PHYSICIAN | 37 5<br>0 0 | | | | | X | | 474,163 | 0 | 47,431 |
| JACKIE BATTISTA MD<br>PHYSICIAN | 37 5<br>0 0 | | | | | X | | 498,278 | 0 | 24,498 |

**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 | | | |
| SHELDON GENACK<br>physician | 37 5<br>0 0 | | | | | X | | 384,944 | 0 | 78,942 |

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# SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

## Public Charity Status and Public Support

**Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.**

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
Episcopal Health Services Inc

**Employer identification number**
11-1665825

**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 331/3% 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 331/3% 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? Yes | (iv) No | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| **Total** | | | | | | |

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

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 **Total.** Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 **Public support.** Subtract line 5 from line 4 | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a)2013 | (b)2014 | (c)2015 | (d)2016 | (e)2017 | (f)Total |
|---|---|---|---|---|---|---|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI ) | | | | | | |
| 11 **Total support.** Add lines 7 through 10 | | | | | | |

12 Gross receipts from related activities, etc (see instructions) **12**

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

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

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2016 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test—2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test—2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

**Part III** **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 **Total.** Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 **Public support.** (Subtract line 7c from line 6 ) | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2013 | (b) 2014 | (c) 2015 | (d) 2016 | (e) 2017 | (f) Total |
|---|---|---|---|---|---|---|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI ) | | | | | | |
| 13 **Total support.** (Add lines 9, 10c, 11, and 12 ) | | | | | | |

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

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

| | | |
|---|---|---|
| 15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2016 Schedule A, Part III, line 15 | 16 | |

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

| | | |
|---|---|---|
| 17 Investment income percentage for **2017** (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from **2016** Schedule A, Part III, line 17 | 18 | |

19a **33 1/3% support tests—2017.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests—2016.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

## Part IV Supporting Organizations

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

### Section A. All Supporting Organizations

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *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* | 1 | | |
| 2 | Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization* | 2 | | |

**Section C. Type II Supporting Organizations**

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

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

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

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

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**

- a ☐ The organization satisfied the Activities Test Complete **line 2** below
- b ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- c ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

| | | | Yes | No |
|---|---|---|---|---|
| 2 | Activities Test **Answer (a) and (b) below.** | | | |
| a | Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *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* | 2a | | |
| 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? *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* | 2b | | |
| 3 | Parent of Supported Organizations **Answer (a) and (b) below.** | | | |
| a | Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.*** | 3a | | |
| b | Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard* | 3b | | |

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

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

| | **Section A - Adjusted Net Income** | | (A) Prior Year | (B) Current Year (optional) |
|---|---|---|---|---|
| 1 | Net short-term capital gain | 1 | | |
| 2 | Recoveries of prior-year distributions | 2 | | |
| 3 | Other gross income (see instructions) | 3 | | |
| 4 | Add lines 1 through 3 | 4 | | |
| 5 | Depreciation and depletion | 5 | | |
| 6 | Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | | |
| 7 | Other expenses (see instructions) | 7 | | |
| 8 | **Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4) | 8 | | |

| | **Section B - Minimum Asset Amount** | | (A) Prior Year | (B) Current Year (optional) |
|---|---|---|---|---|
| 1 | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year) | 1 | | |
| a | Average monthly value of securities | 1a | | |
| b | Average monthly cash balances | 1b | | |
| c | Fair market value of other non-exempt-use assets | 1c | | |
| d | **Total** (add lines 1a, 1b, and 1c) | 1d | | |
| e | **Discount** claimed for blockage or other factors (explain in detail in Part VI) | | | |
| 2 | Acquisition indebtedness applicable to non-exempt use assets | 2 | | |
| 3 | Subtract line 2 from line 1d | 3 | | |
| 4 | Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | | |
| 6 | Multiply line 5 by 035 | 6 | | |
| 7 | Recoveries of prior-year distributions | 7 | | |
| 8 | **Minimum Asset Amount** (add line 7 to line 6) | 8 | | |

| | **Section C - Distributable Amount** | | | Current Year |
|---|---|---|---|---|
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | | |
| 2 | Enter 85% of line 1 | 2 | | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | | |
| 4 | Enter greater of line 2 or line 3 | 4 | | |
| 5 | Income tax imposed in prior year | 5 | | |
| 6 | **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | | |

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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

| **Section D - Distributions** | **Current Year** |
|---|---|
| **1** Amounts paid to supported organizations to accomplish exempt purposes | |
| **2** Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| **3** Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| **4** Amounts paid to acquire exempt-use assets | |
| **5** Qualified set-aside amounts (prior IRS approval required) | |
| **6** Other distributions (describe in **Part VI**) See instructions | |
| **7** **Total annual distributions.** Add lines 1 through 6 | |
| **8** Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**) See instructions | |
| **9** Distributable amount for 2017 from Section C, line 6 | |
| **10** Line 8 amount divided by Line 9 amount | |

| **Section E - Distribution Allocations (see instructions)** | **(i) Excess Distributions** | **(ii) Underdistributions Pre-2017** | **(iii) Distributable Amount for 2017** |
|---|---|---|---|
| **1** Distributable amount for 2017 from Section C, line 6 | | | |
| **2** Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions | | | |
| **3** Excess distributions carryover, if any, to 2017 | | | |
| **a** | | | |
| **b** From 2013. . . . . | | | |
| **c** From 2014. . . . . | | | |
| **d** From 2015. . . . . | | | |
| **e** From 2016. . . . . | | | |
| **f** **Total** of lines 3a through e | | | |
| **g** Applied to underdistributions of prior years | | | |
| **h** Applied to 2017 distributable amount | | | |
| **i** Carryover from 2012 not applied (see instructions) | | | |
| **j** Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| **4** Distributions for 2017 from Section D, line 7 $ | | | |
| **a** Applied to underdistributions of prior years | | | |
| **b** Applied to 2017 distributable amount | | | |
| **c** Remainder Subtract lines 4a and 4b from 4 | | | |
| **5** Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions | | | |
| **6** Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions | | | |
| **7** **Excess distributions carryover to 2018.** Add lines 3j and 4c | | | |
| **8** Breakdown of line 7 | | | |
| **a** Excess from 2013. . . . . | | | |
| **b** Excess from 2014. . . . . | | | |
| **c** Excess from 2015. . . . . | | | |
| **d** Excess from 2016. . . . . | | | |
| **e** Excess from 2017. . . . . | | | |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-1665825

**Name:** Episcopal Health Services Inc



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

| Facts And Circumstances Test |
| --- |
| |

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

Department of the Treasury
Internal Revenue Service

# Political Campaign and Lobbying Activities

**For Organizations Exempt From Income Tax Under section 501(c) and section 527**

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** ***www.irs.gov/form990*****.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

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

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

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

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

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

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

| Name of the organization | Employer identification number |
|---|---|
| Episcopal Health Services Inc | 11-1665825 |

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

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

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

**A** Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

**B** Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | (a) Filing organization's totals | (b) Affiliated group totals |
|---|---|---|
| **1a** Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| **b** Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| **c** Total lobbying expenditures (add lines 1a and 1b) | | |
| **d** Other exempt purpose expenditures | | |
| **e** Total exempt purpose expenditures (add lines 1c and 1d) | | |
| **f** Lobbying nontaxable amount Enter the amount from the following table in both columns | | |
| **g** Grassroots nontaxable amount (enter 25% of line 1f) | | |
| **h** Subtract line 1g from line 1a If zero or less, enter -0- | | |
| **i** Subtract line 1f from line 1c If zero or less, enter -0- | | |

| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: |
|---|---|
| Not over $500,000 | 20% of the amount on line 1e |
| Over $500,000 but not over $1,000,000 | $100,000 plus 15% of the excess over $500,000 |
| Over $1,000,000 but not over $1,500,000 | $175,000 plus 10% of the excess over $1,000,000 |
| Over $1,500,000 but not over $17,000,000 | $225,000 plus 5% of the excess over $1,500,000 |
| Over $17,000,000 | $1,000,000 |

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

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

| Calendar year (or fiscal year beginning in) | (a) 2014 | (b) 2015 | (c) 2016 | (d) 2017 | (e) Total |
|---|---|---|---|---|---|
| **2a** Lobbying nontaxable amount | | | | | |
| **b** Lobbying ceiling amount (150% of line 2a, column(e)) | | | | | |
| **c** Total lobbying expenditures | | | | | |
| **d** Grassroots nontaxable amount | | | | | |
| **e** Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| **f** Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity* | | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|---|
| 1 | 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 | | | |
| a | Volunteers? | | No | |
| b | Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | No | |
| c | Media advertisements? | | No | |
| d | Mailings to members, legislators, or the public? | | No | |
| e | Publications, or published or broadcast statements? | | No | |
| f | Grants to other organizations for lobbying purposes? | | No | |
| g | Direct contact with legislators, their staffs, government officials, or a legislative body? | | No | |
| h | Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | No | |
| i | Other activities? | Yes | | 27,845 |
| j | Total Add lines 1c through 1i | | | 27,845 |
| 2a | Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | No | |
| b | If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| c | If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| d | If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | No | |

**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 |
|---|---|---|---|---|
| 1 | Were substantially all (90% or more) dues received nondeductible by members? | 1 | | |
| 2 | Did the organization make only in-house lobbying expenditures of $2,000 or less? | 2 | | |
| 3 | Did the organization agree to carry over lobbying and political expenditures from the prior year? | 3 | | |

