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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
ST JOSEPH'S HOSPITAL YONKERS

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
127 SOUTH BROADWAY

City or town, state or province, country, and ZIP or foreign postal code
YONKERS, NY 107014006

D Employer identification number
13-1740127

E Telephone number
(914) 378-7000

G Gross receipts $ 233,604,980

F Name and address of principal officer
MICHAEL J SPICER
127 SOUTH BROADWAY
YONKERS, NY 107014006

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 SAINTJOSEPHS ORG

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

L Year of formation 1888

M State of legal domicile NY

Part I Summary

1 Briefly describe the organization's mission or most significant activities
TO PROVIDE AFFORDABLE MEDICAL CARE TO ITS PATIENTS

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**	21
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	19
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	**5**	2,624
6	Total number of volunteers (estimate if necessary)	**6**	134
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)	29,342,014	35,584,972
9	Program service revenue (Part VIII, line 2g)	188,806,970	186,731,709
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	34,610	243,189
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	6,243,691	8,849,244
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	224,427,285	231,409,114
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)	143,279,001	148,936,060
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶593,402		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	86,709,576	83,935,372
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	229,988,577	232,871,432
19	Revenue less expenses Subtract line 18 from line 12	-5,561,292	-1,462,318

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	99,003,687	98,989,589
21	Total liabilities (Part X, line 26)	128,746,572	130,261,805
22	Net assets or fund balances Subtract line 21 from line 20	-29,742,885	-31,272,216

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

****** 2018-11-15
Signature of officer Date

MICHAEL J SPICER PRESIDENT AND CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
JULIUS C GREEN CPA	JULIUS C GREEN CPA			P00350393

Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE LLP — Firm's EIN ▶ 39-0859910

Firm's address ▶ 1650 MARKET STREET SUITE 4500
PHILADELPHIA, PA 191037341 — Phone no (215) 972-0701

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

TO MAKE AVAILABLE OPTIMAL PATIENT CARE WITH CONTINUITY OF SERVICE FOR THE SICK, AND DISABLED AND ALL OTHERS WITHOUT REGARD TO RACE, COLOR OR CREED BY MEANS OF PREVENTION, DIAGNOSIS, TREATMENT, REHABILITATION AND/OR HOME CARE FOR HOSPITALIZED AND AMBULATORY PATIENTS AND/OR OTHER HEALTH RELATED FACILITIES

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 $ 42,808,902 including grants of $ 0) (Revenue $ 40,249,016)

See Additional Data

4b (Code) (Expenses $ 42,039,520 including grants of $ 0) (Revenue $ 39,541,599)

See Additional Data

4c (Code) (Expenses $ 29,543,969 including grants of $ 0) (Revenue $ 27,788,514)

See Additional Data

(Code) (Expenses $ 84,152,805 including grants of $ 0) (Revenue $ 85,139,185)

GENERAL SERVICE FACILITIES FOR MEDICAL/SURGICAL PATIENTS (EXPENSES $24,882,719, REVENUE $23,404,228THE HOSPITAL HAS 122 BEDS AVAILABLE TO THE PUBLIC FOR MEDICAL AND SURGICAL SERVICES IN 2017 THE HOSPITAL HAD 18,430 PATIENT DAYS FOR GENERAL SERVICE THE HOSPITAL HAS APPROXIMATELY 91 MEDICAL PERSONNEL ASSIGNED TO THIS SERVICE EMERGENCY SERVICE (EXPENSES $17,934,313, REVENUE $16,868,685) THE HOSPITAL HAD 34,016 EMERGENCY VISITS DURING THE YEAR OF WHICH 3,788 ADMITTED INTO THE HOSPITAL THERE ARE APPROXIMATELY 51 NURSES, AIDES AND PHYSICIANS ASSIGNED OUTPATIENT PSYCHIATRIC CLINICS (EXPENSES $13,671,022, REVENUE $12,858,712 THERE WERE 70,889 VISITS FOR 2017 AND 52 FTES OUTPATIENT SERVICES (EXPENSES $11,000,394, REVENUE $10,346,768) THERE WERE 133,292 VISITS FOR 2017 AND 51 FTES INTENSIVE CARE UNIT AND CORONARY CARE UNIT (EXPENSES $3,354,225, REVENUE $3,154,922) THERE WERE 6 BEDS AVAILABLE 646 PATIENT DAYS OCCURRED IN 2017 FOR THE COMBINATION OF ICU AND CCU SERVICES APPROXIMATELY 13 FTES ARE ASSIGNED TO THIS AREA COMMUNITY SUPPORT SERVICES (EXPENSES $5,164,369, REVENUE $4,857,511) THERE WERE 6,607 VISITS FOR 2017 RENAL DIALYSIS (EXPENSES $3,392,205, REVENUE $3,190,646) THERE WERE 4,899 INPATIENT AND OUTPATIENT TREATMENTS FOR 2017 APPROXIMATELY 12 MEDICAL AND TECHNICAL PERSONNEL ARE ASSIGNED TO THIS UNIT FOR TREATMENT OF KIDNEY DISORDERS PSYCHIATRIC DAY TREATMENT (EXPENSES $3,402,455, REVENUE $3,200,286) THERE WERE 63,172 VISITS IN 2017 AND 18 FTES PEDIATRIC UNIT (EXPENSES $1,351,103, REVENUE $1,270,822) THERE WERE 2 BEDS AVAILABLE, 68 PATIENT DAYS AND APPROXIMATELY 6 FTES IN 2017 THE HOSPITAL ALSO PROVIDED SERVICES TO RELATED ORGANIZATIONS WHICH YIELDED TOTAL REVENUE OF $5,986,605

4d Other program services (Describe in Schedule O)

(Expenses $ 84,152,805 including grants of $ 0) (Revenue $ 85,139,185)

4e **Total program service expenses** ▶ 198,545,196

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		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	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	Yes	
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		No
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		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	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	Yes	
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**		No
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**		
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**	491		
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**	2,624		
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**		Yes	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**		Yes	
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	21		
	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	19		
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		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		Yes	
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		Yes	
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		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	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 ▶FRANK HAGAN SVP FINANCECFO 127 SOUTH BROADWAY YONKERS, NY 107014006 (914) 378-7000

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

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

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								3,656,368	0	474,857

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 ▶ 233

			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
PARK HILL EMERGENCY PYY SVC 66 WEST GILBERT STREET RED BANK, NJ 07701	MEDICAL SERVICES	1,673,250
YONKERS ATTENDING PHYSICIANS 484 TEMPLE HILL ROAD NEW WINDSOR, NY 12553	MEDICAL SERVICES	1,465,600
RAMAPO ANESTHESIOLOGISTS 100 ROUTE 59 SUITE 105 SUFFERN, NY 10901	ANESTHESIA SERVICES	1,329,167
THERADYNAMICS REHAB 225 CROSSWAYS PARK DRIVE WOODBURY, NY 11797	REHABILITATION SERVICES	624,343
YONKERS PHYSICIAN SERVICE PC 66 WEST GILBERT STREET RED BANK, NJ 07701	MEDICAL SERVICES	550,000

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 ▶ 45

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 274,747				
	d Related organizations 1d 250,000				
	e Government grants (contributions) 1e 33,656,230				
	f All other contributions, gifts, grants, and similar amounts not included above 1f 1,403,995				
	g Noncash contributions included in lines 1a-1f $ _____				
	h **Total.** Add lines 1a-1f . . . . . ▶	35,584,972			
Program Service Revenue		Business Code			
	2a INPATIENT	900099	109,408,534	109,408,534	
	b CLINIC & PSYCHIATRY	621400	58,268,427	58,268,427	
	c EMERGENCY ROOM	900099	9,411,820	9,411,820	
	d AMBULATORY SURGERY	621990	8,772,542	8,772,542	
	e RENAL	621500	870,386	870,386	
	f All other program service revenue				
	g **Total.** Add lines 2a–2f . . . . ▶	186,731,709			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶	40,120			40,120
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties . . . . . ▶				
		(i) Real	(ii) Personal		
	6a Gross rents	812,847			
	b Less rental expenses	765,775			
	c Rental income or (loss)	47,072			
	d Net rental income or (loss) . . . . . ▶	47,072			47,072
		(i) Securities	(ii) Other		
	7a Gross amount from sales of assets other than inventory	1,398,099	30,507		
	b Less cost or other basis and sales expenses	1,225,537	0		
	c Gain or (loss)	172,562	30,507		
	d Net gain or (loss) . . . . . ▶	203,069			203,069
	8a Gross income from fundraising events (not including $ 274,747 of contributions reported on line 1c) See Part IV, line 18 . . . . a	318,655			
	b Less direct expenses . . . b	204,554			
	c Net income or (loss) from fundraising events . . ▶	114,101			114,101
	9a Gross income from gaming activities See Part IV, line 19 . . . a				
	b Less direct expenses . . . b				
	c Net income or (loss) from gaming activities . . ▶				
	10a Gross sales of inventory, less returns and allowances . . a				
	b Less cost of goods sold . . b				
	c Net income or (loss) from sales of inventory . . ▶				
	Miscellaneous Revenue	Business Code			
	11a SERVICES SOLD TO NURSING HOME	900099	5,832,170	5,832,170	
	b SERVICES PROVIDED TO FUND	900099	154,435	154,435	
	c PARKING INCOME	900099	145,382		145,382
	d All other revenue		2,556,084		2,556,084
	e **Total.** Add lines 11a–11d . . . . . ▶		8,688,071		
	12 **Total revenue.** See Instructions . . . . . ▶		231,409,114	192,718,314	0 3,105,828

