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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2018

Open to Public Inspection

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

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

Go to www.irs.gov/Form990 for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

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

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

ST ELIZABETH MEDICAL CENTER

Doing business as

Number and street (or P O box if mail is not delivered to street address)

Room/suite

2209 GENESEE STREET

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

UTICA, NY 135015999

D Employer identification number

15-0532245

E Telephone number

(315) 801-8151

G Gross receipts \$ 228,374,665

F Name and address of principal officer

LOUIS AIELLO

2209 GENESEE STREET

UTICA, NY 135015999

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: ▶ HTTPS //MVHEALTHSYSTEM ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1861

M State of legal domicile NY

Part I

Summary

Activities & Governance

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

ST ELIZABETH MEDICAL CENTER COMMUNITY, INSPIRED BY ST FRANCIS OF ASSISI AND FAITHFUL TO THE TEACHINGS OF THE ROMAN CATHOLIC CHURCH, IS COMMITTED TO EXCELLENCE IN HEALTHCARE AND EDUCATION

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

3 Number of voting members of the governing body (Part VI, line 1a)

20

4 Number of independent voting members of the governing body (Part VI, line 1b)

18

5 Total number of individuals employed in calendar year 2018 (Part V, line 2a)

2,210

6 Total number of volunteers (estimate if necessary)

58

7a Total unrelated business revenue from Part VIII, column (C), line 12

309,841

7b Net unrelated business taxable income from Form 990-T, line 34

0

Revenue

8 Contributions and grants (Part VIII, line 1h)

555,079

9 Program service revenue (Part VIII, line 2g)

213,028,500

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d )

1,539,657

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

6,834,836

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

221,958,072

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3 )

0

14 Benefits paid to or for members (Part IX, column (A), line 4)

0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

125,306,337

16a Professional fundraising fees (Part IX, column (A), line 11e)

0

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

97,660,471

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

222,966,808

19 Revenue less expenses Subtract line 18 from line 12

-1,008,736

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

117,179,581

21 Total liabilities (Part X, line 26)

113,017,092

22 Net assets or fund balances Subtract line 21 from line 20

4,162,489

Beginning of Current Year

End of Year

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

\*\*\*\*\*

Signature of officer

LOUIS AIELLO CFO

Type or print name and title

2019-11-11

Date

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date 2019-11-11

Check ☐ if self-employed

PTIN P00589741

Firm's name ▶ FUST CHARLES CHAMBERS LLP

Firm's EIN ▶ 16-1226221

Firm's address ▶ 5784 WIDEWATERS PARKWAY

SYRACUSE, NY 13214

Phone no (315) 446-3600

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2018)

**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 ELIZABETH MEDICAL CENTER COMMUNITY, INSPIRED BY ST FRANCIS OF ASSISI AND FAITHFUL TO THE TEACHINGS OF THE ROMAN CATHOLIC CHURCH, IS COMMITTED TO EXCELLENCE IN HEALTHCARE AND EDUCATION

**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

<b>4a</b>	(Code )	(Expenses \$	107,366,651	including grants of \$	) (Revenue \$	103,916,387 )
See Additional Data						

<b>4b</b>	(Code )	(Expenses \$	43,750,214	including grants of \$	) (Revenue \$	38,565,116 )
See Additional Data						

<b>4c</b>	(Code )	(Expenses \$	23,291,178	including grants of \$	) (Revenue \$	9,884,798 )
See Additional Data						

	(Code )	(Expenses \$	22,143,386	including grants of \$	) (Revenue \$	73,488,476 )
OTHER PROGRAM SERVICES INCLUDE EMERGENCY ROOM, REFERRED AMBULATORY, CLINICS, FAMILY PRACTICE, SPORTS MEDICINE CENTER, COLLEGE OF NURSING, INTERNS AND RESIDENTS, AND HOME HEALTH AGENCY						

<b>4d</b>	Other program services (Describe in Schedule O )				
	(Expenses \$	22,143,386	including grants of \$	) (Revenue \$	73,488,476 )

<b>4e</b>	<b>Total program service expenses</b> ▶	196,551,429
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b> Yes	
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	<b>5</b>	No
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	<b>6</b>	No
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	<b>7</b> Yes	
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	<b>9</b>	No
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	<b>10</b> Yes	
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	<b>11b</b>	No
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	<b>11c</b>	No
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	<b>14b</b>	No
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	<b>15</b>	No
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	<b>16</b>	No
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	<b>17</b>	No
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	<b>18</b>	No
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	<b>21</b>	No
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	<b>22</b>	No

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

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

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V . . . . . ☐

		Yes	No	
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	1a	161	
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	1b	0	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	1c	Yes	

<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .		<b>2a</b>	2,210			
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				<b>2b</b>	Yes	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .				<b>3a</b>	Yes	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .				<b>3b</b>	Yes	
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .				<b>4a</b>		No
<b>b</b> If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)						
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .				<b>5a</b>		No
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?				<b>5b</b>		No
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .				<b>5c</b>		
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .				<b>6a</b>		No
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .				<b>6b</b>		
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>						
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .				<b>7a</b>		No
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .				<b>7b</b>		
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .				<b>7c</b>		No
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .				<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?				<b>7e</b>		No
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .				<b>7f</b>		No
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .				<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .				<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .						
				<b>8</b>		
<b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . . .				<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .				<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter						
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .				<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities				<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter						
<b>a</b> Gross income from members or shareholders . . . . .				<b>11a</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .				<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?						
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year				<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>						
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O				<b>13a</b>		
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .				<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand . . . . .				<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .				<b>14a</b>		No
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .				<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .				<b>15</b>		No
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .				<b>16</b>		No

**Part VI**

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

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

**Section A. Governing Body and Management**

		Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 20		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O			
<b>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 18		
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	<b>2</b>		No
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>		No
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	<b>9</b>		No

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

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

**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.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

**19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

**20** State the name, address, and telephone number of the person who possesses the organization's books and records:  
 ► LOUIS AIELLO - ST ELIZABETH MEDICAL CENTER 2209 GENESEE STREET UTICA, NY 13501 (315) 624-6143

## 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 ☒

☒

● List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.

● List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."

• List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

● List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations

• List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

[illegible]

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

[illegible]

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	3,993,459	2,135,535	270,614

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 146

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

## Section B. Independent Contractors

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

(A)	(B)	(C)
Name and business address	Description of services	Compensation
UPTOWN ANESTHESIA ASSOCIATION  2405 GENESEE STREET UTICA, NY 13501	ANESTHESIA SERVICES	2,093,791
STAT STAFF PROFESSIONALS  18 DIVISION STREET SARATOGA SPRINGS, NY 12866	MEDICAL STAFFING SERVICES	1,645,859
BROADREACH MEDICAL RESOURCES INC  1350 BROADWAY STE 410 NEW YORK, NY 10018	HEALTH INSURANCE AGENCY	1,494,701
MAYO COLLABORATIVE SERVICES  PO BOX 9146 MINNEAPOLIS, MN 55480	LABRATORY SERVICES	1,009,075
CNY BRAIN AND SPINE NEUROSURGERY  83 GENESEE STREET NEW HARTFORD, NY 13413	COMPREHENSIVE SPINE CENTER	615,200

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 29



**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	<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>	221,366			
	<b>e</b> Government grants (contributions)	<b>1e</b>	239,148			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	11,381			
	<b>g</b> Noncash contributions included in lines 1a - 1f \$ _____					
	<b>h Total.</b> Add lines 1a-1f . . . . . ▶			471,895		
Program Service Revenue		Business Code				
	<b>2a</b> MEDICARE/MEDICAID PATIENT REVENUE	900099	131,933,860	131,933,860		
	<b>b</b> PATIENT SERVICE REVENUE	900099	81,693,568	81,693,568		
	<b>c</b> NURSING HOME & CYTOLOGY LAB TESTI	621500	350,323		350,323	
	<b>d</b> _____					
	<b>e</b> _____					
	<b>f</b> All other program service revenue					
	<b>g Total.</b> Add lines 2a-2f . . . . . ▶			213,977,751		
Other Revenue	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		653,825			653,825
	<b>4</b> Income from investment of tax-exempt bond proceeds ▶					
	<b>5</b> Royalties . . . . . ▶					
	<b>6a</b> Gross rents	(i) Real (ii) Personal				
		743,251				
	<b>b</b> Less rental expenses	139,276				
	<b>c</b> Rental income or (loss)	603,975				
	<b>d</b> Net rental income or (loss) . . . . . ▶		603,975		-40,482	644,457
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities (ii) Other				
		300,594				
	<b>b</b> Less cost or other basis and sales expenses	200,000				
	<b>c</b> Gain or (loss)	100,594				
	<b>d</b> Net gain or (loss) . . . . . ▶		100,594			100,594
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . . <b>a</b>					
	<b>b</b> Less direct expenses . . . . . <b>b</b>					
	<b>c</b> Net income or (loss) from fundraising events . . . . . ▶					
	<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . . <b>a</b>					
	<b>b</b> Less direct expenses . . . . . <b>b</b>					
	<b>c</b> Net income or (loss) from gaming activities . . . . . ▶					
	<b>10a</b> Gross sales of inventory, less returns and allowances . . . . . <b>a</b>					
	<b>b</b> Less cost of goods sold . . . . . <b>b</b>					
	<b>c</b> Net income or (loss) from sales of inventory . . . . . ▶					
Miscellaneous Revenue	Business Code					
<b>11a</b> MLMIC DISTRIBUTION	900099	4,951,001	4,951,001			
<b>b</b> POPULATION HEALTH	900099	3,858,390	3,858,390			
<b>c</b> TUITION AND FEES	900099	2,005,593	2,005,593			
<b>d</b> All other revenue . . . . .		1,412,365	1,412,365			
<b>e Total.</b> Add lines 11a-11d . . . . . ▶		12,227,349				
<b>12 Total revenue.</b> See Instructions . . . . . ▶		228,035,389	225,854,777	309,841	1,398,876	