**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."**

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

**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 |
|---|---|
| SCHEDULE C SUPPLEMENTAL INFO | Episcopal Health Services Inc pays dues to The Healthcare Association of New York State (HANYS),The Greater New York Hospital Association (GNYHA) and Healthcare Education Projects(HEP) In accordance with section 6033 (e) of the Internal Revenue Code, and as reported by HANYS, GNYHA and HEP, a portion of these dues payments are attributable to lobbying activities The lobbying activity costs attributable in 2017 to HANYS, GNYHA and HEP annual dues payments was $11,091, $15,970 and $784 respectively |

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**SCHEDULE D** (Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
Episcopal Health Services Inc

**Employer identification number**
11-1665825

## Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

| | | Held at the End of the Year |
|---|---|---|
| a | Total number of conservation easements | 2a |
| b | Total acreage restricted by conservation easements | 2b |
| c | Number of conservation easements on a certified historic structure included in (a) | 2c |
| d | Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2d |

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

4 Number of states where property subject to conservation easement is located ▶ _____

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

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

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

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

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

## Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under 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 |
|---|---|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |

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

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

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|
| 1a Beginning of year balance | 996,341 | 996,341 | 1,408,181 | 1,408,181 | 1,408,181 |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | 24,464 | 21,443 | 34,265 | 26,583 | 91 |
| d Grants or scholarships | | | 446,105 | | |
| e Other expenditures for facilities and programs | 24,464 | 21,443 | | 26,583 | 91 |
| f Administrative expenses | | | | | |
| g End of year balance | 996,341 | 996,341 | 996,341 | 1,408,181 | 1,408,181 |

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

- a Board designated or quasi-endowment ▶ 0 %
- b Permanent endowment ▶ 100 000 %
- c Temporarily restricted endowment ▶ 0 %

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

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

| | Yes | No |
|---|---|---|
| (i) unrelated organizations | 3a(i) | No |
| (ii) related organizations | 3a(ii) | No |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |

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

## Part VI Land, Buildings, and Equipment.

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|---|---|---|---|---|
| 1a Land | | 929,366 | | 929,366 |
| b Buildings | | 53,878,569 | 39,501,106 | 14,377,463 |
| c Leasehold improvements | | 83,827 | 74,524 | 9,303 |
| d Equipment | | 113,456,183 | 100,926,357 | 12,529,826 |
| e Other | | 13,610,961 | 2,649,355 | 10,961,606 |
| **Total.** Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c) )* ▶ | | | | 38,807,564 |

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

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

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

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

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

| (a) Description | (b) Book value |
|---|---|
| (1) ASSETS WHOSE USE IS LIMITED | 14,102,070 |
| (2) DUE FROM THIRD-PARTY PAYORS | 1,807,003 |
| (3) HEALTHFIRST INVESTMENT | 11,454,281 |
| (4) INV IN & HLD BY CAPTIVE INS CO | 26,131,483 |
| (5) INSURANCE RECOVERABLE | 3,498,015 |
| (6) DUE FROM RELATED ORGANIZATIONS | 1,234,658 |
| (7) OTHER RECEIVABLES | 433,014 |
| (8) OTHER ASSETS | 638,478 |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 15 )* ▶ | 59,299,002 |

**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 THIRD PARTY PAYORS | 28,936,768 |
| OTHER LIABILITIES | 6,809,567 |
| PROFESSIONAL & SELF INSURED LIABILITIES | 23,945,339 |
| ACCRUED PENSION LIABILITY | 1,320,363 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col (B) line 25 )* ▶ | 61,012,037 |

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

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

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

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

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

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

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

## Part XIII Supplemental Information

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

| Return Reference | Explanation |
|---|---|
| See Additional Data Table | |
| | |
| | |
| | |
| | |
| | |
| | |

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

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

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 11-1665825
**Name:** Episcopal Health Services Inc

**Form 990, Schedule D, Part IX, - Other Assets**

| (a) Description | (b) Book value |
|---|---|
| ASSETS WHOSE USE IS LIMITED | 14,102,070 |
| DUE FROM THIRD-PARTY PAYORS | 1,807,003 |
| HEALTHFIRST INVESTMENT | 11,454,281 |
| INV IN & HLD BY CAPTIVE INS CO | 26,131,483 |
| INSURANCE RECOVERABLE | 3,498,015 |
| DUE FROM RELATED ORGANIZATIONS | 1,234,658 |
| OTHER RECEIVABLES | 433,014 |
| OTHER ASSETS | 638,478 |

**Supplemental Information**

| Return Reference | Explanation |
| --- | --- |
| PART V, LINE 4 - INTENDED USES OF ENDOWMENT FUND | Income from endowment funds are to be used to further support the mission of the Organization |

**Supplemental Information**

| Return Reference | Explanation |
|---|---|
| Part x, Line 2 - FIN 48 | EHS recognizes the effect of income tax positions only when the tax positions are more lik ely than not to be sustained Management has determined that EHS had no uncertain tax posi tions that would require financial statement recognition or disclosure EHS is no longer s ubject to examinations by the applicable taxing jurisdictions for periods prior to 2014 |

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

# Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Information about Schedule F (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
Episcopal Health Services Inc

**Employer identification number**
11-1665825

**Part I** **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☐ **Yes** ☐ **No**

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

3 Activites per Region (The following Part I, line 3 table can be duplicated if additional space is needed )

| | **(a)** Region | **(b)** Number of offices in the region | **(c)** Number of employees, agents, and independent contractors in region | **(d)** Activities conducted in region (by type) (e g , fundraising, program services, investments, grants to recipients located in the region) | **(e)** If activity listed in (d) is a program service, describe specific type of service(s) in region | **(f)** Total expenditures for and investments in region |
|---|---|---|---|---|---|---|
| (1) | Central America and the Caribbean | 0 | 0 | Investments | CAPTIVE INSURANCE CO | 26,131,483 |
| (2) | | | | | | |
| (3) | | | | | | |
| (4) | | | | | | |
| (5) | | | | | | |
| 3a | Sub-total | 0 | 0 | | | 26,131,483 |
| b | Total from continuation sheets to Part I | | | | | |
| c | **Totals** (add lines 3a and 3b) | 0 | 0 | | | 26,131,483 |

**Part II** **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

| 1 | (a) Name of organization | (b) IRS code section and EIN (if applicable) | (c) Region | (d) Purpose of grant | (e) Amount of cash grant | (f) Manner of cash disbursement | (g) Amount of non-cash assistance | (h) Description of non-cash assistance | (i) Method of valuation (book, FMV, appraisal, other) |
|---|---|---|---|---|---|---|---|---|---|
| (1) | | | | | | | | | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

3 Enter total number of other organizations or entities . . . . . ▶

**Part III** **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

| (a) Type of grant or assistance | (b) Region | (c) Number of recipients | (d) Amount of cash grant | (e) Manner of cash disbursement | (f) Amount of non-cash assistance | (g) Description of non-cash assistance | (h) Method of valuation (book, FMV, appraisal, other) |
|---|---|---|---|---|---|---|---|
| (1) | | | | | | | |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |
| (8) | | | | | | | |
| (9) | | | | | | | |
| (10) | | | | | | | |
| (11) | | | | | | | |
| (12) | | | | | | | |
| (13) | | | | | | | |
| (14) | | | | | | | |
| (15) | | | | | | | |
| (16) | | | | | | | |
| (17) | | | | | | | |
| (18) | | | | | | | |

## Part IV Foreign Forms

| | | | |
|---|---|---|---|
| 1 | Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes,"the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* | ☐ Yes | ☑ No |
| 2 | Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A, do not file with Form 990)* | ☐ Yes | ☑ No |
| 3 | Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)* | ☐ Yes | ☑ No |
| 4 | Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* | ☐ Yes | ☑ No |
| 5 | Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* | ☐ Yes | ☑ No |
| 6 | Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, do not file with Form 990)* | ☐ Yes | ☑ No |

## Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

| Return Reference | Explanation |
|---|---|
| SCHEDULE F, PART I, LINE 3, COLUMN F | THE HOSPITAL IS A PARTIAL OWNER OF CAPTIVE FOREIGN INSURANCE COMPANIES THE HOSPITAL'S INVESTMENTS IN THE FOREIGN INSURANCE COMPANIES ARE REPORTED AT FAIR MARKET VALUE OR COST |

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

# Hospitals

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

**Name of the organization**
Episcopal Health Services Inc

**Employer identification number**
11-1665825

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year | | | |
| | ☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care | 3a | Yes | |
| | ☑ 100% ☐ 150% ☐ 200% ☐ Other _____ % | | | |
| b | Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care | 3b | Yes | |
| | ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ % | | | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | | No |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care? | 5c | | |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| | Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H | | | |

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

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | | | 6,275,027 | 3,037,227 | 3,237,800 | 1 460 % |
| b Medicaid (from Worksheet 3, column a) | | | 128,611,723 | 94,635,148 | 33,976,575 | 15 370 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d **Total** Financial Assistance and Means-Tested Government Programs | | | 134,886,750 | 97,672,375 | 37,214,375 | 16 830 % |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 1,293,877 | 0 | 1,293,877 | 0 590 % |
| f Health professions education (from Worksheet 5) | | | 39,198,670 | 22,492,801 | 16,705,869 | 7 560 % |
| g Subsidized health services (from Worksheet 6) | | | 44,360,821 | 18,724,629 | 25,739,554 | 11 640 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j **Total.** Other Benefits | | | 84,853,368 | 41,217,430 | 43,739,300 | 19 790 % |
| k **Total.** Add lines 7d and 7j | | | 219,740,118 | 138,889,805 | 80,953,675 | 36 620 % |

## Part II Community Building Activities

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | | | 147,979 | | 147,979 | 0 070 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | 156,767 | | 156,767 | 0 070 % |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | 165,098 | | 165,098 | 0 070 % |
| 9 Other | | | | | | |
| 10 Total | | | 469,844 | | 469,844 | 0 210 % |