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				
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,656,531	2,321,031	335,500	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	107,387,891	94,406,050	12,981,841	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	6,426,782	5,615,132	811,650	
9 Other employee benefits	24,039,174	21,003,215	3,035,959	
10 Payroll taxes	8,425,682	7,361,585	1,064,097	
11 Fees for services (non-employees)				
a Management				
b Legal	1,050,021	404,189	645,832	
c Accounting	167,666		167,666	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	25,212,044	20,131,476	5,080,568	
12 Advertising and promotion	147,036	43,113	103,923	
13 Office expenses	1,135,252	682,472	452,780	
14 Information technology	3,235,681	689,062	2,546,619	
15 Royalties				
16 Occupancy	13,095,741	12,488,683	607,058	
17 Travel	339,090	305,383	33,707	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	32,068	22,257	9,811	
20 Interest	2,023,610	2,023,610		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,790,541	6,790,541		
23 Insurance	4,802,917	3,627	4,799,290	
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	8,620,150	8,620,150		
b PROVISION FOR BAD DEBT	5,380,353	5,380,353		
c PHARMACEUTICALS	3,783,556	3,783,556		
d REPAIRS AND MAINTENANCE	2,295,157	2,087,459	207,698	
e All other expenses	5,824,489	4,382,252	848,835	593,402
25 **Total functional expenses.** Add lines 1 through 24e	232,871,432	198,545,196	33,732,834	593,402
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	49,278	1	95,959
	2	Savings and temporary cash investments	3,746,624	2	2,846,259
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	23,593,715	4	23,904,742
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	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		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	1,588,260	8	1,266,008
	9	Prepaid expenses and deferred charges	1,624,515	9	1,737,734
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 169,197,636			
	b	Less accumulated depreciation — 10b: 124,811,502	48,082,767	10c	44,386,134
	11	Investments—publicly traded securities		11	
	12	Investments—other securities See Part IV, line 11		12	
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets	3,944,449	14	3,944,449
	15	Other assets See Part IV, line 11	16,374,079	15	20,808,304
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	99,003,687	16	98,989,589
Liabilities	17	Accounts payable and accrued expenses	36,885,308	17	40,233,170
	18	Grants payable		18	
	19	Deferred revenue	2,168,552	19	2,994,290
	20	Tax-exempt bond liabilities	3,000,000	20	2,300,000
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	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		22	
	23	Secured mortgages and notes payable to unrelated third parties	28,089,020	23	31,062,028
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	58,603,692	25	53,672,317
	26	**Total liabilities.** Add lines 17 through 25	128,746,572	26	130,261,805
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	-32,734,608	27	-35,009,369
	28	Temporarily restricted net assets	2,841,723	28	3,587,153
	29	Permanently restricted net assets	150,000	29	150,000
		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	-29,742,885	33	-31,272,216
	34	Total liabilities and net assets/fund balances	99,003,687	34	98,989,589

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	231,409,114
2	Total expenses (must equal Part IX, column (A), line 25)	2	232,871,432
3	Revenue less expenses Subtract line 2 from line 1	3	-1,462,318
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-29,742,885
5	Net unrealized gains (losses) on investments	5	-67,013
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	0
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-31,272,216

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	Yes	
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	Yes	

Additional Data

Software ID:

Software Version:

EIN: 13-1740127

Name: ST JOSEPH'S HOSPITAL YONKERS

Form 990 (2017)

Form 990, Part III, Line 4a:

ANCILLARY SERVICES - THERE WERE 478,503 PROCEDURES INCLUDING RADIOLOGY, LAB, CARDIOLOGY, THERAPY, ETC IN 2017

Form 990, Part III, Line 4b:

PSYCHIATRIC INPATIENT & LONG TERM PSYCH - THERE WERE 149 BEDS AVAILABLE FOR THE TREATMENT OF 60,040 PATIENT DAYS FOR 2017 APPROXIMATELY 245 MEDICAL PERSONNEL ARE ASSIGNED TO THIS UNIT THE BREAKDOWN FOR INPATIENT & LONG TERM PSYCH IS AS FOLLOWS INPATIENT HAD 45,505 PATIENT DAYS AND APPROXIMATELY 240 MEDICAL PERSONNEL LONG TERM PSYCH HAD 5,100 PATIENT DAYS AND APPROXIMATELY 5 MEDICAL PERSONNEL

Form 990, Part III, Line 4c:

METHADONE MAINTENANCE TREATMENT PROGRAM CLINIC THERE WERE 542,313 VISITS FOR 2017 AND APPROXIMATELY 136 FULL TIME EMPLOYEES

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			
JAMES J LANDY CHAIRMAN	1 00 2 00	X		X				0	0	0
CARL E PETRILLO VICE CHAIRMAN	1 00 2 00	X		X				0	0	0
JOHN J FLYNN III TREASURER	1 00 2 00	X		X				0	0	0
MICHAEL M MINERVA SECRETARY	1 00 2 00	X		X				0	0	0
SISTER MARGARET A BRICK SECRETARY (UNTIL 6/2017)	1 00 2 00	X		X				0	0	0
MICHAEL J SPICER PRESIDENT & CEO	30 00 5 00	X		X				939,447	0	287,887
MARGARET CUSUMANO RN VP PATIENT CARE SVCS & CNO	27 00 8 00	X		X				224,478	0	31,793
SISTER SHEILA BROSNAN DIRECTOR	1 00 2 00	X						0	0	0
ERNESTINE CHRISTMAS DIRECTOR	1 00 2 00	X						0	0	0
BARRY M DAVIS DIRECTOR	1 00 2 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
SISTER JANE IANNUCELLI DIRECTOR	1 00 2 00	X						0	0	0
MOIRA J KIERNAN DIRECTOR	1 00 2 00	X						0	0	0
MICHAEL M MCHUGH DIRECTOR	1 00 2 00	X						0	0	0
KEVIN M O'CALLAGHAN DIRECTOR	1 00 2 00	X						0	0	0
SISTER ROSEMARY PETRUCELLI DIRECTOR	1 00 2 00	X						0	0	0
SISTER MIRIAM KEVIN PHILLIPS DIRECTOR	1 00 2 00	X						0	0	0
NEIL PRESSMAN DIRECTOR	1 00 2 00	X						0	0	0
WILLIAM T REGAN DIRECTOR	1 00 2 00	X						0	0	0
LEONARD N SPANO DIRECTOR	1 00 2 00	X						0	0	0
SISTER MEG SWEENEY DIRECTOR	1 00 2 00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES J VENERUSO ESQ DIRECTOR	1 00 2 00	X						0	0	0
ANDREW J BALINT DIRECTOR (UNTIL 12/12/17)	1 00 2 00	X						0	0	0
JOAN P CUNNINGHAM DIRECTOR (UNTIL 11/12/17)	1 00 2 00	X						0	0	0
RICHARD J KILSHEIMER DIRECTOR (UNTIL 11/4/17)	1 00 2 00	X						0	0	0
RICHARD H GRIEF MD DIRECTOR	1 00 2 00	X						0	0	0
FRANK HAGAN SENIOR VP OF FINANCE/CFO	28 00 7 00			X				420,903	0	31,793
BERNADETTE KINGHAM-BEZ SENIOR VP OF PSYCHIATRY	35 00				X			406,545	0	43,793
FRANCES CASOLA SENIOR VP OF OPERATIONS	35 00				X			257,892	0	12,000
KIM PAGAN VICE PRESIDENT OF FINANCE	35 00					X		270,271	0	12,228
DEAN HARLAM CHIEF MEDICAL OFFICER	35 00					X		318,545	0	31,793

