

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

# Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047  
**2019**  
Open to Public Inspection

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

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

**C** Name of organization  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

% KENNETH BARRITT  
Doing business as  
See Schedule O

Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
1111 AMSTERDAM AVENUE

City or town, state or province, country, and ZIP or foreign postal code  
NEW YORK, NY 10025

**D** Employer identification number  
13-2997301

**E** Telephone number  
(212) 605-4217

**G** Gross receipts \$ 1,348,216,417

**F** Name and address of principal officer:  
DONALD SCANLON  
150 WEST 42ND STREET  
NEW YORK, NY 10017

**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: ▶ <http://www.mountsinaihealth.org/>

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

**L** Year of formation: 1864 **M** State of legal domicile: NY

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities:  
SERVES THE HEALTH CARE NEEDS OF THE NY COMMUNITY THRU PRIMARY&TERTIARY CARE SVCS TO INPATIENTS & OUTPATIENTS WHILE ALSO PROVIDING CLINICAL EDUCATION&ENGAGING IN CLINICAL RESEARCH.

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	32
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	32
<b>5</b> Total number of individuals employed in calendar year 2019 (Part V, line 2a)	<b>5</b>	7,896
<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	264
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	18,766
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 39	<b>7b</b>	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	13,649,518	12,758,058
<b>9</b> Program service revenue (Part VIII, line 2g)	1,085,143,050	1,214,476,220
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,891,181	7,609,087
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	143,072,439	113,373,052
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,249,756,188	1,348,216,417
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	683,095,362	703,158,685
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	597,957,487	667,425,685
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	1,281,052,849	1,370,584,370
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	-31,296,661	-22,367,953

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	1,220,854,539	1,391,336,904
<b>21</b> Total liabilities (Part X, line 26)	1,137,202,444	1,322,468,361
<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	83,652,095	68,868,543

**Part II Signature Block**

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

**Sign Here**

Signature of officer: \_\_\_\_\_ Date: 2020-11-10

DONALD SCANLON EVP, SYSTEM CFO&CCS  
Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: \_\_\_\_\_ Preparer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ \_\_\_\_\_

Firm's address ▶ 5 TIMES SQUARE Phone no. (212) 773-3000  
NEW YORK, NY 10036

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

**Part III Statement of Program Service Accomplishments**

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

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

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, FORMED BY MERGER IN 1979, IS A COMBINATION OF THREE HOSPITALS, EACH WITH A DISTINGUISHED HISTORY OF ACCOMPLISHMENT AND PUBLIC SERVICE. ST. LUKE'S HOSPITAL WAS FOUNDED IN 1846, IN AFFILIATION WITH THE EPISCOPAL CHURCH TO PROVIDE CARE FOR THE SICK POOR. WOMEN'S HOSPITAL WAS ESTABLISHED IN 1855, FOR THE TREATMENT OF DISEASES PECULIAR TO WOMEN. ROOSEVELT HOSPITAL, CHARTERED IN 1864, WAS DEDICATED TO THE RECEPTION AND RELIEF OF SICK AND DISEASED PERSONS. THE MISSION OF ST. LUKE'S-ROOSEVELT HOSPITAL CENTER IS TO PROVIDE COMPASSIONATE PATIENT CARE WITH SEAMLESS COORDINATION AND TO ADVANCE MEDICINE THROUGH UNRIVALED EDUCATION, RESEARCH, AND OUTREACH IN THE MANY DIVERSE COMMUNITIES WE SERVE.

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

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

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

If "Yes," describe these changes on Schedule O.

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

**4a** (Code: ) (Expenses \$ 1,269,959,179 including grants of \$ 0 ) (Revenue \$ 1,229,810,552 )  
See Additional Data

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

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

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

**4e** Total program service expenses ▶ 1,269,959,179

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Answer (Yes/No). Rows include questions 1 through 21, covering various organizational requirements and reporting obligations.

Part IV Checklist of Required Schedules (continued)

Table with 3 main columns: Question/Description, Yes, No. Rows include questions 22 through 38 regarding grants, compensation, tax-exempt bonds, excess benefit transactions, and related parties.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with 3 main columns: Question/Description, Yes, No. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

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

Table with columns for question ID, question text, and response options (Yes/No). Includes sections for employee reporting, foreign accounts, prohibited tax shelter transactions, deductible contributions, and sponsoring organizations.

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



Section A. Governing Body and Management

Table with 3 main columns: Question, Yes, No. Rows include: 1a (32), 1b (32), 2 (Yes), 3 (No), 4 (Yes), 5 (No), 6 (Yes), 7a (Yes), 7b (Yes), 8a (Yes), 8b (Yes), 9 (No).

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

Table with 3 main columns: Question, Yes, No. Rows include: 10a (No), 10b, 11a (Yes), 12a (Yes), 12b (Yes), 12c (Yes), 13 (Yes), 14 (Yes), 15a (Yes), 15b (Yes), 16a (No), 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NY
18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records: KENNETH BARRITT 150 WEST 42ND STREET NEW YORK, NY 10017 (646) 605-4217

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

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

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

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

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

See instructions for the order in which to list the persons above.

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

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

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

Table with 6 main columns: (A) Name and title, (B) Average hours per week, (C) Position, (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, (F) Estimated amount of other compensation.

Summary rows for sub-totals and totals. Total compensation from related organizations: 17,131,235. Total compensation from the organization: 8,994,726. Total other compensation: 853,586.

Questionnaire section 2: Total number of individuals who received more than \$100,000 of reportable compensation (1,826). Questions 3-5 regarding compensation reporting.

Section B. Independent Contractors

Section B content including question 1 (table of independent contractors with columns for Name and business address, Description of services, Compensation) and question 2 (Total number of independent contractors).



**Part VIII Statement of Revenue**

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>			
	<b>b</b> Membership dues . . . . .	<b>1b</b>			
	<b>c</b> Fundraising events . . . . .	<b>1c</b>			
	<b>d</b> Related organizations . . . . .	<b>1d</b>			
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	12,758,058		
	<b>g</b> Noncash contributions included in lines 1a - 1f:\$ . . . . .	<b>1g</b>	307,029		
	<b>h Total.</b> Add lines 1a-1f . . . . .		12,758,058		

<b>Program Service Revenue</b>			(A)	(B)	(C)	(D)
		Business Code				
<b>2a</b> PATIENT SERVICE REVENUE . . . . .		621110	1,213,014,851	1,213,014,851		
<b>b</b> COMMUNITY MENTAL HEALTH ALCOHOL INCOME . . . . .		624100	1,461,369	1,461,369		
<b>c</b> . . . . .						
<b>d</b> . . . . .						
<b>e</b> . . . . .						
<b>f</b> All other program service revenue . . . . .						
<b>g Total.</b> Add lines 2a-2f. . . . .			1,214,476,220			

<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			7,266,858		18,766	7,248,092	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0				
	<b>5</b> Royalties . . . . .			0				
	<b>6a</b> Gross rents . . . . .	<b>6a</b>	(i) Real	2,701,342				
			(ii) Personal					
		<b>b</b> Less: rental expenses . . . . .	<b>6b</b>					
		<b>c</b> Rental income or (loss) . . . . .	<b>6c</b>	2,701,342	0			
	<b>d</b> Net rental income or (loss) . . . . .			2,701,342			2,701,342	
	<b>7a</b> Gross amount from sales of assets other than inventory . . . . .	<b>7a</b>	(i) Securities	342,229				
			(ii) Other					
		<b>b</b> Less: cost or other basis and sales expenses . . . . .	<b>7b</b>					
		<b>c</b> Gain or (loss) . . . . .	<b>7c</b>	342,229				
	<b>d</b> Net gain or (loss) . . . . .			342,229			342,229	
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>8a</b>			0			
			<b>8b</b>		0			
	<b>c</b> Net income or (loss) from fundraising events . . . . .			0				
	<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>9a</b>			0			
			<b>9b</b>		0			
	<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
	<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>10a</b>			0			
<b>10b</b>				0				
<b>c</b> Net income or (loss) from sales of inventory . . . . .			0					
Miscellaneous Revenue		Business Code						
<b>11a</b> HEALTHFIRST MANAGED CARE POOL . . . . .		900099	9,409,677	9,409,677				
	<b>b</b> REVENUE FROM DRUG STUDIES & NIH GRANTS . . . . .	900099	5,924,655	5,924,655				
	<b>c</b> CAFETERIA/VENDING INCOME . . . . .	531390	3,798,605			3,798,605		
	<b>d</b> All other revenue . . . . .		91,538,773			91,538,773		
<b>e Total.</b> Add lines 11a-11d . . . . .			110,671,710					
<b>12 Total revenue.</b> See instructions . . . . .			1,348,216,417	1,229,810,552	18,766	105,629,041		