**Part IX Statement of Functional Expenses**

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

Check if Schedule O contains a response or note to any line in this Part IX ☐**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	979,461	880,829	98,632	
<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).				
<b>7</b> Other salaries and wages.	103,309,975	89,337,094	13,972,881	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	1,993,783	1,976,876	16,907	
<b>9</b> Other employee benefits.	10,989,570	9,250,452	1,739,118	
<b>10</b> Payroll taxes.	7,441,261	6,434,816	1,006,445	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	269,763	233,277	36,486	
<b>c</b> Accounting.	134,496	116,305	18,191	
<b>d</b> Lobbying.	37,306	32,260	5,046	
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	17,216,009	14,887,509	2,328,500	
<b>12</b> Advertising and promotion.				
<b>13</b> Office expenses.	51,665,237	44,677,410	6,987,827	
<b>14</b> Information technology.				
<b>15</b> Royalties.				
<b>16</b> Occupancy.	2,162,669	1,851,326	311,343	
<b>17</b> Travel.	45,515	39,359	6,156	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	190,602	164,823	25,779	
<b>20</b> Interest.	1,171,494	1,013,047	158,447	
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	9,177,509	7,936,233	1,241,276	
<b>23</b> Insurance.	1,932,548	1,671,167	261,381	
<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> BAD DEBTS	9,285,881	9,285,881		
<b>b</b> EQUIPMENT RENTAL AND MA	6,920,746	5,984,640	936,106	
<b>c</b> DEBT ASSESSMENT	647,525	559,946	87,579	
<b>d</b> PUBLIC RELATIONS	252,304	218,179	34,125	
<b>e</b> All other expenses				
<b>25</b> Total functional expenses. Add lines 1 through 24e.	225,823,654	196,551,429	29,272,225	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 . . . . .		8,958,465	<b>1</b>	8,272,017	
	<b>2</b>	Savings and temporary cash investments . . . . .			<b>2</b>		
	<b>3</b>	Pledges and grants receivable, net . . . . .			<b>3</b>		
	<b>4</b>	Accounts receivable, net . . . . .		23,863,030	<b>4</b>	22,054,067	
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .			<b>5</b>		
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L . . . . .			<b>6</b>		
	<b>7</b>	Notes and loans receivable, net . . . . .			<b>7</b>		
	<b>8</b>	Inventories for sale or use . . . . .		5,699,965	<b>8</b>	6,582,114	
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		1,558,446	<b>9</b>	1,303,981	
	<b>10a</b>	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b>	196,502,473			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b>	136,355,716	60,273,083	<b>10c</b>	60,146,757
	<b>11</b>	Investments—publicly traded securities . . . . .		3,692,689	<b>11</b>	8,541,410	
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .			<b>12</b>		
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>		
	<b>14</b>	Intangible assets . . . . .			<b>14</b>		
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		13,133,903	<b>15</b>	11,470,336	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		117,179,581	<b>16</b>	118,370,682		
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		26,016,583	<b>17</b>	24,569,896	
	<b>18</b>	Grants payable . . . . .			<b>18</b>		
	<b>19</b>	Deferred revenue . . . . .			<b>19</b>		
	<b>20</b>	Tax-exempt bond liabilities . . . . .		22,753,734	<b>20</b>		
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>		
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .			<b>22</b>		
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		2,363,266	<b>23</b>	23,740,736	
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .		3,127,210	<b>24</b>	2,811,125	
	<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		58,756,299	<b>25</b>	65,528,043	
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		113,017,092	<b>26</b>	116,649,800	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>						
	<b>27</b>	Unrestricted net assets		2,524,324	<b>27</b>	273,138	
	<b>28</b>	Temporarily restricted net assets . . . . .		610,612	<b>28</b>	0	
	<b>29</b>	Permanently restricted net assets		1,027,553	<b>29</b>	1,447,744	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>						
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>		
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>		
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>		
<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		4,162,489	<b>33</b>	1,720,882		
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		117,179,581	<b>34</b>	118,370,682		

**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>	228,035,389
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	225,823,654
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	2,211,735
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	4,162,489
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	-1,354,860
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-3,298,482
<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>	1,720,882

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☒

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

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 15-0532245  
**Name:** ST ELIZABETH MEDICAL CENTER

Form 990 (2018)

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

INPATIENT SERVICES- ST ELIZABETH MEDICAL CENTER IS A FULL SERVICE GENERAL HOSPITAL WITH 201 LICENSED BEDS THE HOSPITAL PROVIDES A FULL RANGE OF ROUTINE AND ANCILLARY SERVICES, INCLUDING CARDIAC SURGERY AND ANGIOPLASTY DISBURSEMENTS MADE BY THE HOSPITAL ARE EXCLUSIVELY FOR SERVICES AND MATERIALS USED IN PERFORMING THE HOSPITAL'S EXEMPT FUNCTIONS ST ELIZABETH MEDICAL CENTER PROVIDES CARE TO EVERYONE REGARDLESS OF RACE, RELIGION OR ABILITY TO PAY

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

AMBULATORY SURGERY- ST ELIZABETH MEDICAL CENTER HAS A FULL RANGE OF AMBULATORY SURGERY SERVICES ON ITS CAMPUS FOR PATIENTS THAT DO NOT REQUIRE OVERNIGHT OR LONG INPATIENT STAYS ST ELIZABETH MEDICAL CENTER PROVIDES SERVICES TO EVERYONE REGARDLESS OF RACE, RELIGION, OR ABILITY TO PAY

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

COMMUNITY MEDICINE - IN ADDITION TO HAVING OUTPATIENT VISITS ON SITE, ST ELIZABETH MEDICAL CENTER HAS SEVERAL OFF-SITE CLINICS TO PROVIDE PATIENTS WITH CONVENIENT MEDICAL CARE AT A LOWER COST THAN IN THE HOSPITAL SETTING THE OFF-SITE CLINICS INCLUDE FAMILY PRACTICE AND COMMUNITY MEDICINE

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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			
NORMAN SIEGEL ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
GREGORY MCLEAN ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
GREGORY EVANS ..... SECRETARY	1 00 ..... 2 50	X		X				0	0	0
JOAN COMPSON ..... CHAIR	1 50 ..... 3 50	X		X				0	0	0
RICHARD TANTILLO ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
PAUL DAVIDSON MD ..... DIRECTOR/SEMC MEDICAL STAFF PRESIDENT	1 00 ..... 2 50	X						0	294,733	0
STEPHEN SWEET ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
DOMENIC P AIELLO MD ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
CATHERINE BROWNELL PHD ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
BONNIE WOODS ..... VICE CHAIR	1 00 ..... 2 50	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			
BARBARA BRODOCK ..... DIRECTOR	1 00 ..... 3 50	X						0	0	0
CATHERINE COMINSKY ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
ANDREW KOWALCZYK III ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
SYMEON TSOUPELIS ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
LAUREN BULL ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
RICHARD ZWEIFEL ..... TREASURER	1 00 ..... 2 50	X		X				0	0	0
WALEED ALBERT MD ..... DIRECTOR/FSLH MEDICAL STAFF PRESIDENT	1 00 ..... 2 50	X						0	50,004	0
ROBERT DICKS ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
ALICIA DETRAGLIA MD ..... DIRECTOR	1 00 ..... 2 50	X						0	0	0
KAREN LEACH ..... DIRECTOR	1 00 ..... 2 50	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			
SCOTT PERRA ..... PRESIDENT/CEO	20 00 ..... 35 00			X				0	912,630	31,906
LOUIS AIELLO ..... CFO	18 00 ..... 32 00			X				449,545	0	44,480
LINDA MCCORMACK-MILLER ..... CNO	20 00 ..... 30 00				X			0	280,112	22,890
ROBERT SCHOLEFIELD ..... COO	20 00 ..... 30 00				X			443,313	0	42,124
MICHAEL TREVISANI MD ..... CMO	20 00 ..... 30 00				X			0	417,179	26,097
STEVEN LEVINE MD ..... PHYSICIAN	50 00 .....					X		414,702	0	34,632
NICHOLAS QUANDAH MD ..... PHYSICIAN	50 00 .....					X		602,170	0	7,643
LASZLO FUZESI MD ..... PHYSICIAN	50 00 .....					X		808,166	0	13,482
ANNE CAHILL MD ..... PHYSICIAN	50 00 .....					X		631,918	0	14,609
FREDERICK JOYCE MC ..... PHYSICIAN	50 00 .....					X		643,645	0	32,751



<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> 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 <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for the latest information.	OMB No 1545-0047
		<b>2018</b>
		<b>Open to Public Inspection</b>
Department of the Treasury Internal Revenue Service	<b>Name of the organization</b> ST ELIZABETH MEDICAL CENTER	<b>Employer identification number</b> 15-0532245

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university
- 10

☐

An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☐

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- a

☐

**Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
- b

☐

**Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
- c

☐

**Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
- d

☐

**Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
- e

☐

Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
- f

Enter the number of supported organizations
- g

Provide the following information about the supported organization(s)

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)  
(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

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

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI )						
11	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					<b>12</b>	
13	<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						
14	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))					14
15	Public support percentage for 2017 Schedule A, Part II, line 14					15
16a	<b>33 1/3% support test—2018.</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>33 1/3% support test—2017.</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"/>					
17a	<b>10%-facts-and-circumstances test—2018.</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>10%-facts-and-circumstances test—2017.</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"/>					
18	<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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 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 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