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			
STEVEN SHAINMARK ASSOC DIRECTOR OF PSYCHIATRY	40 00					X		271,796	0	12,228
SAURABH KAUSHIK ASSISTANT DIRECTOR OF PSYCH	41 00					X		253,730	0	0
ESSAM YOUSEF PSYCHIATRIST	40 00					X		292,761	0	11,342

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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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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: 13-1740127

Name: ST JOSEPH'S HOSPITAL YONKERS

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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493319004448

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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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	150,000	150,000	150,000	150,000	150,000
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	150,000	150,000	150,000	150,000	150,000

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		12,429,616		12,429,616
b Buildings		87,849,324	64,846,255	23,003,069
c Leasehold improvements		3,726,477	2,914,129	812,348
d Equipment		64,460,400	56,416,622	8,043,778
e Other		731,819	634,496	97,323
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				44,386,134

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) OTHER RECEIVABLES	6,524,048
(2) BOARD DESIGNATED FUND	2,469,805
(3) MEDICAL MALPRACTICE FUND	870,429
(4) OTHER LIMITED USE ASSETS	156,087
(5) DEBT SERVICE RESERVE FUND	978,342
(6) LETTER OF CREDIT/WORKERS COMPENSATION INSURANCE	41,608
(7) DUE FROM AFFILIATES	9,767,985
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	20,808,304

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	
CAPITALIZED LEASE OBLIGATION	740,352
DUE TO THIRD PARTY PAYORS - NET	14,869,324
EST PROFESS LIAB SELF-INSURANCE	17,976,844
ACCRUED ASSET RETIREMENT OBLIGATION	539,329
PENSION WITHDRAWAL LIABILITY	19,546,468
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	53,672,317

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	231,719,028
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains (losses) on investments	2a	-67,013		
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	-67,013
3	Subtract line **2e** from line **1**			3	231,786,041
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	-376,927		
c	Add lines **4a** and **4b**			4c	-376,927
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	231,409,114

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	233,248,359
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	970,329		
e	Add lines **2a** through **2d**			2e	970,329
3	Subtract line **2e** from line **1**			3	232,278,030
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	593,402		
c	Add lines **4a** and **4b**			4c	593,402
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	232,871,432

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 13-1740127
Name: ST JOSEPH'S HOSPITAL YONKERS

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	PERMANENTLY RESTRICTED NET ASSETS HAVE BEEN RESTRICTED BY DONOR-IMPOSED STIPULATIONS THAT THEY BE MAINTAINED IN PERPETUITY IN THE ABSENCE OF DONOR SPECIFICATION THAT INCOME OR GAI NS ON DONATED FUNDS ARE RESTRICTED, SUCH INCOME IS REPORTED AS INCOME OF UNRESTRICTED ASSE TS

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	THE HOSPITAL ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES RECOGNIZED IN THE FINANCIAL STATEMEN TS USING A RECOGNITION THRESHOLD OF MORE LIKELY THAN NOT AS TO WHETHER THE UNCERTAINTY WIL L BE SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY MEASUREMENT OF THE TA X UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS BEEN MET MANAGEMENT DETERMINED THER E WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION THRESHOLD

Supplemental Information

Return Reference	Explanation
PART XI, LINE 4B - OTHER ADJUSTMENTS	RENTAL EXPENSE -765,775 FUNDRAISING EXPENSES -204,554 CONTRIBUTIONS NETTED WITH EXPENSES ON AFS 593,402

Supplemental Information

Return Reference	Explanation
PART XII, LINE 2D - OTHER ADJUSTMENTS	RENTAL EXPENSE 765,775 FUNDRAISING EXPENSES 204,554

Supplemental Information

Return Reference	Explanation
PART XII, LINE 4B - OTHER ADJUSTMENTS	EXPENSES NETTED WITH CONTRIBUTIONS ON AFS 593,402

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

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

▶ **Information about Schedule G (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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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

1 Indicate whether the organization raised funds through any of the following activities Check all that apply

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? **Yes**	**No**	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col **(i)**	**(vi)** Amount paid to (or retained by) organization
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total		▶					

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

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

Revenue / Direct Expenses		(a) Event #1 GOLF OPEN (event type)	(b) Event #2 LUNCHEON & FASHION SHOW (event type)	(c) Other events 3 (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts	266,056	149,934	177,412	593,402
	2 Less Contributions	96,056	77,770	100,921	274,747
	3 Gross income (line 1 minus line 2)	170,000	72,164	76,491	318,655
Direct Expenses	4 Cash prizes	2,400	4,465		6,865
	5 Noncash prizes	16,131	1,886	310	18,327
	6 Rent/facility costs	53,650	31,727	46,930	132,307
	7 Food and beverages				
	8 Entertainment		10,000	500	10,500
	9 Other direct expenses	2,023	16,493	18,039	36,555
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				204,554
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				114,101

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

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

9 Enter the state(s) in which the organization conducts gaming activities _____

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

b If "No," explain _____

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

b If "Yes," explain _____

11 Does the organization conduct gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity conducted in

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶

----

16 Gaming manager information

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

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

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

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

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ 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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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	Yes	
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		No
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)						
b Medicaid (from Worksheet 3, column a)			114,333,889	100,498,218	13,835,671	6 080 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			114,333,889	100,498,218	13,835,671	6 080 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)			10,939,765	2,340,346	8,599,419	3 780 %
g Subsidized health services (from Worksheet 6)			9,903,280	3,192,703	6,710,577	2 950 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			20,843,045	5,533,049	15,309,996	6 730 %
k **Total.** Add lines 7d and 7j			135,176,934	106,031,267	29,145,667	12 810 %

Part II Community Building Activities

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with 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	4,208,677		
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	809,202		
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	37,187,038		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	27,013,727		
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	10,173,311		
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? **2**

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

FACILITY REPORTING GROUP - A

Name of hospital facility or letter of facility reporting group

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

			Yes	No
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	Yes	
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 SAINTJOSEPHS ORG/ABOUT-US			
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 SAINTJOSEPHS ORG/ABOUT-US			
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)

FACILITY REPORTING GROUP - A

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 150 000000000000 % and FPG family income limit for eligibility for discounted care of 300 000000000000 %			
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) WWW SAINTJOSEPHS ORG/PATIENTS-VISITORS/FINANCIAL-INFORMATION			
b	☑ The FAP application form was widely available on a website (list url) WWW SAINTJOSEPHS ORG/PATIENTS-VISITORS/FINANCIAL-INFORMATION			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW SAINTJOSEPHS ORG/PATIENTS-VISITORS/FINANCIAL-INFORMATION			
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

FACILITY REPORTING GROUP - A

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		No
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)

FACILITY REPORTING GROUP - A

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	

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? **22**

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

Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	GLOBAL COST TO CHARGE RATIO WAS UTILIZED TO COMPUTE COST OF CHARITY CARE PROVIDED ALLOWABLE COST DIVIDED BY TOTAL CHARGES
PART I, LINE 7G	THE FAMILY HEALTH CENTER IS INCLUDED IN SUBSIDIZED HEALTH SERVICES AND ITS TOTAL COST IS $2,473,581 FOR 2017