**Part IX Statement of Functional Expenses**

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

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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	0			
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .	0			
<b>4</b> Benefits paid to or for members . . . . .	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	6,179,665	5,244,682	934,983	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	375,292	375,292		
<b>7</b> Other salaries and wages . . . . .	527,152,925	447,325,585	79,827,340	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	43,789,054	39,410,149	4,378,905	
<b>9</b> Other employee benefits . . . . .	84,977,558	76,874,043	8,103,515	
<b>10</b> Payroll taxes . . . . .	40,684,191	36,615,772	4,068,419	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .	2,831,756	2,831,756		
<b>b</b> Legal . . . . .	1,421,341	1,294,977	126,364	
<b>c</b> Accounting . . . . .	583,454		583,454	
<b>d</b> Lobbying . . . . .	0			
<b>e</b> Professional fundraising services. See Part IV, line 17	0			
<b>f</b> Investment management fees . . . . .	0			
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	180,656,838	180,656,838		
<b>12</b> Advertising and promotion . . . . .	3,593,408	3,593,408		
<b>13</b> Office expenses . . . . .	45,783,499	43,898,871	1,884,628	
<b>14</b> Information technology . . . . .	11,102,699	11,102,699		
<b>15</b> Royalties . . . . .	0			
<b>16</b> Occupancy . . . . .	24,238,111	24,238,111		
<b>17</b> Travel . . . . .	2,907,900	2,843,114	64,786	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0			
<b>19</b> Conferences, conventions, and meetings . . . . .	472,188	429,691	42,497	
<b>20</b> Interest . . . . .	12,738,506	12,738,506		
<b>21</b> Payments to affiliates . . . . .	0			
<b>22</b> Depreciation, depletion, and amortization . . . . .	79,770,666	79,770,666		
<b>23</b> Insurance . . . . .	21,155,456	21,155,456		
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES	218,293,516	218,293,516		
<b>b</b> BAD DEBT	34,270,480	34,270,480		
<b>c</b> PASS THROUGH EXPENSES	2,338,874	2,338,874		
<b>d</b> DUES AND MEMBERSHIPS	934,397	934,397		
<b>e</b> All other expenses	24,332,596	23,722,296	610,300	
<b>25</b> Total functional expenses. Add lines 1 through 24e	1,370,584,370	1,269,959,179	100,625,191	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	51,271,516	<b>1</b>	167,411,752
	<b>2</b> Savings and temporary cash investments . . . . .	0	<b>2</b>	0
	<b>3</b> Pledges and grants receivable, net . . . . .	2,675,973	<b>3</b>	3,980,074
	<b>4</b> Accounts receivable, net . . . . .	123,819,452	<b>4</b>	136,382,718
	<b>5</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .	0	<b>5</b>	0
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .	0	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	16,490,279	<b>8</b>	15,395,222
	<b>9</b> Prepaid expenses and deferred charges . . . . .	4,111,896	<b>9</b>	4,247,659
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 1,966,213,940		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 1,256,183,335	678,948,685	<b>10c</b> 710,030,605
	<b>11</b> Investments—publicly traded securities . . . . .	8,906,778	<b>11</b>	11,562,521
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	34,069,193	<b>12</b>	36,801,004
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .	8,346,899	<b>13</b>	9,345,077
	<b>14</b> Intangible assets . . . . .	0	<b>14</b>	0
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	292,213,868	<b>15</b>	296,180,272
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	1,220,854,539	<b>16</b>	1,391,336,904	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	183,387,701	<b>17</b>	185,465,328
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b> Tax-exempt bond liabilities . . . . .	0	<b>20</b>	0
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D	0	<b>21</b>	0
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .	0	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	227,840,833	<b>23</b>	211,598,249
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	725,973,910	<b>25</b>	925,404,784
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	1,137,202,444	<b>26</b>	1,322,468,361
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions . . . . .	-17,860,750	<b>27</b>	-43,798,662
	<b>28</b> Net assets with donor restrictions . . . . .	101,512,845	<b>28</b>	112,667,205
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds		<b>31</b>	
<b>32</b> Total net assets or fund balances . . . . .	83,652,095	<b>32</b>	68,868,543	
<b>33</b> Total liabilities and net assets/fund balances . . . . .	1,220,854,539	<b>33</b>	1,391,336,904	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,348,216,417
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,370,584,370
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	-22,367,953
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	83,652,095
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	6,944,375
<b>6</b>	Donated services and use of facilities	<b>6</b>	0
<b>7</b>	Investment expenses	<b>7</b>	0
<b>8</b>	Prior period adjustments	<b>8</b>	0
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	640,026
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	68,868,543

**Part XII Financial Statements and Reporting**

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

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

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 13-2997301

**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

Form 990 (2019)

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

THE HOSPITAL PROVIDES SIGNIFICANT LEVELS OF TERTIARY CARE AND SPECIALIZED SERVICES AND PROGRAMS TO TREAT COMPLEX CLINICAL CONDITIONS. THESE INCLUDE A COMPREHENSIVE CARDIOVASCULAR SURGERY PROGRAM, AN ENDOCRINOLOGY AND OBESITY PROGRAM, A COMPREHENSIVE HAND SURGERY PROGRAM, A RENAL TRANSPLANT PROGRAM AND ONE OF THE LARGEST INPATIENT/OUTPATIENT AIDS PROGRAMS IN NEW YORK CITY. IN ADDITION, THE HOSPITAL MAINTAINS A FULL RANGE OF OUTPATIENT SERVICES. THE HOSPITAL HAS BEEN DESIGNATED AS A TRAUMA CENTER BY THE EMERGENCY MEDICAL SYSTEM OF THE CITY OF NEW YORK AND HAS BEEN DESIGNATED AS A DEPARTMENT OF HEALTH. THE HOSPITAL SERVICED INPATIENTS AND PROVIDED 286,918 CLINIC VISITS AND 132,605 EMERGENCY ROOM VISITS. OVER 76% OF THE APPROXIMATELY 212,390 PATIENT DAYS WERE PROVIDED TO MEDICARE AND MEDICAID PATIENTS. AS A MATTER OF POLICY, THE HOSPITAL PROVIDES CARE TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. THE HOSPITAL PROVIDED OVER \$81,578,532 OF CHARITY CARE SERVICES AND INCURRED \$34,270,480 BAD DEBTS DURING 2019.

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Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KENNETH DAVIS MD 2 ..... CHIEF EXECUTIVE OFFICER	8.4 ..... 51.6			X				826,627	4,762,466	69,336
DENNIS CHARNEYMD12 ..... PRESIDENT, ACADEMIC AFFAIRS	8.5 ..... 51.5			X				309,386	1,782,474	46,898
DONALD T SCANLON 2 ..... EVP, FINANCE & CHIEF CORP SERV	7.5 ..... 52.5			X				304,076	1,751,878	57,285
JEREMY BOAL MD 2 ..... EVP, SYSTEM CMO	8.7 ..... 51.3			X				277,157	1,596,792	83,686
ARTHUR KLEIN MD 2 ..... EVP, PRESIDENT HEALTH NETWORK	12.9 ..... 47.1			X				421,446	1,419,732	39,086
EVAN FLATOW MD 2 ..... PRESIDENT- MSW	60.0 ..... 0.0			X				1,640,979	0	47,286
MARGARET PASTUSZKO 2 ..... EVP, SYSTEM CIO	8.7 ..... 51.3			X				230,487	1,327,913	62,892
BETH ESSIG ESQ 2 ..... EVP, GENERAL COUNSEL	7.8 ..... 52.2			X				231,788	1,335,408	29,777
BURTON P DRAYER 2 ..... EVP, SYSTEM CCA	7.2 ..... 52.8			X				187,660	1,313,621	46,562
ARTHUR GIANELLI 2 ..... PRESIDENT- ST LUKE'S	58.5 ..... 1.5			X				1,306,868	0	34,815

**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			
JEFFREY SILBERSTEIN 2 ..... EVP, SYSTEM CAO	8.7 ..... 51.3			X				183,286	1,055,968	32,727
TRACY BREEN 2 ..... CHIEF MEDICAL OFFICER	60.0 ..... 0.0					X		726,040	0	59,082
TIMOTHY DAY 2 ..... CHIEF OPERATING OFFICER	60.0 ..... 0.0					X		716,543	0	51,804
FRANK CINO 2 ..... SVP, SYSTEM CHIEF RISK OFFICER	8.6 ..... 51.4				X			97,778	569,191	59,162
LUC XENOPHON FILLAS2 ..... CHIEF TRANSFORMATION OFFICER	60.0 ..... 0.0					X		415,811	0	33,543
GUY THOMAS COURBOIS 2 ..... CHIEF OPERATING OFFICER	60.0 ..... 0.0					X		407,995	0	37,087
MICHAEL BRUNO 2 ..... FORMER OFFICER	0.0 ..... 0.0						X	215,791	215,792	7,219
WENDY O'BRIEN 2 ..... CHIEF NURSING OFFICER	60.0 ..... 0.0					X		335,507	0	29,123
LAWRENCE ATTIA 2 ..... FORMER EX-OFFICIO TRUSTEE	59.5 ..... 0.5						X	159,501	0	26,216
SUSAN R CULLMAN ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		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			
JOEL S EHRENKRANZ ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
BLAINE V FOGG END 72 ..... TRUSTEE/VICE CHAIR	2.0 ..... 14.0	X		X				0	0	0
DONALD J GOGEL ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
STEVEN HOCHBERG ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 19.0	X		X				0	0	0
JOHN A LEVIN ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
PETER W MAY ..... CHAIRMAN OF BOARD (END 4/2019)	2.0 ..... 14.0	X		X				0	0	0
ERIC MINDICH ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
MICHAEL MINIKES ..... TRUSTEE/VICE CHAIR/TREASURER	2.0 ..... 23.0	X		X				0	0	0
JOEL I PICKET ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 17.0	X		X				0	0	0
RICHARD RAVITCH ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 17.0	X		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			
JUDITH O RUBIN ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
ANDREW M SAUL ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 15.0	X		X				0	0	0
THOMAS W STRAUSS ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
JAMES S TISCH ..... TRUSTEE/CO-CHAIRMAN OF BOARD	2.0 ..... 14.5	X		X				0	0	0
BOBBIE ABRAMS ..... TRUSTEE (END 4/2019)	1.0 ..... 4.0	X						0	0	0
ANDREW M ALPER ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
FRANK BISIGNANO ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0
JEFF T BLAU ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 17.0	X		X				0	0	0
HENRY M CALDERON ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0
EDGAR M CULLMAN JR ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES E FLYNN ..... TRUSTEE	1.0 ..... 6.0	X						0	0	0
JEROME R GOLDSTEIN ..... TRUSTEE (END 4/2019)	1.0 ..... 4.0	X						0	0	0
JOHN B HESS ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
JAMES KEMPNER ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
MARC S LIPSCHULTZ ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
JAMES NEARY ..... TRUSTEE/VICE CHAIRMAN	2.0 ..... 14.0	X		X				0	0	0
ALICE NETTER ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
BERNARD W NUSSBAUM ..... TRUSTEE	1.0 ..... 6.0	X						0	0	0
LEWIS PELL ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0
ROBERT F SAVAGE JR ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID WINDREICH ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
JOHN S WINKLEMAN ..... TRUSTEE	1.0 ..... 4.0	X						0	0	0
WILLIAM H WRIGHT ..... TRUSTEE	1.0 ..... 5.0	X						0	0	0
MICHAEL ZIMMERMAN ..... TRUSTEE	1.0 ..... 3.0	X						0	0	0
BRAD KARP ..... TRUSTEE/SECRETARY (EFF 4/2019)	2.0 ..... 14.0	X		X				0	0	0
JAMES W CRYSTAL ..... VICE CHAIRMAN	2.0 ..... 14.0			X				0	0	0
BONNIE M DAVIS ..... VICE CHAIRMAN	2.0 ..... 14.0			X				0	0	0
GLENN DUBIN ..... VICE CHAIRMAN	2.0 ..... 14.0			X				0	0	0
RICHARD A FRIEDMAN ..... CO-CHAIRMEN OF BOARD	2.0 ..... 14.0			X				0	0	0
HENRY R KRAVIS ..... VICE CHAIRMAN	2.0 ..... 14.0			X				0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
HON ROBERT E RUBIN ..... VICE CHAIRMAN	2.0 ..... 14.0			X				0	0	0
CARL ICAHN ..... VICE CHAIRMAN (EFF 4/2019)	2.0 ..... 14.0			X				0	0	0
HAMILTON JAMES ..... VICE CHAIRMAN (EFF 4/2019)	2.0 ..... 14.0			X				0	0	0