## 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 Heathcare Financial Management Association Statement No 15? | | 1 | Yes | |
| 2 | Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount | 2 | 3,343,321 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 | 491,919 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements | | | | |

### Section B. Medicare

| | | | | | |
|---|---|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 49,599,806 | | |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 44,379,746 | | |
| 7 | Subtract line 6 from line 5 This is the surplus (or shortfall) | 7 | 5,220,060 | | |
| 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 | | | | |

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

### Section C. Collection Practices

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

## Part IV Management Companies and Joint Ventures

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

| | (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|---|---|---|---|
| 1 | | | | | |
| 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 | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
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| | | | | | | | | | | | |
| | | | | | | | | | | | |

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

**Section B. Facility Policies and Practices**

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

**Name of hospital facility or letter of facility reporting group** St Johns Episcopal Hospital

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

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

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

**Financial Assistance Policy (FAP)**

St Johns Episcopal 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 | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | Yes | |
| | If "Yes," indicate the eligibility criteria explained in the FAP | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 100 % and FPG family income limit for eligibility for discounted care of 400 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☐ Asset level | | | |
| d | ☑ Medical indigency | | | |
| e | ☑ Insurance status | | | |
| f | ☑ Underinsurance discount | | | |
| g | ☑ Residency | | | |
| h | ☐ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? | 15 | Yes | |
| | 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) | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | | |
| d | ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | | |
| a | ☑ The FAP was widely available on a website (list url) see Part V Section C | | | |
| b | ☑ The FAP application form was widely available on a website (list url) see Part V Section C | | | |
| c | ☑ A plain language summary of the FAP was widely available on a website (list url) see Part V Section C | | | |
| d | ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g | ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | | |
| h | ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations | | | |
| j | ☐ Other (describe in Section C) | | | |

## Part V Facility Information *(continued)*

### Billing and Collections

St Johns Episcopal Hospital

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

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

### Policy Relating to Emergency Medical Care

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

## Part V Facility Information *(continued)*

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

St Johns Episcopal Hospital

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

| | | Yes | No |
|---|---|---|---|
| **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? . . . . . **23** | | No |
| | 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? . . . . . **24** | | No |
| | If "Yes," explain in Section C | | |

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

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

| Form and Line Reference | Explanation |
|---|---|
| See Add'l Data | |
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**Part V** **Facility Information** *(continued)*

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility** (list in order of size, from largest to smallest)

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

| 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 - EXPLANATION OF COSTING METHODOLOGY | ST JOHN'S EPISCOPAL HOSPITAL COSTING METHODOLOGY WAS BASED UPON THE 2017 NEW YORK STATE INSTITUTIONAL COST REPORT AND THE 2017 MEDICARE (FORM 2552) COST REPORT THESE COST REPORTS ARE FILED WITH THE NEW YORK STATE DEPARTMENT OF HEALTH AND THE APPLICABLE CMS INTERMEDIARY, RESPECTIVELY THE COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGE, WAS USED FOR THE VARIOUS SUB-LINE ITEMS OF LINE #7 |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 2 - BAD DEBT EXPENSE | THE AMOUNT REPORTED ON LINE 2 IS EQUAL TO THE PROVISION FOR BAD DEBTS SHOWN IN THE AUDITED FINANCIAL STATEMENTS ("AFS") THE EXPLANATION OF THE METHODOLOGY USED TO ESTIMATE IS EXCERPTED BELOW ACCOUNTS RECEIVABLE ARE ALSO REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE CORPORATION ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE CORPORATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY) FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL, THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE THE DIFFERENCE BETWEEN DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 3 - BAD DEBT EXPENSE | ST JOHN'S HOSPITAL UTILIZES THE ESTIMATED PERCENTAGE OF PATIENTS LIVING AT OR BELOW THE FEDERAL POVERTY LEVEL 20 4% AND THE SELF PAY PERCENTAGE 72 1319% TO ARRIVE AT THE AMOUNT OF BAD DEBT THAT IS POTENTIALLY ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY |

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 5 - MEDICARE REVENUE | INCLUDED IN THE CALCULATION OF THE MEDICARE REVENUE OF $49,599,806 IS $7,339,950 OF DISPROPORTIONATE SHARE (DSH) PAYMENTS AND $9,485,524 OF INDIRECT MEDICAL EDUCATION (IME) PAYMENTS WHICH TOTAL $16,825,474 RESULTING IN TRUE PATIENT SERVICE REVENUE OF $32,774,332 |