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 24, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES IN THIS COLUMN IS $5,380,353
PART III, LINE 2	THE RATIO OF PATIENT COST TO CHARGE APPLIED TO THE BAD DEBT EXPENSES WAS UTILIZED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	THE RATIO OF PATIENT COST TO CHARGE APPLIED TO THE BAD DEBT EXPENSES WAS UTILIZED THE HOSPITALS ARE LOCATED IN AN IMPOVERISHED AREA IN SOUTHWEST YONKERS, NEW YORK WHICH CONTAINS A LARGE NUMBER OF UNINSURED AND MEDICAID ELIGIBLE PATIENTS MANY OF THESE PATIENTS ARE INDIGENT AND/OR ILLEGAL IMMIGRANTS WHO ARE UNWILLING TO COOPERATE WITH THE HOSPITAL IN APPLYING FOR GOVERNMENT INSURANCE AS A RESULT, UNCOLLECTIBLE AMOUNTS ARE RECORDED AS BAD DEBT EVEN THOUGH THESE PATIENTS TYPICALLY DO NOT HAVE THE ABILITY TO PAY DUE TO THEIR SOCIOECONOMIC STATUS
PART III, LINE 4	PATIENT ACCOUNTS RECEIVABLE ARE REPORTED AT NET REALIZABLE VALUE ACCOUNTS ARE WRITTEN OFF WHEN THEY ARE DETERMINED TO BE UNCOLLECTIBLE BASED UPON MANAGEMENT'S ASSESSMENT OF INDIVIDUAL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL COLLECTIONS AND PROVISION FOR DOUBTFUL COLLECTIONS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE (WHICH INCLUDES PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL ANALYZES CONTRACTUAL AMOUNTS DUE AND PROVIDES AN ALLOWANCE FOR DOUBTFUL COLLECTIONS AND A PROVISION FOR DOUBTFUL COLLECTIONS, IF NECESSARY FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND INSURED PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR DOUBTFUL COLLECTIONS 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 THE BILLED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL COLLECTIONS THE HOSPITAL'S ALLOWANCE FOR SELF-PAY PATIENTS WAS 67% AND 79% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2017 AND DECEMBER 31, 2016, RESPECTIVELY IN ADDITION, THE HOSPITAL'S SELF-PAY ACCOUNT WRITE-OFFS (NET OF RECOVERIES) INCREASED TO $7 2 MILLION IN 2017 FROM $5 3 MILLION IN 2016 THE HOSPITAL HAS NOT CHANGED ITS FINANCIAL ASSISTANCE POLICY IN 2017 OR 2016

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	THE COSTING METHODOLOGY USED FOR ALLOWABLE COSTS IN PART III LINE 6 IS BASED ON THE MEDICARE COSTS INCLUDED IN THE WORKSHEET D SCHEDULES OF THE 2017 MEDICARE COST REPORT THERE WAS A SURPLUS
PART III, LINE 9B	THE COLLECTION POLICY FOR CHARITY CARE PATIENTS IS THE SAME COLLECTION POLICY THAT IS APPLIED TO THE LARGEST NUMBER OF ITS PATIENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	FROM AN ONGOING NEEDS ASSESSMENT BASIS, ST JOSEPH'S IS A PARTICIPANT IN THE HEALTHY YONKERS INITIATIVE WHICH IS A COALITION OF VARIOUS HEALTH CARE PROVIDERS AND SOCIAL SERVICES AGENCIES THE HEALTHY YONKERS INITIATIVE CONDUCTS PERIODIC FOCUS GROUPS TARGETING BOTH PATIENTS AND THEIR FAMILY MEMBERS TO IDENTIFY UNMET HEALTH CARE NEEDS WITHIN THE COMMUNITY A RESULT OF A RECENT FOCUS GROUP WAS TO DEVELOP AN INITIATIVE TO EXPAND AND ENHANCE HEALTH CARE SERVICES FOR INDIVIDUALS DIAGNOSED WITH ASTHMA AND/OR NUTRITIONAL DISORDERS
PART VI, LINE 3	ST JOSEPH'S HOSPITAL MAKES AVAILABLE WRITTEN COMMUNICATIONS IN BOTH ENGLISH AND SPANISH EXPLAINING THE HOSPITAL'S POLICY OF PROVIDING CHARITY CARE AND FINANCIAL ASSISTANCE TO ELIGIBLE PATIENTS NOTICES ARE POSTED THROUGHOUT THE HOSPITAL IN BOTH ENGLISH AND SPANISH STATING THAT CHARITY CARE AND FINANCIAL ASSISTANCE ARE AVAILABLE TO QUALIFYING INDIVIDUALS THAT INCLUDE A TELEPHONE NUMBER FOR PATIENTS TO CONTACT A FINANCIAL COUNSELOR TO DISCUSS ELIGIBILITY IN ADDITION, HOSPITAL REPRESENTATIVES INTERVIEW PATIENTS WITHOUT INSURANCE TO DETERMINE IF THEY MAY QUALIFY FOR MEDICAID OR OTHER GOVERNMENTAL INSURANCE PROGRAMS AND WILL ASSIST THEM IN COMPLETING REQUIRED APPLICATIONS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	ST JOSEPH'S HOSPITAL SERVES A PREDOMINATELY LOW INCOME, MEDICALLY UNDERSERVED POPULATION WITHIN ITS SERVICE AREA ST JOSEPH'S SERVICE AREA POPULATION, WHICH INCLUDES SOUTHWEST YONKERS AND THE NORTH BRONX, IS A MINORITY ONE WITH ALMOST 1/3 OF THE POPULATION AFRICAN-AMERICAN AND ANOTHER 1/3 BEING HISPANIC MANY OF THE PATIENTS DO NOT HAVE A PRIVATE PHYSICIAN AND USE THE HOSPITAL'S EMERGENCY ROOM AND CLINIC FOR THEIR PRIMARY MEDICAL NEEDS SJMC SERVES ALL OF YONKERS, BUT DEFINES ITS PRIMARY SERVICE AREA AS ZIP CODES 10701 AND 10705 THE ESTIMATED POPULATION OF THE PRIMARY ZIP CODES IS 100,276, REPRESENTING APPROXIMATELY 50% OF THE TOTAL YONKERS POPULATION THE PRIMARY SERVICE AREA POPULATION IS MORE CULTURALLY AND ETHNICALLY DIVERSE THAN THE CITY OF YONKERS AND EXPERIENCES GREATER SOCIOECONOMIC DISPARITY THE AREA IS AN URBAN MIX OF HIGH-RISE APARTMENTS, OLDER WOOD FRAME HOMES, AND A DOWNTOWN BUSINESS AREA THAT CONTAINS COMMUNITY-BASED NOT-FOR-PROFIT ORGANIZATIONS ZIP CODES 10701 AND 10705 ARE SOME OF THE MOST POPULATION DENSE AREAS IN NEW YORK STATE WITH A POPULATION DENSITY OF 23,166 PER SQUARE MILE THE POPULATION DENSITY FOR ALL OF YONKERS IS 11,051 RESIDENTS PER SQUARE MILE OUR SECONDARY SERVICE AREA INCLUDES ZIP CODES 10703, 10704, 10710, 10474, 10463, 10470, 10466 AND 10467 WESTCHESTER COUNTY, LOCATED JUST NORTH OF NEW YORK CITY IN THE HUDSON VALLEY, SPANS 450 SQUARE MILES AND 48 MUNICIPALITIES DESIGNATED AS URBAN, SUBURBAN, AND RURAL GEOGRAPHIES THE 2015 ESTIMATED COUNTY POPULATION OF 976,396 IS UP 6 6% FROM 915,916 IN 2005 THE COUNTY SEAT IS THE CITY OF WHITE PLAINS OTHER MAJOR CITIES INCLUDE YONKERS, NEW ROCHELLE, AND MOUNT VERNON THE 2015 MEDIAN HOUSEHOLD INCOME FOR WESTCHESTER COUNTY ($86,108) IS THE FOURTH HIGHEST IN NEW YORK STATE AFTER NASSAU, PUTNAM AND SUFFOLK COUNTIES YONKERS IS 18 4 SQUARE MILES WITH AN ESTIMATED 2015 POPULATION OF 201,116 THE POPULATION INCREASED 3% FROM 2010 APPROXIMATELY 22% OF RESIDENTS ARE UNDER 18 YEARS AND 15% ARE SENIORS THE YONKERS COMMUNITY IS ONE OF THE MOST CULTURALLY AND ETHNICALLY DIVERSE IN WESTCHESTER COUNTY AND NEW YORK STATE DURING THE LAST TWO DECADES, A DEMOGRAPHIC SHIFT HAS TAKEN PLACE IN THE CITY WITH A LARGE INFLUX OF IMMIGRANTS APPROXIMATELY 31% OF THE YONKERS POPULATION IS FOREIGN-BORN, 56% OF FOREIGN BORN RESIDENTS WERE BORN IN A LATIN AMERICAN COUNTRY IMMIGRANTS FROM ALL OVER THE WORLD BRING A GREAT VITALITY TO OUR COMMUNITY, BUT THEY CHALLENGE THE HOSPITAL AND OTHER COMMUNITY SERVICE PROVIDERS TO UNDERSTAND AND MEET THEIR UNIQUE AND COMPLEX HEALTH NEEDS
PART VI, LINE 5	ST JOSEPH'S HOSPITAL HAS A FAMILY PRACTICE TEACHING PROGRAM WHICH INCLUDES APPROXIMATELY 30 RESIDENTS THE RESIDENTS SPEND THE MAJORITY OF THEIR TIME PROVIDING MEDICAL CARE UNDER THE SUPERVISION OF FACULTY TO CLINIC PATIENT, MOST OF WHOM EITHER HAVE NO INSURANCE OR ARE MEDICAID PATIENTS DURING 2017, THE FAMILY HEALTH CENTER, A PRIMARY CARE CLINIC, HAD 24,127 VISITS OF WHICH 77% WERE APPLICABLE TO MEDICAID/MEDICAID HMO OR UNINSURED PATIENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	ST JOSEPH'S HOSPITAL IS PART OF AN AFFILIATED HEALTH SYSTEM WHICH INCLUDES THE FOLLOWING SJMC, INC IS THE PARENT CORPORATION WHICH WAS ESTABLISHED TO COORDINATE, PLAN AND DEVELOP CHARITABLE, EDUCATIONAL AND SCIENTIFIC ACTIVITIES, PROGRAMS AND PROJECTS FOR THE ADVANCEMENT OF QUALITY HEALTH CARE BY AND THROUGH ITS AFFILIATED ENTITIES AND TO PROMOTE AND ADVANCE RELATIONSHIPS AMONG HEALTH CARE INSTITUTIONS AND THE COMMUNITIES THEY SERVE ST JOSEPH'S HOSPITAL YONKERS, A SUBSIDIARY OF SJMC, INC , IS A 327 BED HEALTH CARE PROVIDER THAT PROVIDES MEDICAL, PSYCHIATRIC, EMERGENCY AND OUTPATIENT CLINIC SERVICES TO PATIENTS LOCATED THROUGHOUT WESTCHESTER COUNTY AND THE NEW YORK CITY REGION ST JOSEPH'S HOSPITAL NURSING HOME OF YONKERS, NEW YORK, INC IS AN AFFILIATED ENTITY PROVIDING SKILLED NURSING CARE, LONG TERM HOME HEALTH, AND ADULT DAY CARE TO PATIENTS ST JOSEPH'S HEALTH FUND IS A FUNDRAISING SUBSIDIARY OF SJMC, INC , ITS SOLE BENEFICIARY, AND SOLICITS CONTRIBUTIONS FROM THE COMMUNITY FOR USE IN PROMOTING AND/OR EXPANDING HEALTH PROGRAMS AND SERVICES FOR WHICH THERE IS A COMMUNITY NEED
PART VI, LINE 7, REPORTS FILED WITH STATES	NY