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

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

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

**Name of the organization**  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

**Employer identification number**  
13-2997301

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

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

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

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

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

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

**Section A. Public Support**

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
<b>7</b>	Amounts from line 4. . .						
<b>8</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
<b>9</b>	Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
<b>10</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
<b>11</b>	<b>Total support.</b> Add lines 7 through 10						
<b>12</b>	Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13</b>	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						

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

<b>14</b>	Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>	
<b>15</b>	Public support percentage for 2018 Schedule A, Part II, line 14 . . . . .	<b>15</b>	
<b>16a</b>	<b>33 1/3% support test—2019.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>b</b>	<b>33 1/3% support test—2018.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>17a</b>	<b>10%-facts-and-circumstances test—2019.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>b</b>	<b>10%-facts-and-circumstances test—2018.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ <input type="checkbox"/>		

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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

<b>15</b>	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b>	Public support percentage from 2018 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

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

<b>17</b>	Investment income percentage for <b>2019</b> (line 10c, column (f) divided by line 13, column (f)) . . . . .	<b>17</b>	
<b>18</b>	Investment income percentage from <b>2018</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	

**19a 33 1/3% support tests—2019.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . .

**b 33 1/3% support tests—2018.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . .

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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



**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

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

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

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

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

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

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

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 13-2997301

**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

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

**Facts And Circumstances Test**

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

# Supplemental Financial Statements

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

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

**Name of the organization**  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

**Employer identification number**  
13-2997301

**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 7/25/06, 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:

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

	Amount
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

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

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

**Part V Endowment Funds.**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	59,743,086	59,743,086	59,921,205	59,920,367	59,810,767
<b>b</b> Contributions . . . . .	1,275	0	500	838	109,600
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .			178,619		
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	59,744,361	59,743,086	59,743,086	59,921,205	59,920,367

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

- a** Board designated or quasi-endowment ▶ .....
  - b** Permanent endowment ▶ 100.000 % .....
  - c** Temporarily restricted endowment ▶ .....
- The percentages on lines 2a, 2b, and 2c should equal 100%.

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

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

	Yes	No
<b>3a(i)</b>		No
<b>3a(ii)</b>		No
<b>3b</b>		

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		4,011,676		4,011,676
<b>b</b> Buildings . . . . .	21,596,091	1,151,485,870	683,594,260	489,487,701
<b>c</b> Leasehold improvements		66,117,885	64,253,870	1,864,015
<b>d</b> Equipment . . . . .		660,838,334	508,125,583	152,712,751
<b>e</b> Other . . . . .		62,164,084	209,622	61,954,462
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				710,030,605

**Part VII Investments—Other Securities.**

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

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

**Part VIII Investments—Program Related.**

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

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

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1) SECURITY DEPOSIT RECEIVABLE	338,069
(2) OTHER DEPOSITS RECEIVABLE	35,400
(3) MORTGAGE RESERVE FUND	41,615,452
(4) DEPRECIATION RESERVE FUND	3,000
(5) ESCROW FUND AS REQUIRED	2,512,438
(6) SPECIFIC PURPOSE FUNDS	13,709,359
(7) REINSURANCE RECEIVABLES	210,875,997
(8) RIGHT-OF-USE ASSETS	27,090,557
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 15.)	296,180,272

**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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	0
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 25.)	925,404,784

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

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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	



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

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 13-2997301

**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

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

(a) Description	(b) Book value
SECURITY DEPOSIT RECEIVABLE	338,069
OTHER DEPOSITS RECEIVABLE	35,400
MORTGAGE RESERVE FUND	41,615,452
DEPRECIATION RESERVE FUND	3,000
ESCROW FUND AS REQUIRED	2,512,438
SPECIFIC PURPOSE FUNDS	13,709,359
REINSURANCE RECEIVABLES	210,875,997
RIGHT-OF-USE ASSETS	27,090,557

## Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4 - INTENDED USE OF ENDOWMENT FUNDS	PERMANENTLY RESTRICTED NET ASSETS HAVE BEEN RESTRICTED BY DONORS TO BE MAINTAINED BY ST. LUKE'S-ROOSEVELT HOSPITAL CENTER ("SLR") IN PERPETUITY AND THESE ENDOWMENT FUNDS ARE INCLUDED IN LONG TERM INVESTMENTS. UNDER THE POLICIES ESTABLISHED AND APPROVED BY SLR'S INVESTMENT COMMITTEE, DONOR-RESTRICTED ENDOWMENT FUNDS ARE INVESTED IN INCOME-GENERATING INVESTMENT VEHICLES TO GENERATE INCOME AND TO APPRECIATE AND PRESERVE CAPITAL.

**SCHEDULE F  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

# Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

## 2019

**Open to Public Inspection**

Name of the organization  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

**Employer identification number**  
13-2997301

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

- For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?  Yes  No
- For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.
- Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
Central America and the Caribbean			Investments		676,013
<b>3a</b> Sub-total . . . . .					676,013
<b>b</b> Total from continuation sheets to Part I . . . . .					
<b>c Totals</b> (add lines 3a and 3b)					676,013

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

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

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

**Part III Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.

Part III can be duplicated if additional space is needed.

<b>(a)</b> Type of grant or assistance	<b>(b)</b> Region	<b>(c)</b> Number of recipients	<b>(d)</b> Amount of cash grant	<b>(e)</b> Manner of cash disbursement	<b>(f)</b> Amount of noncash assistance	<b>(g)</b> Description of noncash assistance	<b>(h)</b> Method of valuation (book, FMV, appraisal, other)

**Part IV Foreign Forms**

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

**Part V Supplemental Information**

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

ReturnReference	Explanation



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

# Hospitals

OMB No. 1545-0047  
**2019**  
Open to Public Inspection

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

**Name of the organization**  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

**Employer identification number**  
13-2997301

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

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

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community benefit expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community benefit expense	<b>(f)</b> Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			25,135,414	9,822,765	15,312,648	1.150 %
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			313,921,527	225,446,393	88,475,134	6.620 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			339,056,941	235,269,158	103,787,782	7.770 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4). . . . .			16,599,213		16,599,213	1.240 %
<b>f</b> Health professions education (from Worksheet 5) . . . . .			96,889,931	41,679,191	55,210,740	4.130 %
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			187,167,243	179,318,878	7,848,365	0.590 %
<b>h</b> Research (from Worksheet 7) . . . . .			4,576,497	4,576,497		
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .						
<b>j Total.</b> Other Benefits . . . . .			305,232,884	225,574,566	79,658,318	5.960 %
<b>k Total.</b> Add lines 7d and 7j . . . . .			644,289,825	460,843,724	183,446,100	13.730 %

**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						
<b>10 Total</b>						

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME)	5	210,472,235
6 Enter Medicare allowable costs of care relating to payments on line 5	6	260,610,773
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-50,138,538
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:  <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

**Section C. Collection Practices**

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

**Part IV Management Companies and Joint Ventures**

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

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

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

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

2

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C. . . . .		No
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>see part v, section c</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url): _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>see part V, section C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

ST LUKE'S HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	<b>13</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	<b>15</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	<b>16</b> Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>see part v, section c</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>see part v, section c</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>see part v, section c</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

ST LUKE'S HOSPITAL

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

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

**Policy Relating to Emergency Medical Care**

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

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

ST LUKE'S HOSPITAL

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

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
<b>5</b>	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C. . . . .		No
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>see part v, section c</u>		
<b>b</b>	<input type="checkbox"/> Other website (list url): _____		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>see part V, section C</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		



**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

ROOSEVELT HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	14	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>see part v, section c</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>see part v, section c</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>see part v, section c</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Roosevelt Hospital

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

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

**Policy Relating to Emergency Medical Care**

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

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

ROOSEVELT HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

**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? 3

Name and address	Type of Facility (describe)
<b>1</b> AMBULATORY PSYCHIATRIC CENTER 411 WEST 114TH STREET NEW YORK, NY 10025	HOSPITAL EXTENSION CLINIC
<b>2</b> CTR FOR COMPREHENSIVE CARE W VILLAGE DIV 36 SEVENTH AVENUE NEW YORK, NY 10011	HOSPITAL EXTENSION CLINIC
<b>3</b> SLR COMMUNITY CARE AT 59TH STREET 425 WEST 59TH STREET NEW YORK, NY 10019	HOSPITAL EXTENSION CLINIC
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information.