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

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

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

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

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

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

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

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

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> 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 <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</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 <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</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 <b>Part VI</b>, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).</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 <b>Part VI</b>.</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 <b>Part VI</b>.</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 <b>Part VI</b>.</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 <b>Part VI</b>.</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 (see instructions)		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test. Answer (a) and (b) below.		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>3</b> Parent of Supported Organizations. Answer (a) and (b) below.		
<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>		



<b>Part V</b> <b>Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations</b>			
<div><div>1</div><div><input type="checkbox"/></div><div>Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). <b>See instructions.</b> All other Type III non-functionally integrated supporting organizations must complete Sections A through E.</div></div>			
<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	8	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	
<b>Section C - Distributable Amount</b>			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<div><div><input type="checkbox"/></div><div>Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).</div></div>		

Part V

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

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

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

Additional Data

Software ID:  
Software Version:  
EIN: 15-0532245  
Name: ST ELIZABETH MEDICAL 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 C**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

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

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2018**

**Open to Public Inspection**

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

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

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

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

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

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

Name of the organization ST ELIZABETH MEDICAL CENTER	Employer identification number 15-0532245
---	--

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

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions) ▶

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

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

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

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

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

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

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

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

**Limits on Lobbying Expenditures**  
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing  
organization's  
totals**(b)** Affiliated  
group totals

**1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)

**b** Total lobbying expenditures to influence a legislative body (direct lobbying)

**c** Total lobbying expenditures (add lines 1a and 1b)

**d** Other exempt purpose expenditures

**e** Total exempt purpose expenditures (add lines 1c and 1d)

**f** Lobbying nontaxable amount Enter the amount from the following table in both columns

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

**g** Grassroots nontaxable amount (enter 25% of line 1f)

**h** Subtract line 1g from line 1a If zero or less, enter -0-

**i** Subtract line 1f from line 1c If zero or less, enter -0-

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

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

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

Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?		No	
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?	Yes		37,306
<b>j</b>	Total. Add lines 1c through 1i			37,306
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV Supplemental Information**

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

Return Reference	Explanation
PART II-B, LINE 1	ACTIVITIES INCLUDE THE PORTION OF DUES PAID TO THE HEALTH CARE ASSOCIATION OF NEW YORK STATE

SCHEDULE D  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Financial Statements

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
ST ELIZABETH MEDICAL CENTER

Employer identification number  
15-0532245

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 1
b Total acreage restricted by conservation easements	2b 20 00
c Number of conservation easements on a certified historic structure included in (a)	2c 0
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 0

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 ►

1

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
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

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

☐

Part V

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	1,638,165	1,415,847	1,340,040	1,398,830	1,577,815
b Contributions	126,871	233,401	201,009	443,543	167,788
c Net investment earnings, gains, and losses	-59,273	169,133	93,248	57,198	39,503
d Grants or scholarships	119,411	13,100	21,250	10,450	13,100
e Other expenditures for facilities and programs	138,608	167,116	197,200	549,081	373,176
f Administrative expenses					
g End of year balance	1,447,744	1,638,165	1,415,847	1,340,040	1,398,830

2

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

a

Board designated or quasi-endowment

73 580 %

b

Permanent endowment

26 420 %

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

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

	Yes	No
3a(i)		No
3a(ii)	Yes	
3b	Yes	

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,456,817		6,456,817
b Buildings		76,062,603	54,005,889	22,056,714
c Leasehold improvements				
d Equipment		113,983,053	82,349,827	31,633,226
e Other				
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				60,146,757



Part VII

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

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

Part VIII

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

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

Part IX

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

(a) Description	(b) Book value
(1) GRANT AND TUITION RECEIVABLES	3,990,017
(2) ASSETS WHOSE USE IS LIMITED- BOND FUNDS	1,447,120
(3) INTEREST IN NET ASSETS OF SEMC FOUNDATION	4,572,884
(4) INVESTMENTS RESTRICTED BY DONORS	1,460,315
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	11,470,336

Part X

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
ACCRUED PENSION LIABILITY	47,940,922
LIABILITY TO THIRD PARTY PAYORS	1,402,439
PROFESSIONAL LIABILITY DEDUCTIBLE	4,518,369
OTHER LONG-TERM LIABILITIES	832,421
DUE TO AFFILIATES	6,434,432
OTHER CURRENT LIABILITIES	1,472,780
CAPITAL LEASE OBLIGATIONS	2,926,680
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	65,528,043

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:** 15-0532245  
**Name:** ST ELIZABETH MEDICAL CENTER

**Supplemental Information**

Return Reference	Explanation
PART II, LINE 9	THE AMOUNT OF CONSERVATION EASEMENT IS IMMATERIAL TO FINANCIAL STATEMENTS AND THEREFORE, IS NOT RECORDED AS PART OF TOTAL ASSETS

Supplemental Information	
Return Reference	Explanation
PART V, LINE 4	ENDOWMENT FUNDS - THE INTENDED PURPOSE OF THE MEDICAL CENTER'S ENDOWMENT FUNDS IS TO PROVIDE FUTURE SCHOLARSHIP AWARDS FOR STUDENTS IN THE COLLEGE OF NURSING PROGRAM

## Supplemental Information

Return Reference	Explanation
PART X, LINE 2	THE MEDICAL CENTER AND THE FOUNDATION HAVE BEEN RECOGNIZED AS TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AS OF DECEMBER 31, 2018 AND 2017, THE MEDICAL CENTER AND THE FOUNDATION DID NOT HAVE ANY UNRECOGNIZED TAX BENEFITS OR ANY RELATED ACCRUED INTEREST OR PENALTIES THE TAX YEARS OPEN TO EXAMINATION BY FEDERAL AND STATE TAXING AUTHORITIES ARE 2015 THROUGH 2018 THE MEDICAL CENTER DOES NOT ANTICIPATE THE TOTAL UNRECOGNIZED TAX BENEFITS WILL CHANGE IN THE NEXT TWELVE MONTHS

SCHEDULE H  
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
ST ELIZABETH MEDICAL CENTER

Employer identification number  
15-0532245

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input 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		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 25000 0000000000 %		
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	3b Yes	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 32500 0000000000 %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	No
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H		

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2,284,826	1,254,862	1,029,964	0 480 %
b Medicaid (from Worksheet 3, column a)			43,437,376	33,592,861	9,844,515	4 550 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			4,121,992	2,653,636	1,468,356	0 680 %
d Total Financial Assistance and Means-Tested Government Programs			49,844,194	37,501,359	12,342,835	5 710 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			316,228	0	316,228	0 150 %
f Health professions education (from Worksheet 5)			7,638,141	6,404,331	1,233,810	0 570 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			107,463	7,050	100,413	0 050 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			8,061,832	6,411,381	1,650,451	0 770 %
k Total. Add lines 7d and 7j			57,906,026	43,912,740	13,993,286	6 480 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>						

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>	9,285,881	
<b>3</b> 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.	<b>3</b>	387,000	
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	57,905,031
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	63,054,110
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	-5,149,079
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes	
<b>b</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.	<b>9b</b>	Yes	

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b> MVEC	GASTROENTEROLOGY SERVICES	20.000 %	0 %	0 %
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				



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

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

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

**1**

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

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
ST ELIZABETH MEDICAL CENTER**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

**Community Health Needs Assessment**

	Yes	No
<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? . . . . .	<b>1</b>	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 . . . . .	<b>2</b>	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)	<b>3</b> 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>16</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b> 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 . . . . .	<b>6a</b> 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 . . . . .	<b>6b</b> Yes	
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //MVHEALTHSYSTEM ORG</u>		
<b>b</b> <input checked="" type="checkbox"/> Other website (list url) <u>HTTP //OCGOV NET</u>		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b> Yes	
<b>a</b> If "Yes" (list url) <u>HTTP //MVHEALTHSYSTEM ORG</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<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 ELIZABETH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 000000000000 % and FPG family income limit for eligibility for discounted care of 325 000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input type="checkbox"/> Asset level			
d <input type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input type="checkbox"/> Underinsurance discount			
g <input checked="" type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance? 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	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) HTTP //MVHEALTHSYSTEM ORG			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) HTTP //MVHEALTHSYSTEM ORG			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) HTTP //MVHEALTHSYSTEM ORG			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <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			
j <input type="checkbox"/> Other (describe in Section C)			

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

ST ELIZABETH MEDICAL CENTER

**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? . . . . .	<b>17</b> 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? . . . . .	<b>19</b>	No
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)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b> Yes	
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)		

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

ST ELIZABETH MEDICAL CENTER

**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>22</b>		
<b>23</b>		No
<b>24</b>		No

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

[illegible]

**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? **18**

Name and address	Type of Facility (describe)
<b>1</b> See Additional Data Table	
<b>2</b>	
<b>3</b>	
<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
PART I, LINE 7	THE PATIENTS COST-TO-CHARGE RATIO WAS COMPUTED USING ALL CHARGES AND EXPENSES LESS NON-ALLOWABLE THE COST TO CHARGE RATIO WAS USED TO COMPUTE COST COST-TO-CHARGE WAS DERIVED BY DIVIDING TOTAL CHARGES FROM THE FINANCIAL STATEMENTS INTO TOTAL COST FROM THE FINANCIAL STATEMENTS, LESS NON-PATIENT COSTS



# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$9,285,881

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 4	<p>990 PART III LINE 4 (FOOTNOTE)THE MEDICAL CENTER PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES THE MEDICAL CENTER'S POLICY IS NOT TO PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEREFORE, THESE AMOUNTS ARE NOT REPORTED IN NET PATIENT SERVICE REVENUE DURING 2018 AND 2017, COSTS INCURRED BY THE MEDICAL CENTER IN THE PROVISION OF CHARITY CARE WERE BASED ON THE RATIO OF THE MEDICAL CENTER'S COSTS TO GROSS CHARGES AND APPROXIMATED \$387,000 AND \$616,000 FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017, RESPECTIVELY 990 PART III, LINE 3 THE MEDICAL CENTER GRANTS CREDIT WITHOUT COLLATERAL TO PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY AGREEMENTS ADDITIONS TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS ARE MADE BY MEANS OF THE PROVISION FOR DOUBTFUL ACCOUNTS ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE AND SUBSEQUENT RECOVERIES ARE ADDED THE AMOUNT OF THE PROVISION FOR DOUBTFUL ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENT HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS SERVICES RENDERED TO INDIVIDUALS WHEN PAYMENT IS EXPECTED AND ULTIMATELY NOT RECEIVED ARE WRITTEN OFF TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS</p>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	THE COSTING METHODOLOGY USED TO DETERMINE THE AMOUNT REPORTED ON LINE 6 IS COST TO CHARGE RATIO THE SHORTFALL REPORTED IS COMMUNITY BENEFIT EXPENSE BECAUSE THIS AMOUNT REPRESENTS THE UNREIMBURSED COSTS TO THE MEDICAL CENTER FOR PROVIDING CARE FOR THE COMMUNITY'S ELDERLY AND DISABLED

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	COLLECTION POLICY PROVISIONS PATIENTS THAT QUALIFY FOR THE MEDICAL CENTER'S CHARITY CARE PROGRAM HAVE THE CHARGES ON THEIR ACCOUNTS FORGIVEN AS THEY ARE PLACED IN CHARITY CARE AND THE BALANCES ARE WRITTEN OFF THE MEDICAL CENTER'S CHARITY CARE PROGRAM USED THE FEDERAL POVERTY GUIDELINES (FPG) AS A GUIDE WITH HIGH-END LIMITS AT 300% OF THE FPG IN THOSE SITUATIONS WHERE THE PATIENT'S INCOME IS BETWEEN 200% - 300% OF THE FPG, A SMALL COST SHARE WOULD BE THE ONLY AMOUNT NOT INCLUDED IN CHARITY CARE ADDITIONALLY THIS SMALL COST SHARE WOULD BE THE ONLY AMOUNT TURNED OVER TO COLLECTION WITH THE OPPORTUNITY OF EVENTUALLY BEING WRITTEN OF TO BAD DEBT IF NOT PAID

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 2	<p>A VARIETY OF DATA SOURCES WERE USED TO IDENTIFY AND CONFIRM PRIORITIES INCLUDING THE NYS PREVENTION AGENDA DASHBOARD, HEALTHCONNECTIONS, NEW YORK STATE QUITLINE PARTNERS REPORTS, ONEIDA COUNTY TEEN ASSESSMENT PROJECT (TAP), AND THE PEDIATRIC NUTRITION SURVEILLANCE SYSTEM (PEDNSS) REPORTS THE PLANNING TEAM ALSO REVIEWED DATA FROM THE JOHN SNOW, INC COMMUNITY HEALTH ASSESSMENT FOR THE CENTRAL NEW YORK CARE COLLABORATIVE (CNYCC), THE COUNTY HEALTH RANKINGS, AND BRIDGES COMMUNITY SURVEY THE PLANNING TEAM WORKED TO SOLICIT FEEDBACK FROM COMMUNITY MEMBERS THROUGHOUT THE YEAR ROME MEMORIAL HOSPITAL HOSTED A COMMUNITY FORUM TO SOLICIT FEEDBACK FROM COMMUNITY MEMBERS AND PARTICIPATED IN THE CITY OF ROME'S HUD COMMUNITY NEEDS ASSESSMENT, ACCESS TO SPECIALTY, PRIMARY, AND BEHAVIORAL HEALTH SERVICES WERE THE MAIN COMMUNITY NEEDS IDENTIFIED ADDITIONALLY, THE PLANNING TEAM REVIEWED THE FINDINGS FROM THE CENTRAL NY CARE COLLABORATIVE (CNYCC) NEEDS ASSESSMENT IN WHICH SOME ITS KEY FINDINGS AND RECOMMENDATIONS ARE ADDRESSED IN THE SELECTED CHIP INTERVENTIONS AND TARGET POPULATIONS FINALLY, THE ONEIDA COUNTY HEALTH DEPARTMENT ASKED SPECIFIC QUESTIONS AT HEALTH FAIRS AND EVENTS WHERE ITS STAFF INTERACTS WITH THE PUBLIC 1) WHAT CAN WE DO AS A COMMUNITY TO HELP MORE MOTHERS BREASTFEED THEIR BABIES?2) WHAT CAN WE DO AS A COMMUNITY TO HELP MORE PEOPLE STOP SMOKING?</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3	<p>PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE THIS IS COMMUNICATED THROUGH ST ELIZABETH MEDICAL CENTER'S FACILITATED ENROLLMENT PROGRAM AND THE FINANCIAL ASSISTANCE PROGRAM INFORMATION IS INCLUDED IN THE PATIENT INFORMATION GUIDES PRESENTED TO INPATIENTS AND OUTPATIENTS AND IS AVAILABLE ON THE HOSPITAL'S WEBSITE ST ELIZABETH MEDICAL CENTER'S FINANCIAL ASSISTANCE PROGRAM TO SUPPORT OUR MISSION, THE ST ELIZABETH MEDICAL CENTER HAS DEVELOPED THE FINANCIAL ASSISTANCE PROGRAM THE MEDICAL CENTER WILL MAKE AVAILABLE A REASONABLE AMOUNT OF UNCOMPENSATED SERVICES TO ELIGIBLE PERSONS ST ELIZABETH MEDICAL CENTER'S FACILITATED ENROLLMENT PROGRAM IN 2000, ST ELIZABETH MEDICAL CENTER DEVELOPED AND IMPLEMENTED THE FACILITATED ENROLLMENT PROGRAM AS A RESULT OF THE UNIQUE COLLABORATION THAT WAS FORGED BETWEEN ST ELIZABETH MEDICAL CENTER AND ONEIDA COUNTY SOCIAL SERVICES DEPARTMENT THIS PROGRAM ALLOWS ST ELIZABETH MEDICAL CENTER STAFF, PATIENT ACCOUNT REPRESENTATIVES, TO ACT AS AN AUTHORIZED REPRESENTATIVE OF THE PATIENT AT THE ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES AND SUBMIT THE APPLICATION FOR BENEFITS THIS SUCCESSFUL PROGRAM HAS EXPANDED THROUGHOUT THE PAST SEVERAL YEARS TO INCLUDE OUTPATIENTS AND EMERGENCY DEPARTMENT PATIENTS</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 4	<p>SERVICE AREA THE ONEIDA COUNTY HEALTH DEPARTMENT AND THE HOSPITALS SERVE THE ENTIRE COUNTY HOSPITAL PATIENT CENSUS INCLUDES RESIDENTS FROM HERKIMER AND MADISON AS WELL, WITH APPROXIMATELY 80% OF PATIENTS RESIDING IN ONEIDA COUNTY ZIP CODES. THE THREE HOSPITALS IN THE COUNTY INCLUDE MOHAWK VALLEY HEALTH SYSTEM WHICH INCLUDES FAXTON-ST LUKE'S HEALTHCARE (FSLH) AND ST ELIZABETH MEDICAL CENTER (SEMC), LOCATED IN THE CITY OF UTICA, AND ROME MEMORIAL HOSPITAL (RMH) LOCATED IN THE CITY OF ROME. GEOGRAPHY ONEIDA COUNTY IS LOCATED IN CENTRAL NEW YORK WITH A POPULATION OF APPROXIMATELY 233,944. THERE ARE THREE CITIES IN THE COUNTY: UTICA (POPULATION OF 62,000), ROME (POPULATION OF 33,000), AND THE SMALL CITY OF SHERRILL. THERE ARE 45 TOWNS AND VILLAGES THAT COVER A TOTAL OF 1,257.11 SQUARE MILES. SIXTY-SEVEN PERCENT (67%) OF THE COUNTY'S POPULATION RESIDES IN URBAN AREAS AND 33% IN RURAL AREAS. AGE LIKE MANY OTHER COMMUNITIES, ONEIDA COUNTY HAS A SIGNIFICANT AND GROWING AGING POPULATION WITH A MEDIAN AGE OF 41.2 AND 16.8% OF THE POPULATION 65 YEARS AND OLDER. RACE &amp; ETHNICITY: THE RACIAL AND ETHNIC CHARACTERISTICS OF ONEIDA COUNTY ARE: WHITE (84.9%), BLACK (5.5%), ASIAN (4.0%), OTHER (2.0%), TWO OR MORE RACES (3.1%), AND HISPANIC OR LATINO (5.5%). ONEIDA COUNTY IS THE HOME OF ONE OF THE LARGEST REFUGEE RESETTLEMENT AGENCIES IN THE COUNTRY, THE MOHAWK VALLEY RESOURCE CENTER FOR REFUGEES (MVRRCR). SINCE 1981, THE MVRRCR HAS RESETTLED OVER 15,000 INDIVIDUALS IN THE CITY OF UTICA OF VARYING ETHNICITIES AND NATIONALITIES INCLUDING VIETNAMESE, RUSSIAN, BOSNIAN, SOMALI, BANTU, BURMESE AND NEPALI TO NAME A FEW (MVRRCR). 17.6% FOREIGN-BORN RESIDENTS CONSTITUTE THE POPULATION OF THE CITY OF UTICA. 26.6% HOUSEHOLDS IN UTICA SPEAK A LANGUAGE OTHER THAN ENGLISH. WITHIN THE COUNTY BORDER IS A PORTION OF THE MEMBERS (549) AND TERRITORY OF THE ONEIDA INDIAN NATION (NYS OFFICE OF CHILDREN AND FAMILY SERVICES, "A PROUD HERITAGE - NATIVE AMERICAN SERVICES IN NYS", 2001 EDITION) IN THE COUNTY, THERE ARE POCKETS OF AMISH AND MENNONITE POPULATIONS IN RURAL AREAS (DATA UNAVAILABLE). ECONOMIC -PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL IS 11.7% AND THE PERCENTAGE WITH RELATED CHILDREN UNDER 18 YEARS IS 20.8%, THE PERCENTAGE OF PEOPLE 65 YEARS AND OLDER BELOW THE POVERTY LEVEL IS 9.1%. THE PERCENTAGE OF THE POPULATION 16 YEARS AND OLDER THAT IS UNEMPLOYED IS 4.8%. -PERCENT WITH HIGH SCHOOL GRADUATE DEGREE OR HIGHER IS 87.5%. -PERCENT OF CIVILIAN NON-INSTITUTIONALIZED POPULATION WITH HEALTH INSURANCE COVERAGE IS 93.1%, 67.5% OF THESE HAVE PRIVATE HEALTH INSURANCE AND 40.6% WITH PUBLIC COVERAGE. 6.9% HAVE NO HEALTH INSURANCE COVERAGE. -THE EIGHT COUNTIES OF CNY HAVE A TOTAL OF 277,458 MEDICAID ENROLLEES, ONONDAGA AND ONEIDA COUNTY ACCOUNT FOR 171,713 OR 62% OF ALL OF THE MEDICAID ENROLLEES. (CENTRAL NY CARE COLLABORATIVE COMMUNITY HEALTH ASSESSMENT)</p>