Additional Data

Software ID:

Software Version:

EIN: 13-1740127

Name: ST JOSEPH'S HOSPITAL YONKERS

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **2** 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 JOSEPH'S HOSPITAL OF YONKERS NY 127 SOUTH BROADWAY YONKERS, NY 10701 5907002H	X	X					X			A
2	ST VINCENT'S HOSPITAL WESTCHESTER 275 NORTH STREET HARRISON, NY 10528 5907002H	X	X							24 HR PSYCHIATRIC REFERRAL AND EVALUATION PROGRAM	A

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

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

Form and Line Reference	Explanation
PART V, SECTION B	FACILITY REPORTING GROUP A

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

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP A CONSISTS OF	- FACILITY 1 ST JOSEPH'S HOSPITAL OF YONKERS, NY, - FACILITY 2 ST VINCENT'S HOSPITAL WESTCHESTER

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

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP - A PART V, SECTION B, LINE 5	THE HOSPITAL TOOK INTO ACCOUNT INPUT FROM THE PERSONS WHO REPRESENT THE COMMUNITY BY CONDUCTING THE FOLLOWING OUTREACH EFFORTS FOCUS GROUPS, ACTIVE PARTICIPATION IN EXISTING COMMUNITY HEALTH INITIATIVE MEETINGS AND DISTRIBUTION OF HEALTH NEEDS SURVEYS AT LOCAL HEALTH FAIRS INDIVIDUALS CONSULTED FOR COLLABORATION TO DEVELOP THE HEALTH NEEDS ASSESSMENT AND TO IDENTIFY CONCERNS INCLUDED BUT WAS NOT LIMITED TO LOCAL ELECTED OFFICIALS, RESIDENTS (INFORMAL COMMUNITY LEADERS IN THEIR NEIGHBORHOODS), FAITH BASED REPRESENTATIVES, SCHOOL OFFICIALS, COMMUNITY BASED ORGANIZATIONS, SOCIAL SERVICE AGENCIES AND THE YONKERS OFFICE OF AGING TO ENGAGE THE BROADER COMMUNITY, SURVEY TOOLS WERE COLLABORATIVELY DEVELOPED BY HOSPITAL AND HEALTH DEPARTMENT PARTNERS, AND MADE AVAILABLE IN PAPER AND ONLINE FORMAT IN FIVE DIFFERENT LANGUAGES (ENGLISH, SPANISH, ARABIC, FRENCH CREOLE, AND CHINESE) PAPER SURVEYS WERE DISTRIBUTED IN SERVICE AGENCY AND HOSPITAL WAITING AREAS WITH ONSITE ASSISTANCE PROVIDED BY WESTCHESTER COUNTY DEPARTMENT OF HEALTH (WCDOH) STAFF AT SELECT LOCATIONS ONLINE SURVEYS WERE DISTRIBUTED VIA LISTSERVS PROVIDED BY THE WCDOH, HOSPITALS, AND COMMUNITY ORGANIZATIONS A TOTAL OF 1,318 COMMUNITY SURVEYS AND 218 PROVIDER SURVEYS WERE COMPLETED SAINT JOSEPH'S MEDICAL CENTER CONTINUES TO COLLABORATE IN ADDRESSING COMMUNITY NEEDS THROUGH THE HEALTHY YONKERS INITIATIVE (HYI) ESTABLISHED IN 1998 BY THE CITY OF YONKERS AND ST JOHN'S HOSPITAL THE HEALTHY YONKERS INITIATIVE IS A PARTNERSHIP OF OVER FIFTY COMMUNITY-BASED ORGANIZATIONS, LOCAL HEALTH AND CITY DEPARTMENTS, SCHOOLS, BUSINESSES, FAITH-BASED INSTITUTIONS AND INDIVIDUALS IN THE CITY OF YONKERS THESE COMMUNITY PARTNERS ARE INVOLVED IN THE ASSESSMENT OF COMMUNITY HEALTH NEEDS IN OUR PRIMARY SERVICE AREA, THE CITY OF YONKERS, AND ITS SURROUNDING COMMUNITIES ST JOSEPH'S HAS ACTIVELY PARTICIPATED AND SUPPORTED HYI SINCE ITS INCEPTION THE COMMUNITY PARTNERS CONTINUE TO MEET QUARTERLY, ROTATING VENUES AMONG THE MEMBERS DURING OUR SESSIONS WE SHARE HEALTH INFORMATION FROM THE NEW YORK STATE AND WESTCHESTER COUNTY DEPARTMENTS OF HEALTH AND DISSEMINATE MARKET SHARE DATA

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

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP - A PART V, SECTION B, LINE 6A	ONE CHNA WAS PERFORMED FOR THE TWO HOSPITAL FACILITIES, ST JOSEPH'S HOSPITAL OF YONKERS, NY AND ST VINCENT'S HOSPITAL WESTCHESTER UNDER THE ENTITY ST JOSEPH'S HOSPITAL OF YONKERS, NY FURTHER, SJMC PARTNERED WITH THE WESTCHESTER COUNTY HEALTH DEPARTMENT AS PART OF THE MONTEFIORE HUDSON VALLEY COLLABORATIVE (MHVC), A GROUP OF REGIONAL HOSPITALS AND COMMUNITY BASED ORGANIZATIONS, TO GATHER RESEARCH IN SUPPORT OF THE 2016 CHNA THE FOLLOWING IS A LIST OF THE PARTNERS BURKE REHABILITATION HOSPITAL, HUDSON VALLEY HOSPITAL, LAWRENCE HOSPITAL, MONTEFIORE MOUNT VERNON HOSPITAL, MONTEFIORE NEW ROCHELLE HOSPITAL, MONTEFIORE HEALTH SYSTEM, NORTHERN WESTCHESTER HOSPITAL, SAINT JOHN'S RIVERSIDE HOSPITAL, SAINT JOSEPH'S MEDICAL CENTER, WESTCHESTER COUNTY DEPARTMENT OF HEALTH, AND WHITE PLAINS HOSPITAL