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 6a:	THE COMMUNITY BENEFIT REPORT IS SUBMITTED TO THE NYS DEPARTMENT OF HEALTH, AND IT DESCRIBES THE ROLE OF EACH OF THE HOSPITAL'S FACILITIES. SCHEDULE H, PART I, LINE 7: THE AMOUNTS REPORTED IN PART I, LINES 7A, 7B AND 7G WERE COMPUTED USING A RATIO OF COST TO CHARGES THAT WAS DERIVED FROM WORKSHEET 2 OF SCHEDULE H INSTRUCTIONS.
SCHEDULE H, PART I, LINE 7g:	ALL CLINICS INCLUDED AS SUBSIDIZED HEALTH SERVICES ARE CLINICS OF THE HOSPITAL.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7, COLUMN (F):	BAD DEBT EXPENSE OF \$34,270,480 WAS SUBTRACTED FROM TOTAL EXPENSES AS REPORTED ON FORM 990, PART IX, LINE 24, COLUMN (A) FOR PURPOSES OF CALCULATING THE PERCENTAGES IN THIS COLUMN.
SCHEDULE H, PART III, LINE 2:	<p>WHEN A DISCOUNT IS PROVIDED ON A PATIENT ACCOUNT, THIS IS ACCOUNTED FOR AS A CHARITY ALLOWANCE. CONVERSELY, WHEN NO PAYMENT OR ONLY PARTIAL PAYMENT IS MADE ON A PATIENT ACCOUNT, THIS IS ACCOUNTED FOR AS BAD DEBT EXPENSE. BILLINGS RELATING TO SERVICES RENDERED ARE RECORDED AS NET PATIENT SERVICE REVENUE IN THE PERIOD IN WHICH THE SERVICE IS PERFORMED, NET OF CONTRACTUAL AND OTHER ALLOWANCES WHICH REPRESENT DIFFERENCES BETWEEN GROSS CHARGES AND THE ESTIMATED RECEIPTS UNDER SUCH PROGRAMS. NET PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD-PARTY PAYERS, AND OTHERS FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD-PARTY PAYERS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE DETERMINED. PATIENT ACCOUNTS RECEIVABLE ARE ALSO REDUCED FOR ALLOWANCES FOR UNCOLLECTIBLE ACCOUNTS.</p> <p>SCHEDULE H PART III, LINE 4: IN ACCORDANCE WITH GAAP, THE ORGANIZATIONS AUDITED FINANCIAL STATEMENTS NO LONGER DISCLOSE BAD DEBT EXPENSE. THE ORGANIZATION DETERMINES BAD DEBT EXPENSE AS FOLLOWS: DEDUCTIBLES AND COPAYMENTS UNDER THIRD-PARTY PAYMENT PROGRAMS ARE THE PATIENT'S RESPONSIBILITY, AND THE ORGANIZATION CONSIDERS THESE AMOUNTS IN ITS DETERMINATION OF THE PROVISION FOR BAD DEBTS BASED ON COLLECTION EXPERIENCE. ACCOUNTS RECEIVABLE ARE ALSO REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE ORGANIZATION ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 8:	THE HOSPITAL USED THE MEDICARE PORTION OF ALL INPATIENT AND OUTPATIENT PROGRAMS THAT OPERATE AT A DEFICIT, CALCULATED USING ONLY RCC TO CALCULATE COST, FOR INCLUSION IN SUBSIDIZED HEALTH SERVICES ON SCHEDULE H, PART III, LINE 7 FOR COMMUNITY BENEFIT. THIS IS PARTIALLY OFFSET BY SURPLUSES GENERATED BY OTHER PAYORS FOR THOSE SAME PROGRAMS. THE METHODOLOGY USED TO DETERMINE THE AMOUNT REPORTED ON SCHEDULE H, PART III, SECTION B, LINE 6 IS OBTAINED FROM THE INSTITUTIONAL COST REPORT WHICH USES COST PER DAY TO CALCULATE ROOM AND BOARD COSTS AND RCC FOR ANCILLARY AND OUTPATIENT COSTS.
SCHEDULE H, PART III, LINE 9B:	PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE ARE OFFERED EXTENDED INTEREST FREE PAYMENT PLANS. IF A PATIENT DEFAULTS ON ITS PAYMENT AGREEMENT, THE PATIENT'S ACCOUNT WILL BE CONSIDERED DELINQUENT, AND WILL BE SUBJECT TO THE NORMAL COLLECTION PROCEDURES FOR ALL PATIENTS. HOWEVER, NO LEGAL ACTION MAY BE TAKEN UNTIL IT HAS BEEN DETERMINED THAT THE PATIENT HAS THE MEANS TO PAY OUTSTANDING BALANCES. IN NO SITUATION WILL THE HOSPITAL AUTHORIZE FORECLOSURE ON A PATIENT OR RESPONSIBLE PARTY'S PRIMARY RESIDENCE.



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2:	NEEDS ASSESSMENT DESCRIPTION THE HOSPITAL COMPLETED ITS FIRST COMMUNITY HEALTH NEEDS ASSESSMENT DURING 2013, PERFORMED AN ADDITIONAL CHNA IN 2014 AS PART OF THE DSRIP PROCESS, AND COMPLETED A THIRD CHNA IN 2017. THROUGHOUT THIS PROCESS, THE HOSPITAL WORKED COLLABORATIVELY WITH A NUMBER OF COMMUNITY-BASED ORGANIZATIONS, HEALTH FACILITIES, LOCAL ELECTED OFFICIALS, AND NEW YORK CITY COMMUNITY ADVISORY BOARDS. THE HOSPITAL ALSO HAS ITS OWN INTERNAL ADVISORY BOARD/COUNCIL THAT IS MADE UP OF REPRESENTATIVES OF THESE COMMUNITY PARTNERS AND INTERESTED LOCAL RESIDENTS. THROUGH THEIR PARTICIPATION, THE HOSPITAL SOLICITS COMMENTS ON THE HEALTH CARE NEEDS OF THE COMMUNITY, STRENGTHS AND WEAKNESSES OF THE HOSPITAL, AND CONSTRUCTIVE SUGGESTIONS FOR IMPROVEMENT. THESE COUNCILS ALSO PARTICIPATE IN CHOOSING THE HEALTH PRIORITIES OF THE COMMUNITY. THE HEALTH PRIORITIES OF THE COMMUNITY.
SCHEDULE H, PART VI, LINE 3:	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE THE INSTITUTION RECOGNIZES THAT MANY OF THE PATIENTS IT SERVES MAY NOT HAVE HEALTH INSURANCE OR THE FINANCIAL RESOURCES TO ACCESS QUALITY HEALTH CARE SERVICES WITHOUT FINANCIAL ASSISTANCE. ACCORDINGLY, THE INSTITUTION ADHERES TO ITS FINANCIAL ASSISTANCE POLICY, WHICH EXISTS IN ORDER TO ASSIST PATIENTS WITH GAINING ACCESS TO FINANCIAL ASSISTANCE. PATIENTS CAN OBTAIN INFORMATION ON HOSPITAL CHARGES AND ELIGIBILITY FOR GOVERNMENT OR HOSPITAL PROGRAMS PRIMARILY FROM THE HOSPITAL'S DEPARTMENT OF FINANCIAL COUNSELING. THE AVAILABILITY OF THE INSTITUTION'S FINANCIAL ASSISTANCE IS NOTED ON THE PATIENT'S BILL. ALSO, PATIENTS ARE ALERTED TO THE POLICY BY MULTI-LINGUAL SIGNAGE AND BROCHURES AT POINTS OF PATIENT SERVICE, INFORMATION DISTRIBUTED IN THE ADMISSION PACKAGE, AND THE INSTITUTION'S WEB SITE. ALL HOSPITAL STAFF ARE DIRECTED TO DISTRIBUTE STANDARD INFORMATION OR REFER INQUIRIES TO THE DEPARTMENT OF FINANCIAL COUNSELING OR WEBSITE.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 4:</p>	<p>COMMUNITY INFORMATION THE HOSPITAL OPERATES TWO CAMPUSES, ST. LUKE'S AND ROOSEVELT. TOGETHER THEY SERVE THE WEST SIDE OF MANHATTAN FROM CENTRAL HARLEM/MORNINGSIDE HEIGHTS TO CHELSEA/CLINTON. THE RACIAL AND ETHNIC BACKGROUND OF PATIENTS IS DIVERSE, SERVICING PATIENTS OF ALL RACES AND RELIGIONS. AT ST. LUKE'S, A LARGE MAJORITY OF PATIENTS RECEIVE MEDICAID, MEDICARE, OR HAVE NO INSURANCE. AT ROOSEVELT, THE PERCENTAGE OF FAMILIES WITH CHILDREN EXCEEDS THE MANHATTAN AVERAGE, AS DOES THE MEDIAN AGE.</p>
<p>SCHEDULE H, PART VI, LINE 5:</p>	<p>PROMOTION OF COMMUNITY HEALTH QUANTIFIABLE EXPENSES ASSOCIATED WITH IMPROVING THE GENERAL HEALTH OF THE COMMUNITY HAVE BEEN REPORTED IN PART I. THESE ACTIVITIES INCLUDE HEALTH SCREENINGS AND OTHER ACTIVITIES THAT ARE CLOSELY TARGETED TO THE COMMUNITY'S HEALTH NEEDS. ST. LUKE'S-ROOSEVELT HOSPITAL CENTER (THROUGH THE WORK OF ITS DEPARTMENT OF GOVERNMENT AND COMMUNITY AFFAIRS AND ITS COMMUNITY OUTREACH PROGRAM) HAS FOCUSED ITS OUTREACH AND EDUCATION AS FOLLOWS: -AFRICAN AMERICANS AND LATINOS REPRESENT ONE OF THE HIGHEST-RISK GROUPS FOR TYPE 2 DIABETES AND HYPERTENSION IN TERMS OF PREVALENCE AND DISEASE BURDEN. THE DEPARTMENT OF GOVERNMENT AND COMMUNITY AFFAIRS HAS BEEN ADDRESSING HEALTH DISPARITIES IN THE UNDERSERVED COMMUNITIES BY PROVIDING INNOVATIVE OUTREACH ACTIVITIES OFFERED THROUGH THE DEPARTMENT'S COMMUNITY HEALTH EDUCATION AND OUTREACH PROGRAMS. -LAST YEAR, THE DEPARTMENT PARTICIPATED IN MORE THAN 30 EVENTS, CONFERENCES, LECTURES, STREET FESTIVALS, CULTURAL FESTIVALS, AND OTHER COMMUNITY OUTREACH INITIATIVES, CONDUCTING HEALTH SCREENINGS WHICH INCLUDED BLOOD PRESSURE, TOTAL CHOLESTEROL, HDL, AND BLOOD GLUCOSE, AND PROSTATE CANCER, AT CHURCHES, BEAUTY SALONS, AND COMMUNITY CENTERS IN HARLEM. MORE THAN 1,250 PEOPLE (PREDOMINANTLY AFRICAN AMERICAN AND LATINO/HISPANIC) WERE SCREENED AND, WHEN MEDICALLY NECESSARY, REFERRED PARTICIPANTS TO ONE OF ST. LUKE'S OR ROOSEVELT HOSPITALS' MEDICAL FACILITIES. -IN ADDITION, THIS DEPARTMENT HAS LED THE BARBERSHOP QUARTET INITIATIVE AND CHOSEN PROGRAMS, (CHURCH-BASED HEALTH OUTREACH, SCREENING AND EDUCATION NETWORK) EACH SERVING AS A VEHICLE FOR DELIVERING SCREENING, PREVENTION AND HEALTH EDUCATION SERVICES TO A LARGELY INDIGENT AND MEDICALLY UNDERSERVED AND UNDERREPRESENTED MINORITY POPULATIONS. -THE NEW YORK OBESITY RESEARCH CENTER (TNYORC), AT ST. LUKE'S AND ROOSEVELT HOSPITAL, HAS A STRONG PROFESSIONAL EDUCATION PROGRAM, COMMITTED TO ADVANCING THE TRAINING OF PHYSICIANS AND SCIENTISTS WHO TAKE PRIDE IN SERVING AT-RISK MEMBERS OF OUR COMMUNITIES SURROUNDING HARLEM. ALTHOUGH SPECIFIC PHYSIOLOGICAL AND ENVIRONMENTAL FACTORS ARE KNOWN TO INCREASE THE RISK OF OBESITY, LITTLE IS KNOWN ABOUT HOW THESE FACTORS INTERACT IN INDIVIDUAL CHILDREN AND WITHIN ECONOMICALLY DISADVANTAGED COMMUNITIES WITH A HIGHER THAN AVERAGE PREVALENCE OF OBESITY, SUCH AS THOSE WITHIN SLR'S CATCHMENT AREA. OVER THE LAST DECADE, TNYORC'S HAS MADE COMBATING THE INCREASING CHILDHOOD OBESITY PROBLEM A PRIME FOCUS. THIS IS IN RESPONSE TO THE GROWING RACIAL AND ETHNIC DISPARITIES, AND DISPROPORTIONATE HEALTH OUTCOMES, EXPERIENCED IN OUR COMMUNITIES. SOME WAYS THEY HAVE STRIVED TO COMBAT THIS EPIDEMIC INCLUDE: -BODY COMPOSITION STUDIES: WHERE THEY UTILIZE THEIR PRE-EMINENT BODY COMPOSITION LABORATORY TO ACCOUNT FOR ACCURATE NON-INVASIVE MEASUREMENT OF BMI. -FOOD INTAKE STUDIES: WHERE THEY UTILIZE THE CHILD TASTE AND EATING LAB TO MAKE NUTRITIOUS FOOD MORE APPEALING AND EDIBLE TO CHILDREN. -EPIDEMIOLOGICAL STUDIES: WHERE THEY CONTINUALLY DESIGN RESEARCH PROJECTS THAT FOCUS ON AREAS THAT ASSESS LONG TERM IMPLICATIONS AND OUTCOMES OF CHILDHOOD OBESITY. -THEREAFTER, THEY INTEND TO UTILIZE THIS RESEARCH TO DEVELOP NEW STRATEGIES FOR PREVENTING AND TREATING OBESITY, IN THE LATINO AND AFRICAN AMERICAN COMMUNITIES. -ST. LUKE'S-ROOSEVELT HOSPITAL CENTER HAS ALSO COLLABORATED WITH NUMEROUS COMMUNITY-BASED ORGANIZATIONS TO ENSURE THAT THE HOSPITALS ARE ADDRESSING THE COMMUNITY'S HEALTH NEEDS.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6:	AFFILIATED HEALTH CARE SYSTEM THE ORGANIZATION WORKS CLOSELY WITH ITS AFFILIATED HOSPITALS AS AN INTEGRATED HEALTH CARE PARTNERSHIP. LEADERSHIP IS COMMITTED TO WORKING WITH THE COMMUNITY AND WILL REMAIN COMMITTED TO ALLOCATING SUFFICIENT RESOURCES TO ENSURE THAT THE CLINICAL AND OUTREACH SERVICES OF EACH OF THE AFFILIATED HOSPITALS IS RESPONSIVE TO THE COMMUNITY HEALTH NEEDS BY PROVIDING HIGH QUALITY, ACCESSIBLE, AND COMPASSIONATE HEALTH CARE TO THE MAXIMUM EXTENT POSSIBLE.
SCHEDULE H, PART VI, LINE 7:	STATE FILING OF COMMUNITY BENEFIT REPORT NEW YORK