Form and Line Reference	Explanation
PART VI, LINE 5	<p>THE NEW YORK STATE PREVENTION AGENDA SERVES AS A GUIDE TO HEALTH DEPARTMENTS AND HOSPITALS AS THEY DEVELOP THE CHNA AND PROMOTE COMMUNITY HEALTH. THE SIX PRIORITY AREAS WERE REVISED IN MARCH 2015. THEY ARE 1. IMPROVE HEALTH STATUS AND REDUCE HEALTH DISPARITIES 2. PROMOTE A HEALTHY AND SAFE ENVIRONMENT 3. PREVENT CHRONIC DISEASES * 4. PREVENT HIV/STDs, VACCINE PREVENTABLE DISEASES AND HEALTHCARE-ASSOCIATED INFECTIONS 5. PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN * 6. PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE APPENDIX A - NYS PREVENTION AGENDA DASHBOARD - ONEIDA COUNTY SUMMARIZES SOME OF THE DATA REVIEWED TO ASSESS THE COUNTY'S HEALTH STATUS AND PROGRESS IN ACHIEVING THE NYS PREVENTION AGENDA PRIORITY AREAS OBJECTIVES FOR 2018. THE PLANNING TEAM COLLABORATIVELY ASSESSED WHETHER TO CHANGE OR ADD PRIORITIES BASED ON PROGRESS TO DATE AND OTHER COMMUNITY NEEDS. WHILE THERE WERE MULTIPLE AREAS WORTHY OF SELECTION FOR IMPROVEMENT, THE DATA ANALYSIS BELOW INDICATES THAT THE FOCUS AREAS IDENTIFIED IN THE EXISTING 2013-2017 CHIP MERITED CONTINUED AND SUSTAINED IMPROVEMENT. EFFORTS TO ADDRESS BREASTFEEDING AND TOBACCO CESSATION (SEE TABLE 1). ADDITIONALLY, THE SELECTED PRIORITIES AND GOALS WERE INITIATIVES THAT BOTH HOSPITALS AND PUBLIC HEALTH COULD LEAD AND IMPACT. THE PLANNING TEAM ALSO REGULARLY CONSULTED WITH THE CHIP WORK GROUPS TO ASSESS PROGRESS AND GATHER FEEDBACK ON THE DATA AND GOALS. TABLE 1 IS AN EXTRACTION OF APPENDIX A, AND HIGHLIGHTS INDICATORS RELATED TO THE FOCUS AREAS AND GOALS IN THE CHIP. THE FOLLOWING IS A SUMMARY AND ANALYSIS OF THE FINDINGS. TOBACCO CESSATION: ALTHOUGH THE PERCENTAGE OF ADULTS SMOKING CIGARETTES DECREASED FROM 24% TO 22% SINCE THE 2013 CHIP/CHA, THE PERCENTAGE REMAINS HIGH IN COMPARISON TO NYS (17.3%) AND THE NYS PREVENTION AGENDA OBJECTIVE (12.3%), NOTWITHSTANDING THE FACT THAT SMOKING IS ALSO LINKED TO MULTIPLE CHRONIC DISEASE CONDITIONS INCLUDING DIABETES, HEART DISEASE, STROKE AND ASTHMA. BREASTFEEDING: THE PERCENTAGE OF INFANTS EXCLUSIVELY BREASTFED IN THE HOSPITAL IS 51.7% AND NEAR THE PA OBJECTIVE OF 48.1%. HOWEVER, THERE IS SIGNIFICANT DIFFERENCE BETWEEN THE RATIO FOR AT-RISK POPULATIONS INCLUDING BLACKS (0.39) AND MEDICAID BIRTHS (0.49) AND THE NYS PA OBJECTIVES OF 0.57 AND 0.667, RESPECTIVELY. ALSO, WIC DATA SHOWS IMPROVEMENTS ARE STILL NEEDED FOR INFANTS BREASTFEEDING AT SIX MONTHS (18.5% - PEDNSS 2014). THE INITIATIVES IN THE EXISTING 2013-2017 CHIP ALSO TARGET INDIVIDUALS WITH LOW SOCIOECONOMIC STATUS AND INDIRECTLY IMPACT OTHER INDIVIDUALS WITH DISPARITIES (MINORITIES AND INDIVIDUALS WITH LOW-ENGLISH PROFICIENCY) IDENTIFIED IN THE DEMOGRAPHIC ANALYSIS ABOVE. ADDITIONALLY, FINDINGS IN THE CNY CARE COLLABORATIVE COMMUNITY HEALTH ASSESSMENT, RELATED TO ONEIDA COUNTY, SUPPORT THE NEED FOR INTERVENTIONS TARGETED AT CHRONIC DISEASE PREVENTION (TOBACCO CESSATION) AND PROMOTING HEALTHY WOMEN, INFANTS AND CHILDREN (BREASTFEEDING). THESE INCLUDE THE FOLLOWING: 1. TOTAL PREVENTION QUALITY INDICATORS (PQIS) - PQIS ARE DEFINED AS CONDITIONS FOR WHICH ACCESS TO AND PROVISION OF APPROPRIATE OUTPATIENT CARE CAN PREVENT COMPLICATIONS OF CHRONIC DISEASE AND POTENTIALLY PREVENT THE NEED FOR HOSPITALIZATION. THE LIST OF AREAS THAT REQUIRE CLOSER EXAMINATION RELATED TO INCREASED NEED FOR IMPROVED ACCESS TO OUTPATIENT CARE IN ONEIDA COUNTY INCLUDED UTICA, ROME AND WATERVILLE. THESE AREAS HAVE TOTAL PQI RATES THAT ARE TWO (2) TO FIVE (5) TIMES GREATER THAN THE AVERAGE RATES FOR CENTRAL AND UPSTATE NEW YORK. 2. DIABETES PQI AND INPATIENT HOSPITALIZATION RATES - THE FOLLOWING AREAS HAD ONE OR MORE DIABETES INDICATOR RATES THAT WERE SUBSTANTIALLY HIGHER THAN THE CENTRAL AND UPSTATE NEW YORK BENCHMARK RATES. WOODGATE HAD THE GREATEST NEED. IT HAD THE HIGHEST RATES FOR PQI 1 (SHORT-TERM COMPLICATIONS OF DIABETES) AND PQI 16 (LOWER EXTREMITY AMPUTATION) IN THE EIGHT-COUNTY REGION. IT ALSO HAD THE SECOND HIGHEST RATES FOR PQI 3 (LONG-TERM COMPLICATIONS OF DIABETES). CAMDEN, UTICA AND, TO A LESSER EXTENT, ROME AND A FEW OUTLYING AREAS, ALSO SHOWED UP ON A NUMBER OF DIABETES INDICATORS. 3. RESPIRATORY PQI AND INPATIENT HOSPITALIZATION RATES - THE FOLLOWING AREAS HAD ONE OR MORE RESPIRATORY INDICATOR RATES THAT WERE SUBSTANTIALLY HIGHER THAN THE CENTRAL AND UPSTATE NEW YORK BENCHMARK RATES - THE CITIES OF UTICA AND ROME SHOWED UP CONSISTENTLY ON THE INDICATORS. THERE WERE A FEW AREAS WITH MUCH SMALLER POPULATIONS IN THE COUNTY THAT ALSO APPEARED. 4. CIRCULATORY PQI AND CARDIAC-RELATED INPATIENT HOSPITALIZATION RATES - IN THE CITIES OF ROME AND UTICA, AS WELL AS LEE CENTER, THE RATES OF CORONARY VASCULAR DISEASE DISCHARGES SPECIFICALLY SHOWED A VERY DISTINCT PATTERN. NEARLY ALL OF ONEIDA COUNTY SHOWED HIGH LEVELS OF NEED. GENERAL CONCLUSION: GIVEN THE DISTINCT PATTERN OF CORONARY VASCULAR DISEASE MORBIDITY, IT SEEMS AS THOUGH A BROAD-BASED PROGRAM FOCUSING ON HEALTHY BEHAVIORS SUCH AS PROPER NUTRITION AND EXERCISE WOULD BE VERY BENEFICIAL, NOT ONLY FOR CARDIOVASCULAR-RELATED MORBIDITY, BUT FOR DIABETES.</p>