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP - A PART V, SECTION B, LINE 11	IDENTIFIED PRIORITY AREAS AND HEALTH CONCERNS FOR SJMC SERVICE AREA RESIDENTS WERE DRUG AB USE, VIOLENCE, OBESITY, DIABETES, AND MENTAL HEALTH THE MHVC COLLABORATIVE PARTNERS REVIE WED FINDINGS FROM THE CHNA RESEARCH, INCLUDING INPUT FROM COMMUNITY RESIDENTS AND HEALTH C ARE PROVIDERS AND PUBLIC HEALTH FINDINGS, TO DETERMINE THE HIGHEST PRIORITIES WITHIN WESTC HESTER COUNTY ON WHICH TO FOCUS COMMUNITY HEALTH IMPROVEMENT EFFORTS IN ALIGNMENT WITH TH E NEW YORK STATE PREVENTION AGENDA, THE PARTNERS SELECTED THE FOLLOWING HEALTH PRIORITIES TO ADDRESS DURING THE NEXT THREE YEAR CYCLE PREVENT CHRONIC DISEASES & PROMOTE MENTAL HEA LTH AND PREVENT SUBSTANCE ABUSE IN COORDINATION WITH THE WESTCHESTER COUNTY HEALTH DEPARTM ENT AND IN ALIGNMENT WITH THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM, SA INT JOSEPH'S MEDICAL CENTER WILL FOCUS ON TWO AREAS WITHIN PREVENTING CHRONIC DISEASES AS THMA AND CARDIOVASCULAR DISEASE SJMC IS COMMITTED TO ADDRESSING WESTCHESTER COUNTY'S INIT IATIVE TO PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE SAINT JOSEPH'S OPERATES SAINT VINCENT'S HOSPITAL WESTCHESTER, THE LARGEST BEHAVIORAL HEALTH PROVIDER IN WESTCHESTER COU NTY WITH THIS EXPERTISE AND LONG HISTORY OF PROMOTING COMPREHENSIVE MENTAL HEALTH AND TRE ATING/PREVENTING SUBSTANCE ABUSE, SAINT JOSEPH'S WILL CONTINUE TO PROMOTE, SUPPORT, AND IM PLEMENT INTERVENTIONS AND STRATEGIES TO ADDRESS BEHAVIORAL HEALTH ISSUES SEE BELOW FOR AN OUTLINE OF THE PLAN PREVENTION AGENDA PRIORITY PREVENT CHRONIC DISEASEGOALS - TO ENSURE ALL PATIENTS WITH ASTHMA ACCESS TO CARE CONSISTENT WITH EVIDENCE-BASED MEDICINE GUIDELINE S FOR ASTHMA MANAGEMENT - SUPPORT IMPLEMENTATION OF EVIDENCE-BASED BEST PRACTICES FOR DISE ASE MANAGEMENT IN MEDICAL PRACTICE FOR ADULTS WITH CARDIOVASCULAR CONDITIONS SPECIFIC STRA TEGIES AND PROCESS MEASURES SJMC WILL ASSEMBLE PROJECT TEAMS FOR ASTHMA AND CARDIOVASCULAR DISEASE BASED ON TOOLKITS CREATED BY THE MHVC THE PROJECT TEAMS WILL BE RESPONSIBLE FOR IDENTIFYING COMMUNITY TRAINING/EDUCATIONAL NEEDS AND IMPROVING ACCESS TO CARE AND QUALITY IMPROVEMENT PROJECT TEAM MEMBERS WILL BE ASSIGNED SPECIFIC TASKS AND RESPONSIBILITIES FOR MEASURING PROGRESS SJMC WILL IMPLEMENT PROGRAMS BOTH INTERNALLY AND IN THE COMMUNITY TO I MPROVE ASTHMA AND CARDIOVASCULAR DISEASE OUTCOMES COMMUNITY-BASED PROGRAMS WILL FOCUS ON BUILDING CAPACITY TO IDENTIFY AND SELF-MANAGE CONDITIONS, TARGETING POPULATIONS EXPERIENCI NG DISPARITY SJMC WILL WORK WITH PROVIDERS, MEDICAID MANAGEMENT CARE ORGANIZATIONS, HEALT H HOMES, AND COMMUNITY-BASED ORGANIZATIONS TO IMPLEMENT EVIDENCE-BASED GUIDELINES AND PROT OCOLS ONE PROGRAM TO BE IMPLEMENTED BY SJMC IS THE MILLION HEARTS CAMPAIGN, AN INITIATIVE CO-LED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND THE CENTERS FOR MEDICARE & M EDICAID SERVICES TO IMPROVE HEART DISEASE OUTCOMES HOSPITAL STAFF PROGRAMMING WILL INCREAS E THE NUMBER OF PROVIDERS WHO ARE TRAINED IN PATIENT SELF-MANAGEMENT SUPPORT PRINCIPLES AN D BEST PRACTICES FOR DISEASE D

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP - A PART V, SECTION B, LINE 11	IAGNOSIS, TREATMENT, AND MANAGEMENT A SPECIFIC STRATEGY TO BE IMPLEMENTED BY SJMC IS THE NATIONAL HEART, LUNG AND BLOOD INSTITUTE EXPERT PANEL REPORT 3 (EPR 3) GUIDELINES FOR ASTH MA MANAGEMENT SJMC WILL ALSO INCREASE THE NUMBER OF PROVIDERS WHO DELIVER A CHRONIC DISEA SE SELF-MANAGEMENT PROGRAM FOR PEOPLE WITH HYPERTENSION SJMC WILL DEVELOP AND IMPLEMENT BE ST PRACTICE PROTOCOLS FOR THE ASSESSMENT AND TREATMENT OF PATIENTS WITH ASTHMA AND CARDIOV ASCULAR DISEASE AND EMBED THEM IN ELECTRONIC MEDICAL RECORDS (EMR) RECORDS WILL BE UPDATE D TO MONITOR PATIENT SELF-MANAGEMENT GOALS AND ACTION PLANS, CHANGES IN DISEASE PROGRESS, AND UPDATES FROM THE CARE MANAGEMENT TEAM PROCESS MEASURES FOR MONITORING PROGRESS AND COM MUNITY IMPACT AS A RESULT OF CHRONIC DISEASE INITIATIVES INCLUDE DEVELOPMENT AND IMPLEMEN TATION OF ASTHMA ACTION PLANS THAT INCLUDE PATIENT MONITORING OF SIGNS AND SYMPTOMS AND PE AK FLOW METER READINGS WHEN APPROPRIATE, DOCUMENTATION OF COLLABORATION WITH SCHOOL NURSES , TEACHERS, SCHOOL ADMINISTRATORS, AND DAY CARE CENTERS TO EDUCATE, ASSESS, AND TREAT SCHO OL-AGE CHILDREN WITH ASTHMA, EMBEDDED BEST PRACTICES FOR THE DIAGNOSIS, TREATMENT, AND MAN AGEMENT OF ASTHMA IN SJMC'S EMR, IDENTIFICATION OF ASTHMA AND CARDIOVASCULAR DISEASE PROJE CT TEAM MEMBERS WITH DETERMINED TASKS AND RESPONSIBILITIES, NUMBER OF HOME/WORK/SCHOOL ENV IRONMENT ASSESSMENTS FOR SMOKING, ALLERGENIC MATERIALS, AND OTHER KNOWN ASTHMA TRIGGERS, N UMBER OF PATIENTS THAT PARTICIPATE IN A CHRONIC DISEASE SELF-MANAGEMENT PROGRAM, NUMBER OF PATIENTS WITH ASTHMA (AND CAREGIVERS) PARTICIPATING IN WORKSHOPS TO BETTER MANAGE THEIR C ONDITION, NUMBER OF PATIENTS WITH DOCUMENTED SELF-MANAGEMENT GOALS IN THEIR MEDICAL RECORD , PERCENTAGE OF MCOS AND HEALTH HOMES ACTIVELY ENGAGED IN CARE/TREATMENT COORDINATION WITH THOSE PATIENTS SERVED BY SJMC, PERCENTAGE OF PRIMARY CARE PROVIDERS RECEIVING TRAINING IN EVIDENCE-BASED GUIDELINES FOR ASTHMA AND CARDIOVASCULAR DISEASE DIAGNOSIS, TREATMENT AND MANAGEMENT, PERCENTAGE OF SMOKERS REFERRED TO NYS QUIT LINE, AND PERCENTAGE OF STAFF TRAIN ED/EDUCATED IN PATIENT SELF-MANAGEMENT SUPPORT PRINCIPLES AND MOTIVATIONAL INTERVIEWING PR EVENTION AGENDA PRIORITY PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSEGOALS - IMPROVE CARE COORDINATION FOR BEHAVIORAL HEALTH PATIENTS - INCREASE THE PERCENTAGE OF PATIENTS WI TH DEPRESSION WHOSE CONDITION IS DIAGNOSED - IMPROVE THE INTEGRATION OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES SPECIFIC STRATEGIES AND PROCESS MEASURES IN MARCH OF 2016, A FULL-TIME SOCIAL WORKER WAS ADDED TO THE SAINT JOSEPH'S FAMILY HEALTH CENTER CARE TEAM TO INTEGRATE BEHAVIORAL HEALTH SERVICES WITHIN THE PRIMARY CARE SITE AND PROVIDE IMMEDIATE TH ERAPY SERVICES THE CARE TEAM DELIVERY SYSTEM ENABLES PROVIDERS TO REFER PATIENTS DIRECTLY TO THE SOCIAL WORKER VIA A WARM HANDOFF, LESSENING THE STRESS AND STIGMA ATTACHED WITH HA VING TO SEEK SERVICES AT OUTSIDE FACILITIES THE SOCIAL WORKER WORKS WITH INDIVIDUALS AND F AMILIES TO ADDRESS BOTH HEALTH