# Additional Data

**Software ID:**

**Software Version:**

**EIN:** 13-2997301

**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

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

<b>Section A. Hospital Facilities</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>2</u>											
Name, address, primary website address, and state license number											
1	ST LUKE'S HOSPITAL 1111 AMSTERDAM AVENUE NEW YORK, NY 10025 www.stlukeshospitalnyc.org 7002032H	X	X		X		X	X			
2	ROOSEVELT HOSPITAL 1000 TENTH AVENUE NEW YORK, NY 10019 WWW.ROOSEVELTHOSPITALNYC.ORG 7002032H	X	X		X		X	X			

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

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

Form and Line Reference	Explanation
FOR PURPOSES OF SCHEDULE H, PART V, SECTION C THE DISCLOSURES RELATE TO	<p>BOTH ROOSEVELT HOSPITAL AND ST. LUKE'S HOSPITAL. MOUNT SINAI ST. LUKE'S-ROOSEVELT HOSPITAL CENTER ("MSSLR") CONSISTS OF ROOSEVELT HOSPITAL A.K.A. MOUNT SINAI WEST ("MSW") AND ST. LUKE'S HOSPITAL A.K.A MOUNT SINAI ST. LUKE'S ("MSSL"). Schedule H, PART V, Line 3E The significant health needs of the community identified in the CNHA are prioritized according to the community needs. SCHEDULE H, PART V, LINE 5 The hospital facility took into account input from persons who represent the community, including those with special knowledge of or expertise in public health, through key informant interviews and focus groups conducted from September through December 2017. Input was obtained from 104 individuals representing 40 community organizations. Collectively, these 40 organizations serve a wide-range of community residents; individually, these serve medically underserved communities (such as LGBTQ individuals, immigrant populations, and community members with limited English proficiency), low-income communities (notably children and seniors), and minority populations (including Chinese and Hispanic residents). In addition to the New York City Department of Health and Mental Hygiene, participating organizations included ACMH Inc.; Astoria Blue Feather Early Learning Center; BRC Senior Services Center; Callen-Lorde Community Health Center; Center for Independence of the Disabled in NY; Consolidated Edison, Inc.; Coordinated Behavioral Care (CBC); Dominican Women's Development Center; Educational Alliance; Hearing Loss Association of America, New York City Chapter; Hellenic American Neighborhood Action Committee; Instituto Duarte de Nueva York; La Academia Mundial de Bomberos Inc EEUU; Long Island City Partnership; Lower Eastside Power Partnership; Manhattan Community Board 3; Manhattan Community Board 4; Manhattan Community Board 5; Manhattan Community Board 6; Manhattan Community Board 7; Morningside Heights Residents' Association; Mount Sinai - Mount Sinai Queens; Mount Sinai - Mount Sinai Queens - Community Advisory Board; Mount Sinai Beth Israel - Mount Sinai Brooklyn; Mount Sinai Community Advisory Council; Mount Sinai Health System; Mount Sinai St. Luke's - Mount Sinai West (MSSL &amp; MSW); New York Common Pantry; New York Eye &amp; Ear Infirmary of Mount Sinai; New York Political Club New Generation; Queens Community Board 1; Residents of the New York City Housing Authority; SHAREing &amp; CAREing; STRIVE New York; Stuyvesant Town Peter Cooper Village Tenants Association; Union Square Partnership; William F. Ryan Community Health Center; and William F. Ryan Community Health Network.</p>

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, LINE 6A	THE COMMUNITY HEALTH NEEDS ASSESSMENTS FOR ST. LUKE'S AND ROOSEVELT HOSPITALS WERE CONDUCTED IN CONJUNCTION WITH EACH OTHER. schedule h, part v, line 7a The combined CHNA for St. Luke's Hospital and Roosevelt Hospital is located at the following link: The Community Health Services Section of the site-wide footer at <a href="https://www.mountsinai.org/files/MSHealth/Assets/MSSL/MSSL-MSW-CHNA-December2017.pdf">https://www.mountsinai.org/files/MSHealth/Assets/MSSL/MSSL-MSW-CHNA-December2017.pdf</a> Schedule H, Part V, Line 10a The combined implementation strategy for St. Luke's Hospital and Roosevelt Hospital is located at the following link: <a href="https://www.mountsinai.org/files/MSHealth/Assets/MSSL/IMPLEMENTATIONSTRATEGY-MSSL-MSW-180509-FINALA.PDF">HTTPS://WWW.MOUNTSINAI.ORG/FILES/MSHEALTH/ASSETS/MSSL/IMPLEMENTATIONSTRATEGY-MSSL-MSW-180509-FINALA.PDF</a>