## 990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
| --- | --- |
| PART III, LINE 5 & 6 - MEDICARE REVENUE | PURSUANT TO THE INSTRUCTIONS INCLUDED IN MEDICARE REVENUE RECEIVED ON PART III SECTION B LINE 5 IS REIMBURSEMENT FOR INDIRECT MEDICAL EDUCATION (IME) OF $9 5 MILLION THERE ARE $0 COST INCLUDED IN PART III LINE 6 MEDICARE ALLOWABLE COST RELATED TO IME |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 7 - MEDICARE SURPLUS/SHORTFALL | THE MEDICARE SURPLUS SHOWN OF $5,220,060 INCLUDES THE ADDITIONAL ITEMS OF MEDICARE REVENUE DETAILED IN THE EXPLANATION FOR LINE 5 ABOVE WITHOUT INCLUSION OF ADDITIONAL COSTS RELATED TO THEM HAD THESE AMOUNTS NOT BEEN RECEIVED THE OPERATING MEDICARE SHORTFALL WOULD HAVE BEEN $11,605,414 LOSSES ON TREATING MEDICARE BENEFICIARIES SHOULD BE INCLUDED AS A COMMUNITY BENEFIT IN THEIR ENTIRETY ST JOHN'S EPISCOPAL HOSPITAL INCURRED THIS OPERATING MEDICARE LOSS OF $11 6 MILLION TO DELIVER CARE TO MEDICARE PATIENTS THIS REPRESENTS THE AMOUNT BY WHICH COSTS TO DELIVER CARE TO MEDICARE RECIPIENTS EXCEEDS THE LEVEL OF PAYMENT ST JOHN'S EPISCOPAL HOSPITAL 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 TO OBTAIN 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 LIKE ALL PATIENTS THOSE ON MEDICARE, THE MAJORITY OF WHOM ARE ELDERLY OR DISABLED, ARE NOT TURNED AWAY, SO ST JOHN'S EPISCOPAL HOSPITAL 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 8 - COSTING METHODOLOGY | THE MEDICARE REVENUE AND ALLOWABLE COSTS SHOWN IN PART III SECTION B LINES 5 AND 6, RESPECTIVELY, WERE DERIVED FROM THE AS-FILED 2017 CMS-2552 (MEDICARE COST REPORT) MEDICARE REVENUE IS BASED ON THE MEDICARE PROVIDER STATISTICAL AND REIMBURSEMENT REPORT AND MEDICARE COSTS WERE DEVELOPED UTILIZING A RATIO OF MEDICARE ALLOWABLE COSTS TO CHARGES METHODOLOGY |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART III, LINE 9B - COLLECTION PRACTICES TO BE FOLLOWED RELATIVE TO | PATIENTS THAT QUALIFY FOR THE CHARITY CARE AND FINANCIAL ASSISTANCE POLICIES OF ST JOHN'S EPISCOPAL HOSPITAL (WHICH ARE FURTHER SUMMARIZED IN SCHEDULE H PART VI LINE 3) ENSURE THAT EVERY EFFORT IS MADE TO IDENTIFY PATIENTS THAT ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AND/OR CHARITY CARE INCLUDED BELOW IS A SUMMARY OF THE BILLING AND COLLECTION PROCEDURES FOLLOWED BY ST JOHN'S EPISCOPAL HOSPITAL - THE FORCED SALE OF OR FORECLOSURE ON THE PATIENT'S PRIMARY RESIDENCE IS PROHIBITED - SENDING AN ACCOUNT TO COLLECTION IF THE PATIENT HAS SUBMITTED A COMPLETED APPLICATION FOR FINANCIAL ASSISTANCE, INCLUDING ANY REQUIRED DOCUMENTATION, WHILE THE APPLICATION IS PENDING IS PROHIBITED - PROVIDE WRITTEN NOTIFICATION TO A PATIENT AT LEAST 30 DAYS BEFORE AN ACCOUNT IS SENT TO COLLECTION (WRITTEN NOTICE CAN BE INCLUDED ON A BILL) - REQUIRE THE COLLECTION AGENCY TO HAVE THE HOSPITAL'S WRITTEN CONSENT PRIOR TO STARTING A LEGAL ACTION FOR COLLECTION - REQUIRE ALL HOSPITAL STAFF THAT INTERACTS WITH PATIENTS OR HAVE RESPONSIBILITY FOR BILLING AND COLLECTION TO BE TRAINED IN THE HOSPITAL'S POLICIES - HAVE A WAY OF MEASURING THE HOSPITAL'S COMPLIANCE WITH ITS POLICIES - REQUIRE ANY COLLECTION AGENCY UNDER CONTRACT WITH THE HOSPITAL TO FOLLOW THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY AND PROVIDE INFORMATION TO PATIENTS ON HOW TO APPLY, WHERE APPROPRIATE - PROHIBIT COLLECTION ACTIVITY IF THE PATIENT IS DETERMINED ELIGIBLE FOR MEDICAID FOR THE SERVICES THAT WERE RENDERED AND THE HOSPITAL IS ABLE TO COLLECT MEDICAID PAYMENT |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 2 - NEEDS ASSESSMENT | ST JOHN'S EPISCOPAL HOSPITAL (THE "HOSPITAL"ST JOHN'S") IS A 257 LICENSED BED ACUTE CARE HOSPITAL LOCATED IN FAR ROCKAWAY, NEW YORK ST JOHN'S MEDICAL, P C (FORMERLY ST JOHN'S EMERGENCY SERVICES PC), ST JOHN'S MEDICAL SERVICES PC, FORM THE PATIENT CARE SERVICES OF EPISCOPAL HEALTH SERVICES, INC , FALL UNDER THE AUSPICES OF THE EPISCOPAL DIOCESE OF LONG ISLAND THIS DISCUSSION RELATES TO THE HOSPITAL ONLY AS REQUIRED IN FORM 990 SCHEDULE H AS THE RESULT OF SEVERAL MEETINGS WITH COMMUNITY GROUPS, A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR THE HOSPITAL COMMUNITY WAS DEVELOPED THE REPORT FULFILLS THE REQUIREMENTS OF THE NEW FEDERAL STATUTE ESTABLISHED WITHIN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) THE CHNA PROCESS UNDERTAKEN BY THE HOSPITAL UTILIZED EXTENSIVE INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY IN ADDITION, THIS DOCUMENT SATISFIES THE REQUIREMENTS SET FORTH BY THE NEW YORK STATE DEPARTMENT OF HEALTH (DOH) RELATIVE TO THE PREPARATION OF A COMMUNITY SERVICE PLAN (CSP) THE OVERLAPPING NATURE OF THESE REQUIREMENTS ENABLED THE HOSPITAL TO COMPLETE ONE COMPREHENSIVE DOCUMENT NEW YORK'S RELEVANT STATUTE, SECTION 2803-1 OF THE PUBLIC HEALTH LAW, REQUIRES VOLUNTARY NON-PROFIT HOSPITALS TO SUBMIT A COMPREHENSIVE CSP TO THE STATE DEPARTMENT OF HEALTH (DOH) THAT INCLUDES A SOLICITATION OF THE VIEWS OF THE COMMUNITIES SERVED BY THE HOSPITAL ON SERVICE PRIORITIES, DEMONSTRATES THE HOSPITAL'S OPERATIONAL AND FINANCIAL COMMITMENT TO MEET COMMUNITY HEALTH NEEDS, PROVISION OF CHARITY CARE, AND IMPROVING ACCESS BY THE UNDERSERVED, AMONG OTHER ELEMENTS IN SUBMITTING THEIR CSPS, HOSPITALS ARE REQUIRED TO TAKE STEPS THAT INCLUDE - REAFFIRMING ORGANIZATIONAL MISSION STATEMENTS, - DEFINING THE SERVICE AREA USED FOR COMMUNITY AND LOCAL HEALTH PLANNING AND DESCRIBING THE METHODS USED TO DETERMINE SUCH SERVICE AREA, - IDENTIFYING ALL PARTICIPANTS INVOLVED IN ASSESSING COMMUNITY HEALTH NEEDS AND DESCRIBING AND SUMMARIZING THE HOSPITAL'S PUBLIC INPUT SESSIONS, - DISCUSSING THE IDENTIFIED PUBLIC HEALTH PRIORITIES, INCLUDING THE CRITERIA USED TO SELECT PRIORITIES AND THE STATUS OF PRIORITIES, - ESTABLISHING AN EVOLVING PLAN OF ACTION, AND - DISSEMINATING A WRITTEN SUMMARY OF THE CSP TO THE PUBLIC THROUGH VARIOUS CHANNELS THE STATUTORY CSP REQUIREMENTS WERE RECENTLY ENHANCED BY DOH'S PREVENTION AGENDA INITIATIVE, A PROCESS THAT ASKS HOSPITALS TO WORK WITH LOCAL PUBLIC HEALTH DEPARTMENTS AND COMMUNITY PARTNERS TO ASSESS COMMUNITY HEALTH NEEDS, JOINTLY DEVELOP PLANS TO ADDRESS TWO OR THREE OF THE IDENTIFIED NEEDS, AND INCLUDE THIS COLLABORATIVE WORK IN THE HOSPITAL'S CSP UPDATE SUBMITTED TO DOH ST JOHN'S HAS INCORPORATED THE PREVENTION AGENDA INTO ITS COMMUNITY SERVICE PLAN TO ADVANCE THE GOALS OF THE NEW YORK STATE PREVENTION AGENDA 2013-2017 AND HEALTHY PEOPLE 2020 IN ITS SERVICE AREA, ST JOHN'S REACHED OUT AND PARTNERED WITH NUMEROUS COMMUNITY-BASED ORGANIZATIONS AND OTHER STAKEHOLDERS TO IDENTIFY COMMUNITY HEALTH NEEDS AND DEVELOP PLANS TO ADDRESS THESE NEEDS IN NOVEMBEROF 2015 A LETTER FROM THE NEW YORK STATE DEPARTMENT OF HEALTH COMMISSIONER HOWARD ZUCKER, WAS SENT TO ALL HOSPITALS REGARDING THE PREVENTION AGENDA GOALS? IN THE LETTER THE COMMISSIONER STATED THAT DUE TO MANY HOSPITALS COMPLETING A NEEDS ASSESSMENT AS PART OF THE DSRIP APPLICATION PROCESS, THE DEPARTMENT OF HEALTH IS NOT ASKING FOR A NEW COMPREHENSIVE HEALTH ASSESSMENT FOR 2016 IN LIGHT OF THIS COMMUNICATION, ST JOHN'S CONTINUES TO BE BUILD UPON THE AGENDA GOALS CURRENTLY SET |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE | ST JOHN'S HOSPITAL IS COMMITTED TO PROVIDING ACCESS TO QUALITY HEALTH CARE SERVICES WITH COMPASSION, DIGNITY AND RESPECT FOR ALL PATIENTS, PARTICULARLY THE POOR AND THE UNDERSERVED IN OUR COMMUNITY ACCORDINGLY, ST JOHN'S HOSPITAL HAS IMPLEMENTED A CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS TO HELP FACILITATE THE PROVISION OF MUCH NEEDED CARE THIS PROCESS INCLUDES - PROVIDING PATIENT CARE REGARDLESS OF THE ABILITY TO PAY FOR SERVICES, - ASSISTING PATIENTS WHO CANNOT PAY FOR PART OR ALL OF THE CARE THEY RECEIVE, - FINANCIAL COUNSELORS WILL CONFIDENTIALLY REVIEW THE SITUATION TO SEE IF PATIENTS QUALITY FOR SOME FORM OF GOVERNMENT OR OTHER FINANCIAL ASSISTANCE, - BALANCING NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH THE BROADER FISCAL RESPONSIBILITIES IN ORDER TO SUSTAIN VIABILITY AND PROVIDE THE QUALITY AND QUANTITY OF SERVICES RESIDENTS IN THE COMMUNITY NEED, AND - OFFER INSTALLMENT PLANS TO ALLOW PATIENTS TO PAY OVER TIME WITHOUT THE IMPOSITION OF INTEREST CHARGES |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