Form and Line Reference	Explanation
PART VI, LINE 5	<p>TES, AS WELL (SOURCE CNYCC NEEDS ASSESSMENT) FSLH AND SEMC OFFER NUMEROUS FREE, EDUCATION AL EVENTS EACH YEAR TO THE PUBLIC - MAMMOGRAM AND PAP SCREENINGS FOR UNINSURED WOMEN- A WO MEN'S HEALTH OPEN HOUSE FOR ALL WOMEN - GENERAL HEALTH INFORMATION FOR HEART HEALTH AT THE ANNUAL HEART RUN AND WALK EXPO IN 2017, 390 PEOPLE COMPLETED THE HEALTH ASSESSMENT - WHI CH INCLUDED A CHOLESTEROL SCREENING, DIABETIC RISK SCORE, AND BLOOD PRESSURE AND PULMONARY FUNCTION TESTS ST ELIZABETH MEDICAL CENTER PAID FOR THE HEALTH ASSESSMENT - UTICA COLL EGE YOUNG SCHOLARS PROGRAM</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>ST ELIZABETH MEDICAL CENTER (SEMC) AND FAXTON ST LUKE'S HEALTHCARE (FSLH) AFFILIATED UNDER THE MOHAWK VALLEY HEALTH SYSTEM (MVHS) ON MARCH 6, 2014 MVHS MAIN CAMPUSES ST ELIZABETH CAMPUS - 2209 GENESEE STREET, UTICA, NY ST LUKE'S CAMPUS - 1656 CHAMPLIN AVENUE, NEW HARTFORD, NY FAXTON CAMPUS - 1676 SUNSET AVENUE, UTICA, NY THE MVHS MEDICAL GROUP OFFERS 19 PRIMARY CARE OFFICES LOCATED THROUGHOUT ONEIDA AND HERKIMER COUNTIES, A CHILDREN'S HEALTH CENTER, WOMEN'S HEALTH CENTER AND MULTI-SPECIALTY PROVIDERS INCLUDING GENERAL, ORTHOPEDIC, VASCULAR AND CARDIAC AND THORACIC SURGERY, GASTROENTEROLOGY AND ADVANCED ENDOSCOPY, AND NEURO SCIENCES THE SISTER ROSE VINCENT FAMILY MEDICINE CENTER PROVIDES PATIENT CARE SERVICES AND IS ALSO A TEACHING FACILITY FOR NEW PHYSICIANS FAXTON ST LUKE'S HEALTHCARE AREA NOT-FOR-PROFIT HEALTHCARE ORGANIZATION, FSLH INCLUDES ST LUKE'S HOME, SENIOR NETWORK HEALTH, MOHAWK VALLEY HOME CARE AND THE VISITING NURSE ASSOCIATION OF UTICA AND ONEIDA COUNTY ST LUKE'S CAMPUS - BARIATRIC SURGERY PROGRAM - MATERNAL CHILD SERVICES - MOHAWK VALLEY VASCULAR CENTER - STROKE CENTER- SURGICAL AND AMBULATORY SERVICES - TOTAL JOINT ORTHOPEDIC PROGRAM FAXTON CAMPUS - AMBULATORY SURGICAL CENTER - CANCER CENTER - DIALYSIS CENTER - OUTPATIENT REHABILITATION SERVICES- WELLNESS CENTER CENTER FOR REHABILITATION AND CONTINUING CARE SERVICES - ACUTE INPATIENT REHABILITATION UNIT- ADULT DAY HEALTH CARE SERVICE- OUTPATIENT DIALYSIS CENTER- ST LUKE'S HOME- SENIOR NETWORK HEALTH - VISITING NURSE ASSOCIATION OF UTICA AND ONEIDA COUNTY ST ELIZABETH MEDICAL CENTER A NOT-FOR-PROFIT HEALTHCARE ORGANIZATION, SEMC ALSO INCLUDES ST ELIZABETH HOME CARE, WHICH SERVES PATIENTS IN THEIR HOMES AND ST ELIZABETH HEALTH SUPPORT SERVICES OFFERING RESPIRATORY SERVICES AND DURABLE MEDICAL EQUIPMENT TO PATIENTS IN THEIR HOMES SEMC HAS 202 ACUTE CARE BEDS SEMC MAIN CAMPUS - CARDIAC SERVICES- MOHAWK VALLEY SLEEP DISORDERS CENTER- ORTHOPEDIC SERVICES- ST ELIZABETH COLLEGE OF NURSING- ST ELIZABETH FAMILY MEDICINE RESIDENCY PROGRAM- SURGICAL AND AMBULATORY SERVICES- TRAUMA CENTER- FELLOWSHIP IN HOSPITAL MEDICINE - FELLOWSHIP IN GYNECOLOGIC ENDOSCOPY MEDICAL ARTS CAMPUS - ADVANCED WOUND CARE CENTER- IMAGING - MVHS NEW HARTFORD MEDICAL OFFICE- OUTPATIENT LABORATORY DRAW SITE- OUTPATIENT REHABILITATION SERVICES BOTH HOSPITALS ACCEPT ALL MAJOR INSURANCES AND HAVE DESIGNATED CHARITY CARE PROGRAMS TO HELP PROVIDE FOR INDIVIDUALS WITHOUT INSURANCE OUR AFFILIATION ENHANCES SERVICES FOR THE RESIDENTS OF THE MOHAWK VALLEY THROUGH GREATER COLLABORATION AND IMPROVED CLINICAL QUALITY FOR PATIENT AND RESIDENT CARE AS A LARGE SYSTEM, MVHS HAS MUCH TO OFFER WHEN RECRUITING NEW PHYSICIANS SEMC IS A CATHOLIC HOSPITAL, SPONSORED BY THE SISTERS OF ST FRANCIS OF THE NEUMANN COMMUNITIES SPECIALTIES- THE BARIATRIC SURGERY PROGRAM IS AN AMERICAN SOCIETY FOR METABOLIC &amp; BARIATRIC SURGERY BARIATRIC SURGERY CENTER OF EXCELLENCE AS AN ACCREDITED PROGRAM, MVHS DEMONSTRATES THAT OUR CENTER MEETS THE NEEDS OF BARIATRIC SURGERY PATIENTS BY PROVIDING MULTIDISCIPLINARY, HIGH-QUALITY, PATIENT-CENTERED CARE - THE CANCER CENTER PROVIDES CARE TO PATIENTS IN OUR COMMUNITY FROM THE TIME OF DIAGNOSIS THROUGH TREATMENT AND RECOVERY SERVICES INCLUDE OUTPATIENT INFUSION, RADIATION ONCOLOGY, CLINICAL TRIALS, INPATIENT ONCOLOGY, INTEGRATIVE MEDICINE, A BREAST CARE CENTER, A NURSE NAVIGATOR PROGRAM, CANCER EDUCATION AND SUPPORT SERVICES - THE CENTRAL YORK DIABETES EDUCATION PROGRAM (CNY DIABETES) IS RECOGNIZED BY THE AMERICAN DIABETES ASSOCIATION CNY DIABETES OFFERS THE NATIONAL DIABETES PREVENTION PROGRAM WHICH IS ENDORSED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION - THE DIALYSIS CENTER IS THE SOLE PROVIDER OF DIALYSIS TREATMENT WITHIN A 25 MILE SERVICE AREA EACH YEAR, MORE THAN 400 PATIENTS RECEIVE MORE THAN 69,000 DIALYSIS TREATMENTS AT ONE OF SIX FACILITIES LOCATED THROUGHOUT THE MOHAWK VALLEY DIALYSIS CENTERS ARE LOCATED IN UTICA, ROME, HAMILTON AND HERKIMER - FSLH IS THE ONLY DESIGNATED PRIMARY STROKE CENTER IN THE MOHAWK VALLEY AND ONE OF 115 DESIGNATED STROKE CENTERS IN NEW YORK STATE THE ORGANIZATION IS A RECIPIENT OF THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION'S GET WITH THE GUIDELINES STROKE GOLD PLUS ACHIEVEMENT AWARD THE AWARD RECOGNIZES FSLH'S COMMITMENT AND SUCCESS IN IMPLEMENTING EXCELLENT CARE FOR STROKE PATIENTS, ACCORDING TO EVIDENCE-BASED GUIDELINES - MVHS'S ACUTE INPATIENT REHABILITATION PROGRAM IS ACCREDITED BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES THE REHABILITATION CENTER PROVIDES BOTH INPATIENT AND OUTPATIENT SERVICES WITH LOCATIONS AT THE FAXTON CAMPUS, ST LUKE'S CAMPUS, ST LUKE'S HOME, ST ELIZABETH CAMPUS AND ST ELIZABETH MEDICAL ARTS - ST LUKE'S HOME IS A 202-BED LONG TERM CARE FACILITY WITH A 40-BED SUBACUTE REHABILITATION UNIT ST LUKE'S HOME OPENED IN 1996 ON THE ST LUKE'S CAMPUS AND RECENTLY UNDERWENT A \$31.3 MILLION RENOVATION AND EXPANSION - THE VISITING NURSE ASSOCIATION (VNA) OF UTICA</p>