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

Form and Line Reference	Explanation
<p>SCHEDULE H, PART V, LINE 11</p>	<p>The 2017 CHNA identified a number of significant health needs in the community. The CHNA process considered and assessed a wide range of primary and secondary data sources including structured interviews with persons who represent the broad interests of the community and those with expertise in public health, and assessments and studies prepared by other organizations. The CHNA report identified eleven health needs as significant in the community, as listed below in alphabetical order. Significant Community Health Needs Identified in the 2017 CHNA: - Aging Population - Access to Mental Health Care and Poor Mental Health Status - Access to Primary Health Care Services by Individuals with Limited Resources - Chronic Diseases and Contributing Lifestyle Factors - Environmental Determinants of Health - Homelessness - Navigating a Changing Health Care Provider Environment - Poverty, Financial Hardship, and Basic Needs Insecurity - Safe and Affordable Housing - Economic, Racial, Cultural, Ethnic, and Linguistic Barriers to Care - Substance Abuse The hospital selected the following significant needs to focus its efforts during the 2018-2020 time period: - Access to Mental Health Care and Poor Mental Health Status, - Access to Primary Health Care Services by Individuals with Limited Resources, - Chronic Diseases and Contributing Lifestyle Factors, - Socio-Economic, Racial, Cultural, Ethnic, and Linguistic Barriers to Care, and - Substance Abuse. A. Access to Mental Health Care and Poor Mental Health Status The 2017 MSSL &amp; MSL CHNA found that the mental health status is poor for many residents because of day-to-day pressures, substance abuse, and psychiatric disorders. The supply of mental health providers is insufficient to meet the demand for mental health services. Planned activities to increase access to mental health care and improve the mental health status of community residents are described below. These activities are in addition to the MSSL &amp; MSW activities that impact multiple needs. Health Professions Education The health professions education activities of MSSL &amp; MSW respond to both the current and future community mental health needs. MSSL &amp; MSW actively participates in over thirty residency and fellowship programs. Residency and fellowship programs that are especially related to mental health care services are as follows: - Child and Adolescent Psychiatry Fellowship - Psychiatry Residency Mental Health Services Mental health care services are available at the hospital campuses, outpatient facilities, and physician practices throughout the community. As part of the Mount Sinai Health System, integrated resources such as electronic health records facilitate the referral of patients to needed services provided by other Mount Sinai hospitals and health professionals. Specific mental health services available include the following: Behavioral health The MSSL &amp; MSW hospital is dedicated to providing behavioral health services to meet the mental health</p>

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, LINE 11	<p>lth needs of New York City. MSSL &amp; MSW provides comprehensive, high-quality services that empower individuals to change their lives. MSSL &amp; MSW effects changes in consumer education, outreach, and community collaboration; and helps to shape the future through leading-edge research and development of skilled professional staff to serve individuals and their communities. Mental health evaluation services The Access Center is the initial evaluative point of entry for those seeking psychiatric care at MSSL &amp; MSW. All patients requesting treatment receive a comprehensive psychiatric evaluation that includes an extensive clinical interview and a standardized self-report outcome measure, Basis 24. Treatment recommendations are made if the various divisions of the Department of Psychiatry can offer appropriate treatment. If the programs of the Department of Psychiatry are unable to accommodate the patient's need for care, suggestions are made for care at other facilities. Adult Inpatient Services MSSL &amp; MSW provides programs designed to accommodate the needs of each individual patient. On all inpatient psychiatric units, a therapeutic environment that promotes healing is provided. Active participation in the treatment process is encouraged. Inpatient Psychiatry MSSL &amp; MSW's inpatient psychiatry units provide short-term, acute psychiatric treatment for adults ages 18 and older. Treatment modalities include group, family, and individual therapy and medication therapy. These services are designed to stabilize and prepare the patient for appropriate follow-up treatment in an outpatient setting. Inpatient Treatment Program Individualized treatment plans are developed based on a comprehensive assessment of medical, psychiatric, psychological, social, and functional status. Treatment focuses on alleviating symptoms and solving problems in order to enhance patients' ability to function. Therapy programs are used to help patients understand mental illness, develop coping skills, and promote self-esteem. Treatment programs include ones as follows: - Psychopharmacological management (prescribed medications); - Individual and group therapeutic activities; - Environment structuring/therapeutic environment; and - Patient/family education. Adult Outpatient Clinic The Acute Outpatient Psychiatry Clinic offers comprehensive outpatient treatment for persons diagnosed with Axis I or Axis II disorders whose course is characterized by acute, remitting episodes of illness. These include the treatment of persons with mood disorders, anxiety disorders, and other psychiatric disorders. Individuals with personality disorders are treated with a focus on a return to optimal functioning and improvement in their ability to live meaningful lives. Individuals with severe mental illnesses, such as schizophrenia and very unstable bipolar disorders, are treated at the Psychiatric Recovery Center. Group Therapy A wide variety of short- and long-term groups meet weekly, targeted to focus on</p>



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

Form and Line Reference	Explanation
<p>SCHEDULE H, PART V, LINE 11</p>	<p>particular diagnoses. General psychotherapy groups are offered as well. Most individuals will participate in group, rather than individual, psychotherapy. Individual Time-Limited Psychotherapy Time-limited psychotherapy includes weekly cognitive-behavioral therapy (CBT ), dialectical behavioral therapy (DBT), brief psychodynamic therapy, interpersonal psycho therapy, and supportive treatment. Psychopharmacological Treatment Medication therapy may be the sole therapy for some patients, although it is most effective when combined with ei ther group or individual therapy. After an initial period of more frequent visits for stab ilization and medication management, patients are generally seen monthly, moving toward le ss frequent visits. Treatment for Spanish-Speaking Patients The Outpatient Psychiatric Cli nic (OPC) offers individual, group, and psychopharmacological treatment in Spanish. Pediat ric treatment The Child and Family Institute provides mental health and substance abuse tr eatment for patients aged 0 to 18 years old. Several specialized treatment programs within the Department of Child and Adolescent Psychiatry at Mount Sinai West constitute a range of care. B. Access to Primary Health Care Services by Individuals with Limited Resources T he 2017 MSSL &amp; MSW CHNA found that New York City has a robust health provider network. How ever, access to this network can be limited to individuals with limited financial resource s, including lack of health insurance and relatively high deductibles/co-pays. Planned act ivities to increase access to primary health care for individuals with limited resources a re described below. These activities are in addition to the MSSL &amp; MSW activities that imp act multiple needs. Health professions education The health professions education activiti es of MSSL &amp; MSW respond to both current and future community primary health care needs. M SSL &amp; MSW actively participates in over thirty residency and fellowship programs. Residenc y and fellowship programs that are especially related to primary health care services are as follows: - Emergency Medicine Simulation Residency, - Emergency Medicine Global Health Residency, - Emergency Medicine Residency, - Emergency Ultrasound Fellowship, - General Su rgery Residency, - Internal Medicine Residency, - Obstetrics and Gynecology Residency, and - PGY1 Pharmacy Residency Program. Primary Health Care Services The hospital provides pri mary care at its campuses, as well as physician practices throughout Manhattan. The hospit al, together with The Mount Sinai Health System, is a leader in providing quality health c are to its patients regardless of their ability to pay. Specific primary health care servi ces include ones listed below: Mount Sinai Doctors, West 147th Street - Residents of Harle m are offered quality healthcare within their neighborhood. Board-certified medical doctor s emerge from diverse backgrounds to provide a broad range of healthcare services to meet the community's needs and acce</p>

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

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

Form and Line Reference	Explanation
Schedule H, Part V, Line 16a, 16b, & 16c	THE FAP, THE FAP APPLICATION, AND THE PLAIN LANGUAGE SUMMARY OF THE FAP ARE ALL AVAILABLE AT THE FOLLOWING LINK: <a href="http://www.wehealny.org/services/financialassistance/index.html">http://www.wehealny.org/services/financialassistance/index.html</a> .

**Schedule J**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

## Compensation Information

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

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

OMB No. 1545-0047

# 2019

**Open to Public Inspection**

Name of the organization  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

Employer identification number  
13-2997301

**Part I Questions Regarding Compensation**

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



**Part 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
SUPPLEMENTAL INFORMATION	PART VII, SECTION A & SCHEDULE J COMPENSATION FOOTNOTES OFFICERS OF THE BOARD OF TRUSTEES HOURS REFLECT SERVICE TO ALL RELATED ORGANIZATIONS OF MOUNT SINAI HEALTH SYSTEM. (1) EMPLOYEE HAS AN OUTSTANDING LOAN REFLECTED IN SCHEDULE L, PART II OF ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI'S FORM 990. (2) COMPENSATION AND BENEFITS ARE FUNDED FROM THE MOUNT SINAI HOSPITAL, ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, BETH ISRAEL MEDICAL CENTER, ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, AND/OR NEW YORK EYE AND EAR INFIRMARY. (3) OTHER REPORTABLE COMPENSATION FOR OFFICERS, KEY EMPLOYEES, AND HIGHEST COMPENSATED EMPLOYEES AS IDENTIFIED IN THE FORM 990, PART VII, AND LISTED ON SCHEDULE J MAY INCLUDE VARIOUS TYPES OF SUPPLEMENTAL WAGES. SCHEDULE J, PART I, LINE 4A- SEVERANCE MICHAEL BRUNO RECEIVED \$431,583 IN SEVERANCE PAYMENTS DURING 2019.