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

Form and Line Reference	Explanation
FACILITY REPORTING GROUP - A PART V, SECTION B, LINE 11	AND SOCIAL ISSUES A DETAILED AND COMPREHENSIVE CARE PLAN IS DEVELOPED, INCLUSIVE OF ALL CARE TEAM MEMBERS THE PLAN IS TRANSMITTED TO THE NEW YORK STATE RHIO, A REGIONAL DATABASE THAT CAN BE ACCESSED BY PROVIDERS OUTSIDE OF SAINT JOSEPH'S COMMUNITY INFORMATION SHARIN G PROVIDES A SAFETY NET FOR INSTANCES WHEN PATIENTS ARE NOT ABLE TO RETURN TO THEIR PRIMAR Y CARE PROVIDER, OR FIND THEMSELVES IN AN EMERGENCY SITUATION PATIENTS WITH DEPRESSION ARE TARGETED FOR THE DEVELOPMENT OF A COMPREHENSIVE CARE PLAN ALL PATIENTS ARE PERIODICALLY SCREENED FOR DEPRESSION USING APPROVED EVIDENCE-BASED SCREENING TOOLS PATIENTS WITH A POS ITIVE INITIAL SCREENING RECEIVE FOLLOW-UP SCREENING TO DETERMINE THE EXTENT OF THEIR DEPRE SSION THE PATIENT IS THEN CONNECTED TO A SOCIAL WORKER FOR MORE INTENSIVE MENTAL HEALTH S ERVICES AND PROGRAMS AS NECESSARY IN EARLY 2017, SJMC EXPANDED THE AVAILABILITY OF SOCIAL WORKER SERVICES TO OUR NEARBY LOCATION OF FAMILY MEDICINE THE CHNA IDENTIFIED CANCER CARE, ADOLESCENT CARE AND DOMESTIC VIOLENCE AS PRIORITY AREAS TO BE ADDRESSED THE HOSPITAL IS NOT A CANCER CENTER, AND DOES NOT PROVIDE ADOLESCENT CARE AND THEREFORE IS UNABLE TO ADDRE SS THESE SPECIFIC NEEDS DUE TO BUDGETARY CONSTRAINTS ALTHOUGH THE HOSPITAL DOES PROVIDE M EDICAL AND PSYCHIATRIC CARE TO PATIENTS WHO HAVE EXPERIENCED DOMESTIC VIOLENCE, THE HOSPIT AL DOES NOT HAVE THE RESOURCES TO ADDRESS THE CAUSE OF THIS SPECIFIC NEED HOWEVER, ANY PA TIENT PRESENTING TO THE HOSPITAL WHO REQUIRES CANCER THERAPY, ADOLESCENT CARE OR COUNSELIN G FOR DOMESTIC ABUSE IS REFERRED TO THE APPROPRIATE HEALTHCARE PROVIDER OR SOCIAL SERVICE AGENCY

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

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

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

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

	Name and address	Type of Facility (describe)
1	1 - IMMACULATA HALL 90-10 150TH STREET JAMAICA, NY 11435	RESIDENTIAL - SUPPORTED HOUSING
1	2 - BISHOP SULLIVAN - ST MARY'S RESIDENCE 1534 PROSPECT PLACE BROOKLYN, NY 11213	RESIDENTIAL - SUPPORTED HOUSING
2	3 - FAMILY HEALTH CENTER & SPECIALTY CLINIC 73-81 SOUTH BROADWAY YONKERS, NY 10701	OUTPATIENT CLINIC
3	4 - FAMILY MEDICINE HEALTH CENTER 415 SOUTH BROADWAY YONKERS, NY 10701	OUTPATIENT CLINIC
4	5 - MAXWELL INSTITUTE OF ST VINCENTS 92 YONKERS AVENUE TUCKAHOE, NY 10707	OUTPATIENT CLINIC
5	6 - METHADONE CLINIC I 1480 PROSPECT PLACE BROOKLYN, NY 11213	OUTPATIENT CLINIC
6	7 - METHADONE CLINIC II 639 CLASSON AVENUE BROOKLYN, NY 11238	OUTPATIENT CLINIC
7	8 - METHADONE CLINIC III 211-221 POWELL STREET BROOKLYN, NY 11212	OUTPATIENT CLINIC
8	9 - METH TREAT & ADDICT OUTPATIENT CLINIC 317 SOUTH BROADWAY YONKERS, NY 10705	OUTPATIENT CLINIC
9	10 - SJMC-SVWD METHADONE UNITS I & II 175-20 HILLSIDE AVENUE JAMAICA, NY 11432	OUTPATIENT CLINIC
10	11 - ST MARTIN DE PORRES CLINIC 480 ALABAMA AVENUE BROOKLYN, NY 11207	OUTPATIENT CLINIC
11	12 - ST JOSEPH'S MEDICAL CARDIO CENTER 530 YONKERS AVENUE YONKERS, NY 10701	OUTPATIENT CLINIC & DIAGNOSTIC IMAGING CENTER
12	13 - SJMC IMAGING CENTER 3050 CORLEAR AVENUE BRONX, NY 10463	OUTPATIENT CLINIC & DIAGNOSTIC IMAGING CENTER
13	14 - WHITE PLAINS SATELLITE 199 MAIN STREET WHITE PLAINS, NY 10601	OUTPATIENT CLINIC
14	15 - AUSTIN HOUSE 20 AUSTIN PLACE STATEN ISLAND, NY 10301	RESIDENTIAL - SUPPORTED HOUSING

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

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

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

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

	Name and address	Type of Facility (describe)
16	16 - CHAIT HOUSE - SR JANE MANOR 101 TOMPKINS AVENUE STATEN ISLAND, NY 10304	RESIDENTIAL - SUPPORTED HOUSING
1	17 - CHAIT RESIDENCE - SR JANE MANOR 101 TOMPKINS AVENUE 4TH FLOOR STATEN ISLAND, NY 10304	RESIDENTIAL - SUPPORTED HOUSING
2	18 - SR ANNE MARY REGAN RESIDENCE 18 SPRING STREET PORT CHESTER, NY 10573	RESIDENTIAL - SUPPORTED HOUSING
3	19 - SR JANE MANOR CRSRO 101 TOMPKINS AVENUE 1ST FLOOR STATEN ISLAND, NY 10304	RESIDENTIAL - SUPPORTED HOUSING
4	20 - SR LOUISE DEMARILLAC MANOR 19 HYGEIA PLACE STATEN ISLAND, NY 10304	RESIDENTIAL - SUPPORTED HOUSING
5	21 - SR MARY ASSISIUM RESIDENCE 382 WESTERVELT AVENUE STATEN ISLAND, NY 10301	RESIDENTIAL - SUPPORTED HOUSING
6	22 - TOMPKINS RESIDENCE 1150 CASTLETON AVENUE STATEN ISLAND, NY 10310	RESIDENTIAL - SUPPORTED HOUSING

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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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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**	Yes	
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**	Yes	
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**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
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							

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	APARTMENT RENT IS INCLUDED IN TAXABLE COMPENSATION FOR THE PRESIDENT & CEO, MICHAEL J SPICER
PART I, LINE 4B	THE FOLLOWING INDIVIDUAL PARTICPATED IN A SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN DURING 2017, BUT DID NOT RECEIVE A DISTRIBUTION MICHAEL J SPICER, PRESIDENT & CEO