|---|---|
| PART VI, LINE 4 - COMMUNITY INFORMATION | THE ROCKAWAY PENINSULA IS A NARROW STRIP OF LAND BORDERED BY THE ATLANTIC OCEAN AND JAMAICA BAY AND IS A PART OF QUEENS COUNTY, NEW YORK CITY AND ALSO BORDERS NASSAU COUNTY ON LONG ISLAND SUPERSTORM SANDY HAD A DEVASTATING IMPACT ON THE ROCKAWAY PENINSULA MUCH OF THE COMMUNITY WAS WITHOUT GAS AND ELECTRIC FOR WEEKS FOLLOWING THE STORM HOMES AND BUSINESSES WERE IN RUIN, SOME CLAIMED BY THE SEA, OTHERS BY FIRE, ENTIRE BLOCKS IN BELLE HARBOR AND ROCKAWAY PARK WERE ENGULFED IN FLAMES, A CONSIDERABLE PORTION OF BREEZY POINT LITERALLY BURNED TO THE GROUND DEBRIS AND SAND WERE EVERYWHERE, INCLUDING THE INSIDE OF HOMES CARS THAT HAD BEEN FLOODED WERE SCATTERED THROUGHOUT THE STREETS OF THE COMMUNITY THE REBUILDING HAS BEEN EXTREMELY SLOW, AND IS AN ONGOING PROCESS, WITH MANY DISPLACED RESIDENTS HAVING STILL NOT RETURNED TO THEIR HOMES MANY NURSING HOMES AND ADULT HOMES - SOURCES OF ADMISSIONS TO THE HOSPITAL, AS WELL AS OTHER LOCAL BUSINESSES NEVER REOPENED TRANSPORTATION BETWEEN THE PENINSULA AND THE MAINLAND IS A LONG TIME COMMITMENT FOR RESIDENTS AS THE PENINSULA IS CONNECTED TO NEW YORK CITY BY TWO TOLL BRIDGES, THE MARINE PARK BRIDGE AND THE CROSS BAY BRIDGE, AND BY THE "A" SUBWAY LINE OF THE NEW YORK CITY METROPOLITAN TRANSIT AUTHORITY, WHICH WAS OUT OF COMMISSION UNTIL LATE SUMMER 2013 ST JOHN'S HAS SERVED THE COMMUNITY FOR MORE THAN 100 YEARS AS A NOT-FOR-PROFIT FAITH-BASED INSTITUTION THAT IS DEEPLY AWARE OF THE COMMUNITY'S GEOGRAPHIC ISOLATION AND VULNERABILITIES, IT IS DEEPLY COMMITTED TO CONTINUING TO SERVE THE COMMUNITY WELL INTO THE FUTURE IT IS ALSO COMMITTED TO IMPROVING THE HEALTH OF THE COMMUNITY AND CONTINUINGTO OFFER AND INCREASE A WIDE RANGE OF SERVICES, AS WELL AS COMMUNITY OUTREACH AND HEALTH EDUCATION WHILE COMMUNITY CAN BE DEFINED IN MANY WAYS, THE HOSPITAL DEFINED ITS SERVICE AREA AS THE 5 ZIP CODES FROM WHICH APPROXIMATELY 70% DISCHARGES CAME BY THIS DETERMINATION, THE HOSPITALS SERVICE AREA IS DEFINED AS, INWOOD, FAR ROCKAWAY, ARVERNE, ROCKAWAY BEACH, BELLE HARBOR IN 2016 THE ROCKAWAYS HAD A POPULATION TOTALING OVER 127,000 WITH ALMOST 30% OF THE SERVICE AREA'S POPULATION UNDER THE AGE OF 20, AND ALMOST 13% OVER THE AGE OF 65 MORE THAN 20% LIVE UNDER THE FEDERAL POVERTY LEVEL, WHILE THE OVERALL QUEENS COUNTY RATE IS JUST BELOW 14% THE PERCENTAGE OF THE SERVICE AREA POPULATION WHO ARE DEEMED TO BE MINORITIES IS 65 4%, WITH AFRICAN AMERICANS COMPRISING 38% OF THE POPULATION A LARGE POPULATION OF HISPANICS RESIDE IN INWOOD, WHICH IS THE MOST NORTHEAST BOUNDARY OF THE SERVICE AREA |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH | IN 2017, ST JOHNS HELD ITS FIRST COMMUNITY AND BACK TO SCHOOL WELLNESS FAIR IN WHICH OVER 2000 PEOPLE WERE IN ATTENDANCE THIS EVENT HAD OVER 50 COMMUNITY VENDORS DISSEMINATING HE ALTH AND WELLNESS INFORMATION AND 1000 BACK PACKS WERE GIVEN OUT TO THE CHIDLREN IN ATTEND ANCE IN ADDITION, PARTICIPATION IS GIVEN TO OTHER COMMUNITY HEALTH FAIRS AND EVENTS ACROS S THE PENINSULA IN WHICH ST JOHN'S MEDICAL STAFF AND RESIDENTS PROVIDE FREE BLOOD PRESSUR E SCREENINGS, EDUCATION ON PRIMARY CARE AND OTHER HEALTH AREAS BROCHURES WERE HANDED OUT O N A VARIETY OF TOPICS, INCLUDING DIABETES CARE, HYPERTENSION AND HEART HEALTH, OBESITY, PR EGNANCY,CHRONIC DECEASE MANAGEMENT BREASTFEEDING AND SMOKING PREVENTION ST JOHN'S CLINIC AL NUTRITION STAFF PROVIDED NUTRITIONAL INFORMATION ON VARIOUS TOPICS INCLUDING MY PLATE, HOW TO EAT HEALTHY, REDUCING SODIUM IN THE DIET, LOW CHOLESTEROL TIPS AND HOW TO MAKE MEA LS HEALTHIER MENTAL HEALTH AND SUBSTANCE ABUSE SCREENINGS ST JOHN'S COMMUNITY MENTAL HE ALTH CENTER SCREENED 350 PATIENTS AND 87 SCREENED POSITIVE FOR SUBSTANCE ABUSE EIGHTY THR EE OF THOSE PATIENTS WERE TREATED AT THE CMHC AND 5 WERE REFERRED TO A SPECIALIZED SUBSTAN CE ABUSE TREATMENT PROGRAM THE WELLNESS AND RECOVERY CENTER SCREENED 147 PATIENTS AND 66 SCREENED POSITIVE FOR SUBSTANCE USE TREATMENT WAS PROVIDED TO 64 OF THOSE PATIENTS AND 2 WERE REFERRED TO A SPECIALIZED SUBSTANCE ABUSE TREATMENT PROGRAM SURFSIDE MANOR CLINIC SC REENED 33 PATIENTS FOR SUBSTANCE ABUSE AND 3 SCREENED POSITIVE THEY WERE ALL TREATED BY T HAT CLINIC- NONE WERE REFERRED OUT FRC SCREENED 247 INDIVIDUALS FOR SUBSTANCE USE AND 7 S CREENED POSITIVE- BECAUSE THIS PROGRAM IS NOT CLINICAL, ALL INDIVIDUALS WERE REFERRED TO O UTSIDE PROVIDER HOMEBASED CRISIS INTERVENTION/ BLENDED CASE MANAGEMENT SCREENED 57 INDIVI DUALS AND 1 SCREENED POSITIVE AND WAS REFERRED TO AN OUTSIDE PROVIDER IN ADDIITON, THE OF FICE OF THE MISSION PARTICIPATED IN THE FOLLOWING 2017 CHARITABLE PROGRAMS HOSPITAL VOLUN TEER & INTERN PROGRAMS DESCRIPTION ST JOHN'S EPISCOPAL HOSPITAL WELCOMES PEOPLE WHO WANT TO GIVE OF THEIR TIME AND TALENTS IN 2017 NINETY-SIX (96) PEOPLE SERVED A TOTAL OF 12,84 1 HOURS IN THESE PROGRAMS VOLUNTEERS AND INTERNS ARE IMPORTANT MEMBERS OF OUR TEAM, LIKE STAFF, THEIR EFFORTS PROMOTE THE HEALTH OF THE COMMUNITY THE HOSPITAL VALUES VOLUNTEERS B ECAUSE THEY PROVIDE AN OPPORTUNITY FOR THE HOSPITAL TO GIVE BACK TO THE COMMUNITY BECAUSE THEY ARE MESSENGERS WITH FIRSTHAND EXPERIENCE OF HOSPITAL STAFF AND SERVICES THIS HOSPITA L, UNLIKE OTHER HOSPITALS IN THE REGION, CONSIDERS VOLUNTEERS TEAM MEMBERS THE HOSPITAL W ELCOMES AND UTILIZES VOLUNTEERS AND INTERNS IN NEARLY EVERY DEPARTMENT AND ON MANY COMMITT EES PEOPLE SEEKING VOLUNTEER SERVICE OPPORTUNITIES AT THIS HOSPITAL ARE RETIREES LOOKING FOR MEANINGFUL WAYS TO SHARE THEIR TALENTS AND KEEP ACTIVE, JUNIOR HIGH AND HIGH SCHOOL ST UDENTS SEEKING COMMUNITY SERVICE OPPORTUNITIES AND PEOPLE CONSIDERING CAREERS IN HEALTH CA RE THERE ARE THREE CLASSIFICATION OF VOLUNTEERS ADULT VOLUNTEERS, INTERNS, AND YOUTH VOL UNTEERS VOLUNTEERS ARE ASKED TO SERVE AT LEAST 100 HOURS A YEAR AND THEY SERVE IN DEPARTM ENTS THROUGHOUT THE HOSPITAL SUPPORTING THE WORK OF STAFF INTERNS ARE STUDENTS ENROLLED I N UNDERGRADUATE, GRADUATE AND PROFESSIONAL SCHOOLS CONTRACTED WITH THE HOSPITAL TO OFFER S TUDENTS HANDS ON LEARNING IN NURSING, HEALTH INFORMATION MANAGEMENT, ADMINISTRATION, SOCIA L WORK, OCCUPATIONAL AND PHYSICAL THERAPY, DIETARY, INFORMATION TECHNOLOGY AND OTHER SERVI CES THE HOSPITAL RECEIVES NO COMPENSATION OR EXPENSE REIMBURSEMENT FOR STAFF TIME, SPACE AND EQUIPMENT USE OR SUPPLIES USED BY VOLUNTEERS AND INTERNS THE HOSPITAL IS NOT REIMBURS ED FOR THE MEALS (BREAKFAST AND LUNCH) SERVICE TO VOLUNTEERS AND INTERNS OR THE FREE PARKI NG AVAILABLE TO VOLUNTEERS VOLUNTEERS AND INTERNS ENHANCE THE HOSPITAL'S MISSION AND RESO URCE STAFF WHILE BRINGING THE JOY TO PATIENTS AND PATIENT FAMILIES THESE PROGRAMS ARE VEH ICLES FOR THIS HOSPITAL TO FOSTER CAREERS IN HEALTH CARE AND HEALTH RELATED PROFESSIONS WH ILE IMPROVING EMPLOYMENT AND ECONOMIC OPPORTUNITIES IN FAR ROCKAWAY IN 2017 LADDER FOR LE ADERS ALONG WITH THE ROCKAWAY DEVELOPMENT AND REVITALIZATION CORPORATION (RDRC) SENT YOUTH ENROLLED IN THE NEW YORK SUMMER YOUTH EMPLOYMENT PROGRAM TO SERVE AT THE HOSPITAL RDRC W AS COMPENSATED FOR ITS MANAGEMENT OF THIS PROGRAM, BUT THE HOSPITAL WAS NOT THE HOSPITAL WELCOMED THE YOUTH IN THIS PROGRAM AS PART OF ITS COMMITMENT TO THE COMMUNITY IN ORDER TO ENSURE THE SUCCESS OF THESE YOUTH (WHO ARE GROWING UP IN HOUSEHOLDS WITH ADULTS WITH LIMI TED EDUCATION AND PROFESSIONAL EXPERIENCE) THE HOSPITAL PROVIDED TRAINING IN CUSTOMER SERV ICE AND JOB READINESS ALONG WITH BI-WEEKLY HUDDLES TO HELP THE YOUTH PROCESS EXPERIENCES THE EXPENSES INCURRED BY THE HOSPITAL FOR VOLUNTEER AND INTERN PROGRAMS ARE CAPTURED IN TH E DEPARTMENT EXPENSES HOSPITAL AUXILIARY THIS GROUP OF 60 PEOPLE MEET 12 TO 14 TIMES A YE AR (FOR GENERAL MEMBERSHIP AND WORKING GROUP SESSI |