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 13-2997301  
**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JEREMY BOAL MD 2 EVP, SYSTEM CMO	(i)	147,900	28,338	100,919	4,141	8,236	289,534	0
	(ii)	852,100	163,262	581,430	23,859	47,450	1,668,101	0
1 MICHAEL BRUNO 2 FORMER OFFICER	(i)	0	0	215,791	0	3,609	219,400	0
	(ii)	0	0	215,792	0	3,610	219,402	0
2 DENNIS CHARNEY MD 12 PRESIDENT, ACADEMIC AFFAIRS	(i)	162,690	56,675	90,021	4,141	2,795	316,322	0
	(ii)	937,310	326,525	518,639	23,859	16,103	1,822,436	0
3 KENNETH DAVIS MD 2 CHIEF EXECUTIVE OFFICER	(i)	354,960	221,850	249,817	4,141	6,114	836,882	0
	(ii)	2,045,040	1,278,150	1,439,276	23,859	35,222	4,821,547	0
4 BURTON P DRAYER 2 EVP, SYSTEM CCA	(i)	37,500	23,950	126,210	3,500	2,320	193,480	0
	(ii)	262,500	167,650	883,471	24,500	16,242	1,354,363	0
5 BETH ESSIG ESQ 2 EVP, GENERAL COUNSEL	(i)	164,169	55,258	12,361	4,141	263	236,192	0
	(ii)	945,831	318,362	71,215	23,859	1,514	1,360,781	0
6 EVAN FLATOW MD 2 PRESIDENT- MSW	(i)	800,000	191,600	649,379	28,000	19,286	1,688,265	0
	(ii)	0	0	0	0	0	0	0
7 ARTHUR GIANELLI 2 PRESIDENT- ST LUKE'S	(i)	950,000	293,030	63,838	28,000	6,815	1,341,683	0
	(ii)	0	0	0	0	0	0	0
8 ARTHUR KLEIN MD 2 EVP, PRESIDENT HEALTH NETWORK	(i)	228,900	34,335	158,211	6,409	2,538	430,393	0
	(ii)	771,100	115,665	532,967	21,591	8,548	1,449,871	0
9 MARGARET PASTUSZKO 2 EVP, SYSTEM CIO	(i)	158,993	53,310	18,184	4,141	5,161	239,789	0
	(ii)	916,007	307,138	104,768	23,859	29,731	1,381,503	0
10 DONALD T SCANLON 2 EVP, FINANCE & CHIEF CORP SERV	(i)	177,480	71,907	54,689	4,141	4,331	312,548	0
	(ii)	1,022,520	414,278	315,080	23,859	24,954	1,800,691	0
11 JEFFREY SILBERSTEIN 2 EVP, SYSTEM CAO	(i)	124,014	41,090	18,182	4,141	699	188,126	0
	(ii)	714,486	236,730	104,752	23,859	4,028	1,083,855	0
12 FRANK CINO 2 SVP, SYSTEM CHIEF RISK OFFICER	(i)	74,033	22,502	1,243	4,105	4,568	106,451	0
	(ii)	430,967	130,988	7,236	23,895	26,594	619,680	0
13 TRACY BREEN 2 CHIEF MEDICAL OFFICER	(i)	575,000	137,713	13,327	28,000	31,082	785,122	0
	(ii)	0	0	0	0	0	0	0
14 WENDY O'BRIEN 2 CHIEF NURSING OFFICER	(i)	267,965	65,863	1,679	23,100	6,023	364,630	0
	(ii)	0	0	0	0	0	0	0
15 GUY THOMAS COURBOIS 2 CHIEF OPERATING OFFICER	(i)	322,572	75,802	9,621	23,100	13,987	445,082	0
	(ii)	0	0	0	0	0	0	0
16 TIMOTHY DAY 2 CHIEF OPERATING OFFICER	(i)	558,495	133,760	24,288	22,400	29,404	768,347	0
	(ii)	0	0	0	0	0	0	0
17 LUC XENOPHON FILLAS 2 CHIEF TRANSFORMATION OFFICER	(i)	335,546	77,418	2,847	23,100	10,443	449,354	0
	(ii)	0	0	0	0	0	0	0
18 LAWRENCE ATTIA 2 FORMER EX-OFFICIO TRUSTEE	(i)	158,478	0	1,023	12,250	13,966	185,717	0
	(ii)	0	0	0	0	0	0	0

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No. 1545-0047

**2019**

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

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

Employer identification number  
13-2997301

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . . .				
2 Art—Historical treasures . . . . .				
3 Art—Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities—Publicly traded . . . . .	X	4	307,029	FMV
10 Securities—Closely held stock . . . . .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . . . . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . . .				
15 Real estate—Residential . . . . .				
16 Real estate—Commercial . . . . .				
17 Real estate—Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ ( _____ )				
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

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

	Yes	No
<b>30a</b> During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? . . . . .		No
<b>b</b> If "Yes," describe the arrangement in Part II.		
<b>31</b> Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	Yes	
<b>32a</b> Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? . . . . .		No
<b>b</b> If "Yes," describe in Part II.		
<b>33</b> If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

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

Return Reference	Explanation
Schedule M, Part I, Column (b)	THE NUMBER IN COLUMN (B) REPRESENTS THE NUMBER OF CONTRIBUTIONS.



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

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

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Department of the Treasury

Name of the Organization

ST LUKE'S-ROOSEVELT HOSPITAL CENTER

Employer identification number

13-2997301

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
form 990, box c - doing business as	<p>st. luke's-roosevelt hospital center does business as Mount Sinai St.Luke's - Roosevelt Hospital Center which is comprised of two campuses: Mount Sinai St. Luke's and Mount Sinai West. FORM 990, PART VI, LINE 2 - BUSINESS AND FAMILY RELATIONSHIPS 1. TRUSTEES EDGAR CULLMAN, JR. AND SUSAN CULLMAN HAVE A FAMILY RELATIONSHIP. 2. TRUSTEES STEVEN HOCHBERG AND JAMES FLYNN HAVE A BUSINESS RELATIONSHIP. 3. TRUSTEES STEVEN HOCHBERG AND JOEL PICKET HAVE A BUSINESS RELATIONSHIP. 4. TRUSTEES MARC LIPSCHULTZ AND JOHN HESS HAVE A BUSINESS RELATIONSHIP. 5. OFFICERS KENNETH DAVIS, MD AND DENNIS CHARNEY, MD HAVE A BUSINESS RELATIONSHIP. 6. OFFICER KENNETH DAVIS, MD AND TRUSTEE DAVID WINDREICH HAVE A BUSINESS RELATIONSHIP. 7. OFFICER DENNIS CHARNEY, MD AND TRUSTEE DAVID WINDREICH HAVE A BUSINESS RELATIONSHIP. PART VI, SECTION A, LINE 4 GOVERNING DOCUMENTS ON APRIL 22, 2019, THE BYLAWS FOR ST. LUKE'S-ROOSEVELT HOSPITAL CENTER WERE AMENDED TO CLARIFY THAT THE BOARD OF TRUSTEES HAS THE DISCRETION, BUT IS NOT REQUIRED, TO APPOINT ANY SENIOR VICE CHAIRMAN TO THE BOARD OF TRUSTEES. THEN ON JUNE 12, 2019, THE BYLAWS OF ST. LUKE'S-ROOSEVELT HOSPITAL CENTER WERE AMENDED TO PERMIT A QUORUM, SOLELY IN THE CASE OF APPOINTMENTS TO THE HOSPITAL STAFF BY THE BOARD OF TRUSTEES, TO REQUIRE THE PRESENCE OF ONE TRUSTEE FOR EVERY TEN TRUSTEES (OR FRACTION THEREOF) ENTITLED TO VOTE FOR SUCH APPOINTMENTS. THEN ON SEPTEMBER 16, 2019, THE BYLAWS OF ST.LUKE'S-ROOSEVELT HOSPITAL CENTER WERE AMENDED TO REVISE THE LISTING OF BOARD COMMITTEES AND RENAME AND CLARIFY THE MISSION OF CERTAIN COMMITTEES. FORM 990, PART VI, LINE 6 MOUNT SINAI HOSPITALS GROUP, INC. IS THE SOLE MEMBER OF THE ORGANIZATION.</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 7A	THE MEMBER HAS THE POWER TO ELECT THE MEMBERS OF THE GOVERNING BODY OF THE ORGANIZATION.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 7B	THE BOARD OF TRUSTEES OF THE ORGANIZATION CANNOT AMEND THE BYLAWS WITHOUT THE CONSENT OF THE MEMBER IF SUCH AMENDMENT REMOVED ANY POWERS OF THE MEMBER.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 11B	<p>The Finance Department gathered the relevant information and prepared the tax returns. The Tax department of our outside auditors, Ernst &amp; Young (EY), participated in the preparation of, and reviewed, all tax returns. A questionnaire was circulated to all trustees, directors, officers and key employees in order to elicit the information required to be reported on the tax returns. The Trustee Conflicts of Interest Review Committee reviewed the responses provided by trustees and certain officers in the questionnaires and assessed additional pertinent facts gathered by the institution in order to evaluate the applicability of IRS reporting requirements. The Review Committee then determined the appropriate trustee (and certain officer) disclosures that should be made on Form 990 based on the recommendations of the Finance Department, the General Counsel's office and the Audit and Compliance Department. These recommendations were reviewed and approved by EY. The same process was conducted by the Finance Department, the General Counsel's office, the Audit and Compliance Department and EY with respect to the questionnaires submitted by other officers and key employees. The Audit and Compliance Committee of the Board of Trustees conducted a review of the entire tax return, with the participation of EY, the Finance Department, the General Counsel's office, and the Audit and Compliance Department. The Audit Committee approved the tax returns as presented. The Audit Committee's report of its review of the tax returns and its recommendation to file the returns were presented to, and accepted by, the Executive Committee of the Board of Trustees (the "Executive Committee"). In addition to authorizing the filing of the tax returns, the Executive Committee directed that the returns, which will be filed on or before November 15, 2020, be provided to all trustees via the trustees' confidential website, and those returns were so provided before being filed.</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINE 12C	MONITORING AND ENFORCING COMPLIANCE WITH THE POLICY Compliance with the Organization's Business Conflicts of Interest Policy (the Policy) is required of trustees, employees, medical staff and non-employee members of institutional committees and includes an ongoing duty to disclose potential conflicts. Compliance with the Policy is monitored and enforced regularly and consistently. All disclosures with the potential for conflict are reviewed by an appropriate committee where they are carefully evaluated. When appropriate, a plan, which may involve measures including, but not limited to, recusal from participating in affected transactions, is developed to manage the potential conflict.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINES 15A & 15B	<p>Process for determination of compensation (FOR RELATED ORGS) The Compensation, Employee Benefits and Employee Relations Committee of the Board of Trustees (the Compensation Committee) determines the compensation for the CEO and other executives, including physician leaders, who are or may be disqualified persons as that term is defined in IRC Section 4958. The Compensation Committee also reviews the compensation of other senior and/or highly compensated personnel. The Compensation Committees' Operating Procedures are designed to ensure that the compensation of all such officers and key employees is reasonable (i.e. the value of services is the amount that would ordinarily be paid for like services by like enterprises under like circumstances), and with respect to disqualified persons to follow the specific steps outlined in the IRC regulations for establishing the rebuttable presumption of reasonableness that a transaction is not an excess benefit transaction. The Compensation Committee consists exclusively of independent trustees without any conflict of interest (as defined in the applicable IRC regulations) with regard to the compensation arrangements being reviewed or approved. The absence of any conflict of interest with respect to items on that meeting's agenda is confirmed at the beginning of each meeting of the Compensation Committee. The Compensation Committee selects and engages an independent, qualified compensation consultant which performs such valuations on a regular basis to provide appropriate comparability data. Comparability data includes, but is not limited to, compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the availability of similar services in Mount Sinai's geographic area; current compensation surveys compiled by independent firms; customized surveys in specific circumstances, and actual written offers from similar institutions competing for the services of the disqualified person. The sources of the comparability data used by the compensation consultant are provided to the Compensation Committee. In appropriate circumstances formal written opinions are obtained from the Compensation Consultant. With respect to Executives as they are defined in the policy which includes all of the institution's disqualified persons, the Compensation Committee receives and reviews the comparability data and any analysis provided by the Compensation Consultant, as well as information provided by management, or in the case of the CEO, by the Chairman of the Board of Trustees, including information about the individual's performance, and for new employees, the individual's job description. When a written opinion is obtained from the Compensation Consultant, that written opinion is also reviewed by the Compensation Committee. After considering all of the facts, the Compensation Committee then determines the appropriate compensation in relation to the comparability</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, LINES 15A & 15B	<p>data and in light of the written opinion, recommendations of the Compensation Consultant. As more fully set forth in the Compensation Committee's Operating Guidelines, the Compensation Committee also reviews the compensation arrangements for those other senior management and/or highly compensated personnel who are not Executives. The Compensation Committee is provided details of the compensation arrangement of the individual's job and job performance, the benchmark(s) used and, in certain cases, a description of the role of the Compensation Consultant and a brief description of why the arrangement is appropriate. The Compensation Committee contemporaneously documents in written minutes the terms of the transaction that was approved and the date it was approved; the members of the Compensation Committee who were present; the discussion at the Compensation Committee meeting; the comparability data and any other information obtained and relied on; how the comparability data was obtained; and the Compensation Committee's basis for the decisions, if the approved compensation is outside the range of comparability data. These minutes are prepared before the later of the next meeting of the Compensation Committee or 60 days after the final actions of the Compensation Committee are taken with respect to the compensation decisions made. The minutes are reviewed and approved by the Compensation Committee within a reasonable time thereafter.</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 19	Governing documents and conflict of interest policy available to the public. The organization makes its Business Conflicts of Interest Policy available on its website ( <a href="http://www.mountsinai.org">www.mountsinai.org</a> ) and makes its governing documents and financial statements available upon request.