Additional Data

Software ID:

Software Version:

EIN: 13-1740127

Name: ST JOSEPH'S HOSPITAL YONKERS

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				
1MICHAEL J SPICER PRESIDENT & CEO	(i)	878,483	0	60,964	256,094	31,793	1,227,334	0
	(ii)	0	0	0	0	0	0	0
1 MARGARET CUSUMANO RN VP PATIENT CARE SVCS & CNO	(i)	223,962	0	516	0	31,793	256,271	0
	(ii)	0	0	0	0	0	0	0
2FRANK HAGAN SENIOR VP OF FINANCE/CFO	(i)	420,314	0	589	0	31,793	452,696	0
	(ii)	0	0	0	0	0	0	0
3 BERNADETTE KINGHAM-BEZ SENIOR VP OF PSYCHIATRY	(i)	405,000	0	1,545	12,000	31,793	450,338	0
	(ii)	0	0	0	0	0	0	0
4FRANCES CASOLA SENIOR VP OF OPERATIONS	(i)	257,376	0	516	12,000	0	269,892	0
	(ii)	0	0	0	0	0	0	0
5KIM PAGAN VICE PRESIDENT OF FINANCE	(i)	269,995	0	276	0	12,228	282,499	0
	(ii)	0	0	0	0	0	0	0
6DEAN HARLAM CHIEF MEDICAL OFFICER	(i)	317,000	0	1,545	0	31,793	350,338	0
	(ii)	0	0	0	0	0	0	0
7STEVEN SHAINMARK ASSOC DIRECTOR OF PSYCHIATRY	(i)	271,280	0	516	0	12,228	284,024	0
	(ii)	0	0	0	0	0	0	0
8SAURABH KAUSHIK ASSISTANT DIRECTOR OF PSYCH	(i)	253,550	0	180	0	0	253,730	0
	(ii)	0	0	0	0	0	0	0
9ESSAM YOUSEF PSYCHIATRIST	(i)	291,969	0	792	0	11,342	304,103	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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE ORGANIZATION HAS A SINGLE MEMBER, SJMC, INC , WHICH IS A TAX-EXEMPT ORGANIZATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE SOLE SINGLE MEMBER, SJMC, INC , ELECTS THE GOVERNING BODY OF THE ORGANIZATION ALL BOARD MEMBERS HAVE EQUAL VOTING RIGHTS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	DECISIONS OF THE GOVERNING BODY THAT REQUIRE APPROVAL BY THE PARENT ORGANIZATION, SJMC, IN C INCLUDE DISPOSITION OF SUBSTANTIALLY ALL OF THE ORGANIZATION'S ASSETS, MERGER OR CONSOL IDATION WITH ANOTHER ENTITY OR SYSTEM, DISSOLUTION OF THE ORGANIZATION, AND CHANGE IN THE CHARACTER OF THE OPERATION OF THE ORGANIZATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	A DRAFT OF FORM 990 IS COMPLETED BY THE ACCOUNTING STAFF AND PROVIDED TO THE SENIOR VICE P RESIDENT OF FINANCE FOR REVIEW BY MANAGEMENT UPON DETERMINATION THAT THE DRAFT IS ACCURAT E AND PROPERLY PRESENTS THE STATUS OF THE ORGANIZATION AND AFTER REVIEW BY THE HOSPITAL'S TAX ACCOUNTANTS, A COPY IS PROVIDED TO THE BOARD OF TRUSTEES FOR REVIEW PRIOR TO ISSUANCE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST FORM ANNUALLY THE VP OF RISK MANAGEMENT ORGANIZES THE COMPLETION OF THE CONFLICT OF INTEREST STATEMENTS ANY DISCLOSURE MADE BY AN OFFICER OR TRUSTEE SHALL BE REVIEWED BY ST JOSEPH'S HOSPITAL, YONKERS BOARD OF TRUSTEES POTENTIAL CONFLICTS MUST BE RESOLVED AND ANY ACTIONS TAKEN MUST BE DOCUMENTED IN THE BOARD MINUTES ANY DISCLOSURE MADE BY AN EMPLOYEE SHALL B E REVIEWED BY THE CORPORATE COMPLIANCE COMMITTEE POTENTIAL CONFLICTS MUST BE RESOLVED BY THE COMMITTEE AND REPORTED TO THE BOARD OF TRUSTEES

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE AMOUNT OF COMPENSATION PAID TO THE HOSPITAL'S CEO, OFFICERS OR KEY EMPLOYEES IS REVIEW ED PERIODICALLY BY THE COMPENSATION REVIEW COMMITTEE WHICH IS COMPRISED OF MEMBERS OF THE BOARD OF TRUSTEES THE AMOUNT OF COMPENSATION IS EVALUATED FOR COMPARABILITY WITH OTHER SI MILAR TYPES OF ORGANIZATIONS USING THE GUIDESTAR COMPENSATION REPORT FINDINGS OF THE COMP ENSATION COMMITTEE ARE REPORTED TO THE BOARD OF TRUSTEES AND DOCUMENTED IN THE MINUTES

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION'S GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	CONSULTING PROGRAM SERVICE EXPENSES 87,617 MANAGEMENT AND GENERAL EXPENSES 631,170 FUND RAISING EXPENSES 0 TOTAL EXPENSES 718,787 CONTRACTED SERVICES PROGRAM SERVICE EXPENSES 960,817 MANAGEMENT AND GENERAL EXPENSES 1,427,806 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,388,623 OTHER PURCHASED SERVICES PROGRAM SERVICE EXPENSES 4,965,546 MANAGEMENT AND G ENERAL EXPENSES 1,985,190 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 6,950,736 AGENCY FEES PROGRAM SERVICE EXPENSES 999,078 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 999,078 PHYSICIAN FEES PROGRAM SERVICE EXPENSES 2,657,825 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,657,825 PURCHASED MEDICA L SERVICES PROGRAM SERVICE EXPENSES 9,156,956 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAI SING EXPENSES 0 TOTAL EXPENSES 9,156,956 OUTSIDE LAB SERVICES PROGRAM SERVICE EXPENSES 1,107,265 MANAGEMENT AND GENERAL EXPENSES 2,982 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 1 ,110,247 TEMPORARY HELP PROGRAM SERVICE EXPENSES 39,340 MANAGEMENT AND GENERAL EXPENSES 44,911 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 84,251 BILLING & COLLECTIONS EXPENSE PRO GRAM SERVICE EXPENSES 0 MANAGEMENT AND GENERAL EXPENSES 623,041 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 623,041 PAYROLL PROCESSING PROGRAM SERVICE EXPENSES 86,059 MANAGEMENT AN D GENERAL EXPENSES 303,368 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 389,427 EXECUTIVE SEAR CH FEES PROGRAM SERVICE EXPENSES 50,809 MANAGEMENT AND GENERAL EXPENSES 62,100 FUNDRAIS ING EXPENSES 0 TOTAL EXPENSES 112,909 NETWORK & DATA PROCESSING PROGRAM SERVICE EXPENSE S 20,164 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 20,164

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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
ST JOSEPH'S HOSPITAL YONKERS

Employer identification number
13-1740127

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1)SJMC INC 127 SOUTH BROADWAY YONKERS, NY 10701 13-3497559	PARENT	NY	501(C)(3)	LINE 7	SRS CHARITY		No
(2)ST JOSEPHS HOSPITAL NURSING HOME YONKERS 127 SOUTH BROADWAY YONKERS, NY 10701 13-2861611	NURSING HOME	NY	501(C)(3)	LINE 10	SRS CHARITY		No
(3)ST JOSEPHS HEALTH FUND 127 SOUTH BROADWAY YONKERS, NY 10701 13-3833645	FUNDRAISING	NY	501(C)(3)	LINE 7	SJMC INC		No
(4)SJMC SENIOR HOUSING DEVELOPMENT FUND CO 127 SOUTH BROADWAY YONKERS, NY 10701 13-4103604	SENIOR HOUSING	NY	501(C)(3)	LINE 7	SJMC INC		No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) 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

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)ST JOSEPHS VENTURE INC 127 SOUTH BROADWAY YONKERS, NY 10701 13-3497550	INACTIVE	NY	N/A	C					No
(2)ST JOSEPHS MEDICAL PRACTICE PC 127 SOUTH BROADWAY YONKERS, NY 10701 30-0710052	MEDICAL PRACTICE	NY	N/A	C					No

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

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

		Yes	No
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		No
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	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
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

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) 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	

Part VII **Supplemental Information**

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