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH | ONS) THEY IDENTIFY, PLAN AND IMPLEMENT INITIATIVES FOR PATIENTS AND PATIENT HOUSEHOLDS WH OSE SOCIAL LOCATIONS UNDERMINE COMPLIANCE WITH THE CARE PLANS ESTABLISHED BY SJEH PROVIDER S THE MATERIALS DISTRIBUTED TO SJEH PATIENTS AND PATIENT HOUSEHOLDS ARE EITHER PURCHASED BY AUXILIANS OR COME FROM DONORS SOLICITED BY AUXILIANS THE AUXILIARY AIM IS TO IMPROVE T HE QUALITY OF LIFE FOR PATIENTS AND THEIR FAMILIES AS A MEANS OF IMPROVING CARE PLAN COMPL IANCE, AND, THEREBY, THE HEALTH STATUS OF PATIENTS AND COMMUNITY MEMBERS GENERAL MEMBERSH IP MEETINGS RUN ABOUT 2 HOURS AND INCLUDE A MEAL, UPDATES FROM HOSPITAL ADMINISTRATION, RE PORTS FROM WORKING GROUPS AND PRESENTATIONS/DISCUSSIONS ABOUT POTENTIAL INITIATIVES WORKI NG GROUP SESSIONS RUN ABOUT 3 HOURS AND TAKE PLACE OFF-SITE AT THE MERCER SCHOOL OF THEOLO GY IN GARDEN CITY, ORGANIZATIONS IN FAR ROCKAWAY OR CONGREGATIONS IN THE EPISCOPAL DIOCESE OF LONG ISLAND THE LOGISTICS WORKING GROUP MEETS AT THE HOSPITAL TO INVENTORY AND STORE OR PACK BABY BAGS, BOOK BAGS AND BOOK BOXES AUXILIARY MEMBERS ARE RESIDENTS OF THE COMMUN ITIES SERVED BY THE HOSPITAL (FAR ROCKAWAY, THE FIVE TOWNS AND LONG BEACH), ACTIVE AND RET IRED EMPLOYEES AND COMMUNICANTS IN THE EPISCOPAL DIOCESE OF LONG ISLAND THEY ARE YOUNG AN D OLD, MALE AND FEMALE FROM A SIDE VARIETY OF RACIAL ETHNIC GROUPS FOLLOWING IS A LIST OF THE INITIATIVES MANAGED BY THE AUXILIARY IN 2017 BABY BAGS, FIRST BABY OF THE NEW YEAR, BACK TO SCHOOL, BOOKS, ADOPT-A-FAMILY, AND CHILDREN'S HOLIDAY PARTY AUXILIARY BABY BAGS I NITIATIVE DESCRIPTION EACH MOTHER WHO DELIVERS A BABY AT THE HOSPITAL RECEIVES A BABY BAG THE BAGS ARE FILLED WITH HANDMADE BABY ITEMS (HATS, BOOTIES, SWEATERS OR BLANKETS), TOIL ETRIES, DIAPERS, WIPES, LINENS AND CLOTHING THE HOSPITAL AUXILIARY MEMBERS SOLICIT DONATI ON OF NEW ITEMS FOR THE BAGS THE OFFICE FOR THE VP OF MISSION SENDS LETTERS, FLIERS AND V ISITS DONORS AND THE ORGANIZATIONS THEY ARE AFFILIATED WITH TO SOLICIT DONATIONS AND THANK DONORS THE SJEH STAFF PICKS-UP DONATIONS THAT CANNOT BE DELIVERED THE PATIENT ADVOCATES SORT THE DONATIONS AND PACKS AND LABELS THE BABY BAGS THE MATERIALS MANAGEMENT STAFF KEE PS THE POSTPARTUM NURSING UNIT STOCKED WITH BAGS THE POSTPARTUM NURSING UNIT PURCHASE THE BAGS AND PATIENTS RECEIVE THEIR BAGS FROM NURSING STAFF ON THE DAY OF DISCHARGE WHEN NUR SING OR MEDICAL STAFF IDENTIFY NEEDS FOR MORE DURABLE ITEMS, CRIB, TUB, DIAPER PAIL, MONIT OR, ETC THE AUXILIANS FIND DONORS OR SUPPLY THE FUNDS NEEDED TO PURCHASE FIRST BABY/BABI ES OF THE NEW YEAR DESCRIPTION THE HOSPITAL RECOGNIZES AND CELEBRATES THE MOTHER WHO GIVE S BIRTH TO THE FIRST BABY OF THE NEW YEAR WITH THE MOTHER'S CONSENT, THE HOSPITAL FEATURE S HER, HER BABY AND FAMILY IN THE HOSPITAL'S NEWS VEHICLES SHE RECEIVES AN ASSORTMENT OF GIFTS BABY MONITOR, BABY CLOTHING, FIRST AID KIT, DIAPER PAIL, HANDMADE ITEMS AND MORE A MEMBER OF THE EXECUTIVE STAFF CONGRATULATES HER, PRESENTS HER WITH THE GIFTS AND, ALONG W ITH KEY STAFF FROM THE UNIT AND HER BABY, POSES FOR PICTURES THE HOSPITAL AUXILIARY MEMBE RS AND THE CONGREGATIONS THEY ARE AFFILIATED WITH DONATE THE GIFTS, NURSING STAFF ON THE P OSTPARTUM UNIT WRAP THE GIFTS, A MEMBER OF THE COMMUNICATIONS OFFICE TAKES PICTURES AND CR AFTS NEWS ARTICLES AND PRESS RELEASES SCHOOL BACK-PACKS THE PEDIATRIC OFFICE, THE FAMILY RESOURCE CENTER AND COMMUNITY MENTAL HEALTH PROGRAM DISTRIBUTED 200 BACK-PACKS FILLED WITH SCHOOL SUPPLIES TO THEIR PATIENTS/CLIENTS EACH FALL THE HOSPITAL AUXILIARY MEMBERS AND T HE CONGREGATIONS THEY ARE AFFILIATED WITH DONATED COMPOSITION NOTEBOOKS, THREE RING BINDER S, PENS, PENCILS, CRAYONS, MARKERS, RULERS, PROTRACTORS, POST-IT NOTES, TAPE, GLUE, MEMORY STICKS AND MORE AUXILIANS GAVE FILLED BACKPACKS TO THE PEDIATRICS OFFICE, THE COMMUNITY MENTAL HEALTH PROGRAM AND FAMILY RESOURCE CENTER CHILDREN'S BOOKS CHILDREN WHO ARE PATIEN TS OF THE PEDIATRIC OFFICE OR CLIENTS OF FAMILY RESOURCE CENTER ARE GIVEN BOOKS THIS IS D ONE TO ENCOURAGE PARENTS TO READ TO THEI |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM ROLES AND PROMOTION | NOT APPLICABLE |