Form and Line Reference	Explanation
PART VI, LINE 6	CA AND ONEIDA COUNTY IS ACCREDITED BY THE COMMUNITY HEALTH ACCREDITATION PROGRAM, INC THE VNA OF UTICA AND ONEIDA COUNTY CELEBRATED ITS 100TH ANNIVERSARY IN 2015 AND SERVES NEARLY 2,200 PATIENTS ANNUALLY

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	NY

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 15-0532245  
**Name:** ST ELIZABETH MEDICAL CENTER

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

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	ST ELIZABETH MEDICAL CENTER 2209 GENESEE STREET UTICA, NY 13501	X			X			X	X	TEACHING HOSPITAL AND 24 HOUR ER	

**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
ST ELIZABETH MEDICAL CENTER	<p>PART V, SECTION B, LINE 5 IN 2013, THE ONEIDA COUNTY HEALTH DEPARTMENT (OCHD), HOSPITALS, AND REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS CONVENED TO DEVELOP THE 2013-2018 COMMUNITY HEALTH ASSESSMENT AND COMMUNITY HEALTH IMPROVEMENT PLAN. THE PLANNING GROUP MET REGULARLY TO DISCUSS THE DATA, COMMUNITY INPUT, AND HEALTH PRIORITIES. INPUT WAS COLLECTED FROM A LARGE COMMUNITY FORUM WITH STAKEHOLDER FEEDBACK ON COMMUNITY STRENGTHS, WEAKNESSES, AND PRIORITY AREAS FOR IMPROVEMENT. A CHA/CHIP PLANNING TEAM COMPRISED OF OCHD, FSL, SEMC AND RMH STAFF MET REGULARLY STARTING IN EARLY 2016. THE PLANNING TEAM MET TO REVIEW AND DISCUSS THE 2016-2018 CHA/CHIP UPDATE PROCESS, CLARIFY EXPECTATIONS, AND DEVELOP A DETAILED WORK PLAN WITH TEAM RESPONSIBILITIES, ASSIGNED TASKS, AND DEADLINES TO DEVELOP AND FINALIZE THE PLAN UPDATE. THE PLANNING TEAM CAME TO CONSENSUS ON THE APPROACH TO UPDATE THE CHA AND REASSESS PRIORITIES ESTABLISHED IN THE CHIP. DATA FROM THE ONEIDA COUNTY PREVENTION AGENDA DASHBOARD, NEW YORK STATE QUILLINE PARTNERS REPORTS, ONEIDA COUNTY TEEN ASSESSMENT PROJECT (TAP), PEDIATRIC NUTRITION SURVEILLANCE SYSTEM (PEDNSS) REPORTS, COUNTY HEALTH RANKINGS, BRIDGES COMMUNITY SURVEY, AND THE CNY CARE COLLABORATIVE (CNYCC) COMMUNITY HEALTH ASSESSMENT WERE REVIEWED TO ASSESS AREAS FOR IMPROVEMENT AND STATUS IN ACHIEVING THE GOALS AND OBJECTIVES OUTLINED IN THE PREVIOUS CHIP. THE CNYCC COMMUNITY HEALTH ASSESSMENT AND WORK TO SUPPORT THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP), AN INITIATIVE TO TRANSFORM THE HEALTH SYSTEM OF NEW YORK STATE, WERE ALSO FACTORED INTO THE ASSESSMENT PROCESS. IN MARCH 2016, THE PLANNING TEAM PRESENTED TO THE ONEIDA COUNTY HEALTH COALITION GENERAL MEMBERSHIP (APPROXIMATELY 60 PEOPLE IN ATTENDANCE) INFORMATION ON THE CHA AND CHIP ACTIVITIES. THE OCHD IS COMPRISED OF BROAD REPRESENTATION OF SECTORS AND ORGANIZATIONS THAT CONVEENE UNDER THE DIRECTION OF THE OCHD TO DISCUSS AND ANALYZE DATA ON VARIOUS HEALTH ISSUES AND TRENDS. PARTNERS WERE PROVIDED WITH A SUMMARY OF THE PREVENTION AGENDA DATA AND THE SELECTED CHIP FOCUS AREAS AND WORK GROUP ACTIVITIES. MEMBERS WERE APPRISED OF AND INVITED TO PARTICIPATE IN THE WORK GROUPS AND COMMUNITY HEALTH ASSESSMENT ACTIVITIES. AS A FOLLOW UP TO COLLECT MORE IN-DEPTH PARTNER FEEDBACK, IN MAY 2016, THE PLANNING TEAM CONVENED MEMBERS OF THE ONEIDA COUNTY HEALTH COALITION STEERING COMMITTEE, A GROUP OF APPROXIMATELY 20 COMMUNITY AGENCIES AND ORGANIZATIONS THAT OVERSEE AND GUIDE THE LARGER COMMUNITY HEALTH PARTNERSHIP. PARTNERS WERE PRESENTED WITH AN OVERVIEW OF THE COMMUNITY HEALTH ASSESSMENT UPDATE AND COMMUNITY HEALTH IMPROVEMENT PLAN REQUIREMENTS, CHIP WORK GROUP PROJECTS, TIMELINES, AND STATUS IN ACHIEVING THE DEFINED GOALS AND OBJECTIVES. THE PREVENTION AGENDA INDICATOR DATA AND GOALS WERE REVIEWED ALONG WITH AN OVERVIEW OF HOW EACH OF THE FOCUS AREAS ALIGN WITH HOSPITAL DSRIP INITIATIVES, SPECIFICALLY THE INITIATIVES OF THE TOBACCO CESSATION WORK GROUP ALIGNED WITH DSRIP FOCUS.</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
ST ELIZABETH MEDICAL CENTER	S AREAS TO DSRIP 4 D I - REDUCE PRETERM BIRTHS AND DSRIP 3 B I - CARDIOVASCULAR DISEASE MANAGEMENT AND THE INITIATIVES OF THE BREASTFEEDING WORK GROUP INDIRECTLY ALIGN WITH DSRIP GOALS (E G , HEALTHY START FOR BABIES AND HEALTH BENEFITS TO MOTHER) TO REDUCE UNNECESSAR Y UTILIZATION THROUGH PRIMARY PREVENTION THE PLANNING TEAM OUTLINED ITS SUCCESSES AND CHA LLENGES AND OBTAINED INPUT FROM THE STEERING COMMITTEE ON AREAS FOR IMPROVEMENT AND IDENTI FIED OTHER POTENTIAL PARTNERS OR RESOURCES THAT COULD SUPPORT CHIP WORK GROUP ACTIVITIES AS A RESULT OF THE DIALOGUE, THE OCHC STEERING COMMITTEE REAFFIRMED THAT THE PLANNING TEAM AND WORK GROUPS SHOULD CONTINUE THEIR EFFORTS TO ADDRESS THE CHIP FOCUS AREAS AND GOALS O UTLINED IN THE 2013-2018 CHIP THE PLANNING TEAM ALSO ESTABLISHED MECHANISMS TO COLLECT CO MMUNITY PERSPECTIVE ON THE CHIP FOCUS AREAS HEALTH DEPARTMENT STAFF PRESENTED A SHORT COM MENT CARD TO COMMUNITY MEMBERS AT ALL SEVEN (7) PUBLIC HEALTH EVENTS ON NEEDS AND PERCEPTI ONS RELATED TO TOBACCO CESSATION AND BREASTFEEDING THE RESULTS OF THIS FEEDBACK ARE IN AP PENDIX B ADDITIONALLY, THE PLANNING TEAM REVIEWED THE FINDINGS FROM THE CNYCC NEEDS ASSES SMENT WHICH INCLUDED A PRIMARY CARE ASSESSMENT, CNY CONSUMER ACCESS SURVEY, CNY SAFETY NET ASSESSMENT (MEDICAID AND SELF-PAY POPULATIONS) AND KEP INFORMANT INTERVIEWS

**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
ST ELIZABETH MEDICAL CENTER	PART V, SECTION B, LINE 6A OTHER REPRESENTATIVES INCLUDED FAXTON ST -LUKE'S HEALTHCARE, ST ELIZABETH MEDICAL CENTER, AND ROME MEMORIAL HOSPITAL



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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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
ST ELIZABETH MEDICAL CENTER	PART V, SECTION B, LINE 6B IN ADDITION TO ONEIDA COUNTY HEALTH DEPARTMENT, CENTRAL NEW YORK HOME HEALTH CARE, HERKIMER-ONEIDA COMPREHENSIVE PLANNING PROGRAM, UTICA COMMUNITY HEALTH CENTER, MOHAWK VALLEY PERINATAL NETWORK, ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES, THE COMMUNITY FOUNDATION OF HERKIMER AND ONEIDA COUNTIES, CORNELL COOPERATIVE EXTENSION, THE PARKWAY CENTER, AMERICAN CANCER SOCIETY, UPSTATE CEREBRAL PALSY, UNITED WAY, ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH, CENTER FOR FAMILY LIFE & RECOVERY, AND THE HOUSE OF THE GOOD SHEPHERD