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART XI, LINE 9 - OTHER CHANGES IN NET ASSETS	CHANGE IN PENSION AND POST-RETIREMENT BENEFITS: -\$1,007,579 MS AMBULATORY JOINT VENTURE \$1,647,605 Total: \$640,026

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION:PHYSICIAN SERVICES TOTAL FEES:124515435

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION:OTHER TEMPORARY SERVICES TOTAL FEES:13559032

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION:CONTRACT SERVICES TOTAL FEES:36964516

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION:CONSULTING FEES TOTAL FEES:3614056

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990 PART IX LINE 11G	DESCRIPTION:COLLECTION AGENCY TOTAL FEES:2003799

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2019**

**Open to Public  
Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ST LUKE'S-ROOSEVELT HOSPITAL CENTER

**Employer identification number**

13-2997301

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
<b>(1)</b> SLRHC 425 WEST 59TH ST CONDO LLC 150 EAST 42ND STREET NEW YORK, NY 10017	REAL ESTATE	NY	9,070,034	43,745,348	SLR

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

See Additional Data Table

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

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

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

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

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No



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

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

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

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

See Additional Data Table

(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) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

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

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

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE R, PART II, COLUMN (F)	DIRECT CONTROLLING ENTITY OF MSMC REALTY CORPORATION: ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, THE MOUNT SINAI HOSPITAL AND THE MSMC REALTY CORPORATION ARE ALL MEMBERS OF THIS ENTITY.

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE R, PART II, COLUMN (F)	DIRECT CONTROLLING ENTITY OF MSMC RESIDENTIAL REALTY LLC: ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, THE MOUNT SINAI HOSPITAL, THE MSMC REALTY CORPORATION AND THE MSMC RESIDENTIAL REALTY MANAGER, INC. ARE ALL MEMBERS OF THIS ENTITY.

<b>Return Reference</b>	<b>Explanation</b>
SCHEDULE R, PART II, COLUMN (F)	DIRECT CONTROLLING ENTITY OF MSMC RESIDENTIAL REALTY MANAGER, INC: ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI, THE MOUNT SINAI HOSPITAL AND THE MSMC REALTY CORPORATION ARE ALL MEMBERS OF THIS ENTITY.

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 13-2997301  
**Name:** ST LUKE'S-ROOSEVELT HOSPITAL CENTER

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3939476	HOLDING CO	NY	501(C)(3)	12 TYPE I	NA		No
FIRST AVENUE AT 16TH STREET NEW YORK, NY 10003 13-5564934	HOSPITAL	NY	501(C)(3)	3	MSHG	Yes	
FIRST AVENUE AT 16TH STREET NEW YORK, NY 10003 13-3444730	HOLDING CO	NY	501(C)(3)	12 TYPE I	BIMC	Yes	
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3838460	SURGICENTER	NY	501(C)(3)	3	BIMC HOLDCO	Yes	
327 EAST 17TH STREET NEW YORK, NY 10003 13-3627753	NURSING HOME	NY	501(C)(3)	3	BIMC HOLDCO	Yes	
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3547502	REAL ESTATE	NY	501(C)(3)	10	BIMC HOLDCO	Yes	
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 11-1018985	HOSPITAL	NY	501(C)(3)	3	CHP		No
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3392851	REAL ESTATE	NY	501(C)(3)	12 TYPE I	SLR	Yes	
1111 AMSTERDAM AVENUE NEW YORK, NY 10025 13-2914343	RESEARCH	NY	501(C)(3)	4	SLR	Yes	
310 EAST 14TH STREET NEW YORK, NY 10003 13-5562304	HOSPITAL	NY	501(C)(3)	3	MSHG	Yes	
310 EAST 14TH STREET NEW YORK, NY 10003 13-4012469	PRIVATE FDN	NY	501(C)(3)	PF	NYEE	Yes	
317-327 EAST 13TH STREET NEW YORK, NY 10003 31-1696826	REAL ESTATE	NY	501(C)(2)	N/A	NYEE	Yes	
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 30-0571387	FUNDRAISING	NY	501(C)(3)	7	BIMC	Yes	
150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 30-0571390	FUNDRAISING	NY	501(C)(3)	7	SLR	Yes	
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 13-6271888	SUPPORT	NY	501(C)(3)	12 TYPE II	MSHS		No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 13-1624096	HOSPITAL	NY	501(C)(3)	3	MSHG	Yes	
1190 FIFTH AVENUE NEW YORK, NY 10029 80-0468600	RESEARCH	NY	501(C)(3)	12 TYPE I	ISMMS		No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 22-3059294	SUPPORT	NY	501(C)(3)	12 TYPE I	ISMMS		No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 13-3852596	REAL ESTATE	NY	501(C)(3)	12 TYPE I	SEE PART VII	Yes	
1425 MADISON AVENUE NEW YORK, NY 10029 20-0244426	REAL ESTATE	NY	501(C)(3)	12 TYPE I	SEE PART VII	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 45-0537391	DIAG CLINIC	NY	501(C)(3)	3	MSH	Yes	
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 20-1289396	MANAGEMENT	NY	501(C)(3)	12 TYPE II	SEE PART VII	Yes	
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 80-0952088	SUPPORT	NY	501(C)(3)	12 TYPE I	ISMMS & MSH	Yes	
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 46-4248304	HOLDING CO	NY	501(C)(3)	12 TYPE II	NA		No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 46-4242915	HOLDING CO	NY	501(C)(3)	12 TYPE II	MSHS		No
ONE GUSTAVE L LEVY PLACE NEW YORK, NY 10029 13-6171197	SCHOOL	NY	501(C)(3)	2	MSHS		No
28 EAST 28TH STREET NEW YORK, NY 10016 13-2914141	RISK MGMT	NY	501(C)(3)	11 TYPE III	NA		No
150 EAST 42ND STREET NEW YORK, NY 10017 81-2057452	healthcare	NY	501(C)(3)	10	MSH		No
ONE HEALTHY WAY OCEANSIDE, NY 115721551 11-1352310	HOSPITAL	NY	501(C)(3)	3	MSHG		No
28 EAST 28TH STREET 14TH FL NEW YORK, NY 10016 82-3994798	SUPPORT	NY	501(C)(3)	12 TYPE II	MSHS		No

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
GREATER METROPOLITAN IPA II 150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3977019	INACTIVE	NY	BIMCSLR	C	0	0	50.000 %		No
GREATER METROPOLITAN IPA V 150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-4141695	INACTIVE	NY	BIMCSLR	C	0	0	50.000 %		No
MANHATTAN MANAGEMENT SERVICES 1780 BROADWAY 7TH FL NEW YORK, NY 10019 13-3618543	MGMT SERVICES	NY	SLR	C	538	2,280,417	100.000 %	Yes	
SLR MANAGEMENT SERVICES 150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3853145	Inactive	NY	SLR	C	0	0	100.000 %	Yes	
WEST CARE MEDICAL PC 150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 13-3811203	INACTIVE	NY	SLR	C	0	0	100.000 %	Yes	
MOUNT SINAI HC VENTURES INC 150 EAST 42ND STREET 5TH FL NEW YORK, NY 10017 46-0953126	HEALTH CARE MGMT	NY	BIMC HOLDCO	C					No
MOUNT SINAI GENOMICS INC 1425 MADISON AVE NEW YORK, NY 10029 47-5349024	CLINICAL LAB	DE	ISMMS	C					No
HIBER-CELL INC 850 NEW BURTON ROAD SUITE 201 DOVER, DE 19904 82-0608182	clinical lab	DE	ismms	c					No
amathus therapeutics inc 1506 boston providence highway ste norwood, MA 02062 81-4373501	biotech/pharma	MA	ismms	c					No



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

<b>(a)</b> Name of related organization	<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
the mount sinai hospital	o	91,009,561	cost
MANHATTAN MANAGEMENT SERVICES INC	R	58,653	COST
the MOUNT SINAI MEDICAL CENTER inc	I	5,387,568	COST
ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI	P	113,569,326	COST
icahn school of medicine at mount sinai	o	42,594,796	cost
icahn school of medicine at mount sinai	q	68,958,943	cost
icahn school of medicine at mount sinai	n	6,143,208	cost
Beth Israel Medical Center	O	1,426,512	cost