**990 Schedule H, Supplemental Information**

| Form and Line Reference | Explanation |
| --- | --- |
| PART VI, LINE 7 -STATES WHERE COMMUNITY BENEFIT REPORT IS FILED | NEW YORK |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-1665825

**Name:** Episcopal Health Services Inc

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

| **Section A. Hospital Facilities**<br><br>(list in order of size from largest to smallest—see instructions)<br>How many hospital facilities did the organization operate during the tax year?<br>**1**<br><br>Name, address, primary website address, and state license number | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | **Other (Describe)** | **Facility reporting group** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | St John's Episcopal Hospital<br>327 Beach 19th Street<br>Far Rockaway, NY 11691 | X | 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|---|---|
| Schedule H, Part V SEC B, Line 5 | PUBLIC PARTICIPATION TO ADVANCE THE GOALS OF THE NEW YORK STATE PREVENTION AGENDA 2013-2017 AND HEALTHY PEOPLE 2020 IN ITS SERVICE AREA, ST JOHN'S EPISCOPAL HOSPITAL REACHED OUT AND PARTNERED WITH NUMEROUS COMMUNITY-BASED ORGANIZATIONS AND OTHER STAKEHOLDERS TO CONTINUE TO DEVELOP PLANS TO ADDRESS THESE NEEDS THE PARTICIPATING ORGANIZATIONS INCLUDED -ST JOHN'S EPISCOPAL HOSPITAL COMMUNITY ADVISORY COMMITTEE -JOSEPH P ADDABBO FAMILY HEALTH CENTER -NAACP OF ROCKAWAY -ROCKAWAY BEACH CHANNEL LONG TERM RECOVERY -ROCKAWAY UNITED -COMMUNITY BOARD 14 -DEERFIELD AREA CIVIC ASSOCIATION -ROCKAWAY DEVELOPMENT AND REVITALIZATION CORP -VISITING NURSE SERVICE OF NEW YORK -COALITION FOR CONCERNED MEDICAL PROFESSIONALS -QUEENS PUBLIC LIBRARY -LUCILLE ROSE DAY CARE -ROCKAWAY BEACH CIVIC ASSOCIATION -INWOOD CIVIC ASSOCIATION -BELLE HARBOR CIVIC ASSOCIATION -BLACK NURSES ROCK -QUEENS HIGH SCHOOL FOR INFOMRATION RESEARCH AND TECHNOLOGY -FAR ROCKAWAY ARVERNE NON PROFIT COALITION -NYC DEPARTMENT OF YOUTH DEVELOPMENT -PS 104Q -ROCKAWAY WALKS -ROCKAWAY YOUTH TASK FORCE -FIRST PRESBYTERIAN CHURCH -REDFERN COMMUNITY CENTER -NYS SENATOR JOSEPH ADDABBO JR -NYS SENATOR JAMES SANDERS JR -NYS ASSEMBLYWOMAN MICHELE TITUS -NYC COUNCILMAN DONOVAN RICHARDS JR -NYC QUEENS BOROUGH PRESIDENT MELINDA KATZ -FRIENDS OF THE 59TH STREET PLAYGROUND -HATZALAH COMMUNITY MEETINGS SAMPLING PUBLIC OPINION EIGHT INITIAL COMMUNITY MEETINGS WERE HELD TO GATHER INPUT FROM THE PUBLIC ON THE HEALTH CONCERNS OF THE COMMUNITY THE MEETINGS WERE HELD ON -JANUARY 11, 2017 AT 7PM AT ST JOHNS EPISCOPAL HOSPITAL 25 ATTENDEES -FEBRUARY 17, 2017 AT 7PM AT ST JOHNS EPISCOPAL HOSPITAL 30 ATTENDEES -APRIL 26, 2017 AT 7PN AT ST JOHNS EPISCOPAL HOSPITAL 14 ATTENDEES -MAY 18, 2017 AT 6PM AT NAACP FAR ROCKAWAY CHAPTER 15 ATTENDEES -JULY 12, 2017 AT 7PM AT ST JOHNS EPISCOPAL HOSPITAL 22 ATTENDEES -OCTOBER 18, 2017 AT 7PM AT ST JOHNS EPISCOPAL HOSPITAL 20 ATTENDEES THE MEETINGS WERE PUBLICIZED THROUGH A COMMUNITY EMAIL BLAST, SOCIAL MEDIA, AND ST JOHN'S WEBSITE DISCUSSION AT THESE MEETINGS ALSO INCLUDED THE NEED FOR ADDITIONAL MENTAL HEALTH SERVICES WITH MORE OF A PERSONAL TOUCH, THE HOSPITAL'S CROWDED EMERGENCY ROOM, COORDINATION OF SERVICES, EDUCATION AND THE NEED FOR MORE TEEN SERVICES, DIALYSIS SERVICES ON THE ROCKAWAYS, NEED FOR DIABETES SERVICES, NEED FOR TRAUMA SERVICES ON THE ROCKAWAYS |
| Schedule H, Part V SEC B, Line 11 | THE HOSPITAL RECOGNIZES THERE IS A NEED TO ADDRESS ALL IDENTIFIED HEALTH CONCERNS DUE TO LIMITATIONS IN STAFFING AND RESOURCES, THE HOSPITAL FOCUSED ITS EFFORTS ON THOSE PRIORITIES THAT APPEARED TO BE OF THE MOST NEED AND HAD THE STAFFING AND RESOURCES TO COMMIT TO A THREE-YEAR PLAN OF IMPLEMENTATION HIV AND AIDS SERVICES ARE CURRENTLY OFFERED AT THE JOSEPH P ADDABO FAMILY HEALTH CENTER THE COMMUNITY HEALTH PRIORITIES THAT THE HOSPTAL IDENTIFIED IN ITS HEALTH NEEDS ASSESSMENT BUT DOES NOT INTEND TO MEET ARE CANCER, RESPIRATORY DISEASE, HIV AND AIDS, MATERNAL CHILD HEALTH |

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

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

| Form and Line Reference | Explanation |
|---|---|
| SCHEDULE H, PART V SEC B, LINE 16A, LINE 16B AND LINE 16C | THE FINANCIAL ASSISTANCE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY CAN BE FOUND AT THE FOLLOWING WEBSITE https //ehs org/patients-visitors/financial-assistance |
| Schedule H, Part V SEC B, Line 22D | DURING 2017, THE HOSPITAL DETERMINED THAT THE MAXIMUM AMOUNT THAT CAN BE CHARGED TO FAP-ELIGIBLE INDIVIDUALS WAS A FLAT FEE PLUS THE FOLLOWING, BASED ON THE FEDERAL POVERTY LEVEL THE INDIVIDUAL QUALIFIED FOR -PERCENTAGE OF THE APR-DRG RATE (MEDICARE INPATIENT RATE) -PERCENTAGE OF THE APG RATE (MEDICAID OUTPATIENT RATE OR AMBULATORY FEE SCHEDULE RATE) -PERCENTAGE OF THE ANCILLARY CHARGES |

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493316035288

**Schedule J** (Form 990)

Department of the Treasury
Internal Revenue Service

# Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
Episcopal Health Services Inc

**Employer identification number**
11-1665825

## Part I Questions Regarding Compensation

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropiate 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 | | | |
| | ☐ First-class or charter travel | ☐ Housing allowance or residence for personal use | | |
| | ☐ Travel for companions | ☐ Payments for business use of personal residence | | |
| | ☐ Tax idemnification and gross-up payments | ☐ Health or social club dues or initiation fees | | |
| | ☐ Discretionary spending account | ☐ Personal services (e g , maid, chauffeur, chef) | | |
| **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 | **1b** | | |
| **2** | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | **2** | | |
| **3** | Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III | | | |
| | ☐ Compensation committee | ☑ Written employment contract | | |
| | ☐ Independent compensation consultant | ☑ Compensation survey or study | | |
| | ☐ Form 990 of other organizations | ☑ Approval by the board or compensation committee | | |
| **4** | During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization | | | |
| **a** | Receive a severance payment or change-of-control payment? | **4a** | Yes | |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | **4b** | | No |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement? | **4c** | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III | | | |
| | **Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.** | | | |
| **5** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of | | | |
| **a** | The organization? | **5a** | | No |
| **b** | Any related organization? | **5b** | | No |
| | If "Yes," on line 5a or 5b, describe in Part III | | | |
| **6** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of | | | |
| **a** | The organization? | **6a** | | No |
| **b** | Any related organization? | **6b** | | No |
| | If "Yes," on line 6a or 6b, describe in Part III | | | |
| **7** | For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III | **7** | | No |
| **8** | Were any amounts reported on Form 990, Part VII, paid or accured 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 | **8** | | No |
| **9** | If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)? | **9** | | |

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

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

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

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

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

| Return Reference | Explanation |
|---|---|
| Part I, line 4a | Francine Nigrello, chief compliance officer, left the organization in Jan 2017 She received a severance payment of $90,323 from the organization, which is included in her 2017 W-2 Part II Dr Strogan was paid as an administrator at the Hospital and not as a member of the board Dr Strogen devotes 2 5 hours per week on average to the board and 37 5 hours per week as a physician at the hospital |

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 11-1665825

**Name:** Episcopal Health Services Inc

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| **1**GERARD WALSH<br>CHIEF EXECUTIVE OFFICER | (I) | 503,097 | 125,000 | 7,524 | 15,769 | 29,443 | 680,833 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **1**DR ALBERT STROjan<br>Chief Acad Off/Board Member | (I) | 411,081 | 0 | 0 | 0 | 0 | 411,081 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **2**CHRISTOPHER PARKER<br>CHIEF OPERATING OFFICER | (I) | 393,149 | 80,340 | 3,354 | 31,000 | 32,315 | 540,158 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **3**STEVEN GUIDO<br>CHIEF FINANCIAL OFFICER | (I) | 378,889 | 78,280 | 1,170 | 25,000 | 47,592 | 530,931 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **4**JAMES HENRY<br>CHIEF OF ORTHOPEDICS | (I) | 343,402 | 0 | 0 | 31,000 | 2,500 | 376,902 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **5**RAYMOND PASTORE<br>CHIEF MEDICAL OFFICER | (I) | 437,722 | | 2,472 | 7,000 | 0 | 447,194 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **6**SHELDON MARKOWITZ<br>CHAIR - DEPT OF MEDICINE | (I) | 251,928 | 0 | 3,810 | 27,500 | 44,992 | 328,230 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **7**NATALIE SCHWARTZ<br>VP, REGULATORY AFFAIRS | (I) | 277,831 | 0 | 3,564 | 30,998 | 45,392 | 357,785 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **8**<br>FRANCINE NIGRELLO thru 117<br>CHIEF COMPLIANCE OFFICER | (I) | 62,407 | 0 | 90,624 | 2,496 | 0 | 155,527 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **9**<br>GWENDOLYN SEYMORE-PINCKNEY<br>CHIEF NURSING OFFICER | (I) | 233,125 | 0 | 1,242 | 31,000 | 47,992 | 313,359 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **10**SHARIKA GORDON<br>VP, HUMAN RESOURCES | (I) | 191,046 | 0 | 810 | 7,000 | 22,758 | 221,614 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **11**JOHN ROCCO<br>VP, OPERATIONS | (I) | 219,986 | 0 | 1,242 | 25,274 | 35,564 | 282,066 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **12**DELBURT JOINER<br>CHIEF QUALITY OFFICER | (I) | 240,974 | 0 | 6,858 | 25,768 | 549 | 274,149 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **13**ANNCY THOMAS<br>CHIEF MEDICAL INFO OFFICER | (I) | 211,763 | 0 | 182 | 22,600 | 0 | 234,545 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **14**JAVIER ANDRADE MD<br>PHYSICIAN | (I) | 521,233 | 0 | 300 | 25,000 | 29,032 | 575,565 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **15**DONALD MORRISH MD<br>PHYSICIAN | (I) | 424,289 | 51,579 | 6,570 | 25,000 | 45,392 | 552,830 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **16**NEYSA VALENTIN MD<br>PHYSICIAN | (I) | 392,273 | 81,200 | 690 | 20,000 | 27,431 | 521,594 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **17**JACKIE BATTISTA MD<br>PHYSICIAN | (I) | 432,678 | 65,300 | 300 | 24,498 | 0 | 522,776 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **18**WILLIAM FEDORICH LLM<br>Chief Corporate General Counci | (I) | 281,576 | 0 | 2,322 | 11,386 | 18,130 | 313,414 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **19**<br>THOMAS LUBESKI as of 0117<br>medical director | (I) | 305,246 | 0 | 1,183 | 16,608 | 42,608 | 365,645 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| **21** EILEEN VAN REUSEN as of 0217 vp, medical group | (I) | 160,191 | 0 | 2,450 | 17,000 | 10,273 | 189,914 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **1**KEVIN SHIPPY Chief Innovation Officer | (I) | 152,115 | 0 | 0 | 0 | 0 | 152,115 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **2**SHELDON GENACK physician | (I) | 383,978 | 0 | 966 | 31,000 | 47,942 | 463,886 | 0 |
| | (II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

**Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.**
**▶ Attach to Form 990 or 990-EZ.**
**▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
Episcopal Health Services Inc

**Employer identification number**
11-1665825

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, LINE 8B | THERE ARE NO SEPARATE COMMITTEES WITH AUTHORITY TO ACT ON BEHALF OF THE GOVERNING BODY |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, LINE 11B | THE FORM 990 AND APPROPRIATE SCHEDULES, AS REQUIRED (FORM 990), IS COMPLETED BY THE ACCOUN TING AND FINANCE STAFF OF THE ORGANIZATION AND REVIEWED INTERNALLY BY MANAGEMENT IT IS TH EN REVIEWED BY OUTSIDE TAX ADVISORS AND ANY NECESSARY ADJUSTMENTS ARE MADE, AFTER WHICH TI ME IT IS CONSIDERED AN initial DRAFT THE DRAFT OF THE FORM 990 IS THEN PRESENTED TO THE E PISCOPAL HEALTH SERVICES AUDIT COMMITTEE (THE COMMITTEE) OF THE BOARD OF TRUSTEES(THE BOAR D), WHICH HAS BEEN DELEGATED THE DETAILED REVIEW FUNCTION BY THE BOARD ONCE THE Committee 'S REVIEW IS COMPLETE THE FORM 990 IS THEN PROVIDED TO ALL VOTING MEMBERS OF THE BOARD |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 12C | The Corporate Compliance and Privacy Office distributes, gathers and reviews all annual co nflict of interest questionnaires Where positive responses are indicated additional infor mation is gathered to determine if a conflict actually exists If a conflict exists, appro priate action is taken to eliminate the conflict, including such steps as notifying the bo ard, reassignment of responsibilities or establishment of protective agreements If a matt er involves a board member or officer, appropriate action, including recusal and additiona l disclosures, will be determined by the board |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, LINE 15A | THE COMPENSATION REVIEW & APPROVAL PROCESS INCLUDES A COMPARISON OF COMPENSATION RATES PAI D for Executive level positions that are compared to COMPARABLE POSITIONS IN THE Northeast and Greater New York Region The Human Resources Department reviews each position and use s published external salary surveys to recommend fair and equitable salaries Positions ar e evaluated against Hospitals with similar Bed Size, Full-time equivalents and revenue siz e COMPENSATION WAS REVIEWED AND APPROVED BY THE ORGANIZATION'S BOARD OF DIRECTORS BOARD DECISIONS ARE CONTEMPORANEOUSLY DOCUMENTED IN BOARD MINUTES |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 15B | THE COMPENSATION OF KEY EMPLOYEES IS DETERMINED AND/OR APPROVED AFTER COMPARISON TO CURREN T COMPENSATION RATES PAID FOR COMPARABLE POSITIONS IN THE ORGANIZATION'S REGION BOARD DEC ISIONS ARE CONTEMPORANEOUSLY DOCUMENTED IN BOARD MINUTES |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VI, LINE 19 | UPON REQUEST, THE ORGANIZATION WILL MAKE AVAILABLE THOSE DOCUMENTS REQUIRED TO BE DISCLOSED UNDER THE PUBLIC INSPECTION LAWS |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART VII, SECTION A | DR ALBERT STROGEN IS COMPENSATED FOR SERVICES RENDERED AS A PHYSICIAN OF THE HOSPITAL AND NOT AS A MEMBER OF THE BOARD DR STROGEN DEVOTES 2 5 HOURS PER WEEK ON AVERAGE TO THE BO ARD AND 37 5 HOURS PER WEEK AS A PHYSICIAN AT THE HOSPITAL |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990, PART XI, LINE 9 - OTHER CHANGES IN NET ASSETS | change in pension liability 1,269,932 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION PURCHASED SERVICES TOTAL FEES 7334303 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION PHYSICIAN FEES TOTAL FEES 8629040 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION CONSULTANTS TOTAL FEES 2731801 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION TEMPORARY HELP TOTAL FEES 1729847 |

## 990 Schedule O, Supplemental Information

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION RECEIVABLE RESERVE TOTAL FEES 1523628 |

**990 Schedule O, Supplemental Information**

| Return Reference | Explanation |
| --- | --- |
| FORM 990 PART IX LINE 11G | DESCRIPTION OTHER TOTAL FEES 1575487 |

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# SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization
Episcopal Health Services Inc

**Employer identification number**
11-1665825

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | (g) No |
|---|---|---|---|---|---|---|---|
| **(1)**BISHOP HENRY B HUCLES NURSING HOME<br>700 HICKSVILLE ROAD SUITE 210<br><br>Bethpage, NY 11714<br>11-3277961 | Nursing/Rehab | NY | 501(C)(3) | LINE 10 | EHS inc | Yes | |
| **(2)**St John's Medical PC<br>700 HICKSVILLE ROAD SUITE 210<br><br>BETHPAGE, NY 11714<br>26-2884115 | ER SERVICES | NY | 501(C)(3) | LINE 12A | EHS inc | Yes | |
| **(3)**ST JOHN'S MEDICAL SERVICE PC<br>700 HICKSVILLE ROAD SUITE 210<br><br>BETHPAGE, NY 11714<br>54-2164621 | MEDICAL SVCS | NY | 501(C)(3) | LINE 12A | EHS inc | Yes | |
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**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) Disproprtionate allocations? Yes | (h) No | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? Yes | (j) No | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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**Part IV** **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? Yes | (i) No |
|---|---|---|---|---|---|---|---|---|---|
| **(1)**church charity corporation and sub<br><br>700 hicksville road suite 210<br>bethpage, NY 11714<br>11-2797706 | charity | NY | na | c corp | 0 | 0 | 0 % | | No |
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**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 |
|---|---|---|---|
| **1** During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV? | | | |
| **a** Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or**(iv)** rent from a controlled entity | 1a | | No |
| **b** Gift, grant, or capital contribution to related organization(s) | 1b | | No |
| **c** Gift, grant, or capital contribution from related organization(s) | 1c | | No |
| **d** Loans or loan guarantees to or for related organization(s) | 1d | | No |
| **e** Loans or loan guarantees by related organization(s) | 1e | | No |
| **f** Dividends from related organization(s) | 1f | | |
| **g** Sale of assets to related organization(s) | 1g | | No |
| **h** Purchase of assets from related organization(s) | 1h | | No |
| **i** Exchange of assets with related organization(s) | 1i | | No |
| **j** Lease of facilities, equipment, or other assets to related organization(s) | 1j | | No |
| **k** Lease of facilities, equipment, or other assets from related organization(s) | 1k | | No |
| **l** Performance of services or membership or fundraising solicitations for related organization(s) | 1l | | No |
| **m** Performance of services or membership or fundraising solicitations by related organization(s) | 1m | | No |
| **n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | 1n | | No |
| **o** Sharing of paid employees with related organization(s) | 1o | Yes | |
| **p** Reimbursement paid to related organization(s) for expenses | 1p | Yes | |
| **q** Reimbursement paid by related organization(s) for expenses | 1q | Yes | |
| **r** Other transfer of cash or property to related organization(s) | 1r | Yes | |
| **s** Other transfer of cash or property from related organization(s) | 1s | Yes | |

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

See Additional Data Table

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|---|---|---|
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**Part VI** **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

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

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

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

# Additional Data

**Software ID:**
**Software Version:**
**EIN:** 11-1665825
**Name:** Episcopal Health Services Inc

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|---|---|---|---|
| Bishop Henry B Hucles nursing Home Inc | P | 265,694 | Cost |
| BISHOP HENRY B HUCLES NURSING HOME INC | q | 146,461 | COST |
| ST JOHN'S MEDICAL PC | o | 149,156 | COST |
| ST JOHN'S MEDICAL PC | q | 128,281 | cost |
| ST JOHN'S MEDICAL PC | R | 2,558,610 | COST |
| ST JOHN'S MEDICAL PC | S | 2,772,235 | COST |
| ST JOHN'S MEDICAL SERVICES | o | 149,156 | COST |
| ST JOHN'S MEDICAL SERVICES | P | 63,572 | COST |
| ST JOHN'S MEDICAL SERVICES | R | 1,064,506 | COST |
| ST JOHN'S MEDICAL SERVICES | S | 353,754 | COST |