**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
ST ELIZABETH MEDICAL CENTER	<p>PART V, SECTION B, LINE 11 SINCE 2014, THE TOBACCO CESSATION AND BREASTFEEDING WORK GROUPS HAVE BEEN MEETING QUARTERLY TO REVIEW WORK PLANS AND MONITOR DATA IN CONSULTATION WITH THE PLANNING TEAM, WORK GROUPS REVIEWED THE PREVENTION AGENDA INDICATORS SPECIFIC TO THEIR GOALS, ASSESSED CURRENT STATUS, REAFFIRMED INITIATIVES AND COMMUNITY PARTNERS AND ADJUSTED WORK PLANS FOR 2017-2018 EACH OF THE WORK GROUPS' MAJOR ACCOMPLISHMENTS AND CHALLENGES TO DATE WERE OUTLINED AS FOLLOWS A TOBACCO CESSATION WORK GROUP1 SUCCESSFULLY IMPLEMENTED FAX-TO-QUIT/OPT-TO-QUIT POLICIES WITHIN THREE HOSPITALS IN THE COUNTY AND APPLICABLE OCHD PROGRAM, CONTRIBUTING TO THE INCREASE IN CESSATION REFERRALS 2 SUCCESSFULLY ESTABLISHED RELATIONSHIPS WITH AREA SCHOOLS TO OFFER TOBACCO PREVENTION EDUCATION SESSIONS 3 SUCCESSFULLY DEVELOPED PARTNERSHIPS TO OFFER CESSATION CLASSES 4 SAW AN INCREASE IN NUMBER OF CALLS TO THE QUITLINE 458 (2015) TO 980 (2016 YTD)5 ONEIDA COUNTY HEALTH DEPARTMENT CLINIC STAFF TRAINED IN AN USING 5 A'S WITH PATIENTS B BREASTFEEDING WORK GROUP1 SUCCESSFULLY SUPPORTED COMMUNITY PEER-TO-PEER SUPPORTS FOR BREASTFEEDING WOMEN 2 SUCCESSFULLY IMPLEMENTED DIRECT REFERRAL SYSTEMS FOR TWO OB CLINICS TO REFER WOMEN TO WIC 3 SUCCESSFULLY STARTED PARTNERSHIP WITH EDUCATION FOR CHILD CARE PROVIDERS 4 SUCCESSFULLY IMPLEMENTED THE BREASTFEEDING FRIENDLY PLACES IN THE COMMUNITY THROUGH THE BREASTFEED YOUR BABY HERE (BYBH) INITIATIVE 5 MEDIA PROMOTION TO SUPPORT OPENING OF ADDITIONAL BREASTFEEDING CARE LOCATIONS THROUGH TARGETING UNDESERVED POPULATIONS 6 FSLH PARTICIPATED IN GREAT BEGINNINGS LEARNING COLLABORATIVE 7 COMMUNITY EDUCATION AND WEIGH STATIONS PROVIDED ONGOING BREASTFEEDING SUPPORT (RMH AND OCHD) 8 CHALLENGE IN EFFECTIVENESS OF FEEDING COUNSELING SESSIONS AT OB CLINICS ALTHOUGH A SUBSTANTIAL AMOUNT OF WOMEN WERE EDUCATED, SIGNIFICANT CHANGES IN BREASTFEEDING OUTCOMES AT DELIVERY WERE NOT SEEN AND IT WAS NOT A SUSTAINABLE MODEL 9 CHALLENGE IN CONNECTING DELIVERY PATIENTS WITH WIC PEER COUNCELORS UPON DELIVERY IDENTIFIED INDIRECT WAYS TO MAKE THIS TIMELY CONNECTION, MAINLY THROUGH USING SOCIAL MEDIA</p>

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

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

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

Name and address	Type of Facility (describe)
1 1 - MEDICAL ARTS 4401 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	OUTPATIENT LAB
1 2 - SEMC AT FAMILY PRACTICE CENTER 120 HOBART STREET UTICA, NY 13501	OUTPATIENT PHYSICIAN CLINIC/OUTPATIENT LAB/X-RAY
2 3 - WOMEN & CHILDREN'S FAMILY HEALTH CENTER 2212 GENESEE STREET UTICA, NY 13501	OUTPATIENT PHYSICIAN CLINIC
3 4 - WOUND CARE SERVICES 4401 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	OUTPATIENT PHYSICIAN CLINIC
4 5 - FAMILY PRACTICE NEW HARTFORD 4401 MIDDLE SETTLEMENT ROAD NEW HARTFORD, NY 13413	OUTPATIENT PHYSICIAN CLINIC
5 6 - COMMUNITY MEDICINE AT EAST UTICA 1256 CULVER AVENUE UTICA, NY 13501	OUTPATIENT PHYSICIAN CLINIC/OUTPATIENT LAB
6 7 - MARIAN MEDICAL 2211 GENESEE STREET UTICA, NY 13501	OUTPATIENT LAB/PHYSICIAN CLINIC/CT SURGERY GROUP
7 8 - LITTLE FALLS FAMILY PRACTICE 500 EAST MAIN STREET LITTLE FALLS, NY 13365	OUTPATIENT PHYSICIAN CLINIC/OUTPATIENT LAB
8 9 - TOWN OF WEBB HEALTH CENTER 114 SOUTH SHORE ROAD OLD FORGE, NY 13420	OUTPATIENT PHYSICIAN CLINIC/OUTPATIENT LAB
9 10 - SLEEP DISORDERS CENTER 2215 GENESEE STREET UTICA, NY 13501	OUTPATIENT PHYSICIAN CLINIC
10 11 - COMMUNITY MEDICAL SERVICES SOUTH UTICA 6 HAMPDEN PLACE UTICA, NY 13501	OUTPATIENT PHYSICIAN CLINIC
11 12 - ST ELIZABETH LAB 86 GENESEE STREET NEW HARTFORD, NY 13413	OUTPATIENT LAB
12 13 - ST ELIZABETH LAB - ONEIDA 131 MAIN STREET ONEIDA, NY 13421	OUTPATIENT LAB
13 14 - ST ELIZABETH LAB - RIDGE MILLS 7845 ROME WESTERNVILLE ROAD ROME, NY 13440	OUTPATIENT LAB
14 15 - ST ELIZABETH LAB UPSTATE CEREBRAL PALSY 1427 GENESEE STREET UTICA, NY 13501	OUTPATIENT LAB

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

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

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

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

Name and address	Type of Facility (describe)
<b>16</b> 16 - ST ELIZABETH LAB AT UTICA BUSINESS PARK 125 BUSINESS PARK DRIVE SUITE 135 UTICA, NY 13502	OUTPATIENT LAB
<b>1</b> 17 - ST ELIZABETH LAB - WASHINGTON MILLS 3946 ONEIDA STREET NEW HARTFORD, NY 13413	OUTPATIENT LAB
<b>2</b> 18 - ST ELIZABETH LAB - WHITESBORO 37 MAIN STREET WHITESBORO, NY 13492	OUTPATIENT LAB

**Schedule J**  
(Form 990)

**Compensation Information**

OMB No 1545-0047

**2018**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

- 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 for instructions and the latest information.**

Name of the organization  
ST ELIZABETH MEDICAL CENTER

Employer identification number  
15-0532245

**Part I Questions Regarding Compensation**

**1a** 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

- |  |  |
|--|--|
| <input type="checkbox"/> First-class or charter travel             | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees   |
| <input type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

**b** If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?

**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input checked="" type="checkbox"/> Written employment contract                     |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input checked="" type="checkbox"/> Form 990 of other organizations     | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

**4** During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization

**a** Receive a severance payment or change-of-control payment?

**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?

**c** Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

**Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

**5** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

**a** The organization?

**b** Any related organization?

If "Yes," on line 5a or 5b, describe in Part III

**6** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of

**a** The organization?

**b** Any related organization?

If "Yes," on line 6a or 6b, describe in Part III

**7** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III

**8** 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

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

Yes No

**1b**

**2**

**4a**

No

**4b**

No

**4c**

No

**5a**

No

**5b**

No

**6a**

Yes

**6b**

Yes

**7**

No

**8**

No

**9**

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

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

See Additional Data Table**Schedule J (Form 990) 2018**

**Part III**   **Supplemental Information**

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

Return Reference	Explanation
PART I, LINE 6	AN INCENTIVE COMPENSATION PLAN EXISTS FOR THE EXECUTIVE STAFF. COMPENSATION IS BASED ON PERFORMANCE RELATIVE, IN PART, TO THE ORGANIZATION NET EARNINGS TARGETS, AS WELL AS, VARIOUS OTHER QUALITY RELATED PERFORMANCE TARGETS. THE INCENTIVES ARE ONLY PAID OUT UPON ACHIEVEMENT OF THESE SET TARGETS.





Additional Data

Software ID:  
Software Version:  
EIN: 15-0532245  
Name: ST ELIZABETH MEDICAL 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				
PAUL DAVIDSON MD DIRECTOR/SEMC MEDICAL STAFF PRESIDEN	(i)	0	0	0	0	0	0	0
	(ii)	68,658	0	226,075	0	0	294,733	0
SCOTT PERRA PRESIDENT/CEO	(i)	0	0	0	0	0	0	0
	(ii)	700,000	70,000	142,630	20,469	11,437	944,536	0
LOUIS AIELLO CFO	(i)	391,076	38,000	20,469	25,694	18,786	494,025	0
	(ii)	0	0	0	0	0	0	0
LINDA MCCORMACK-MILLER CNO	(i)	0	0	0	0	0	0	0
	(ii)	268,000	8,750	3,362	14,386	8,504	303,002	0
ROBERT SCHOLEFIELD COO	(i)	388,846	36,000	18,467	28,397	13,727	485,437	0
	(ii)	0	0	0	0	0	0	0
MICHAEL TREVISANI MD CMO	(i)	0	0	0	0	0	0	0
	(ii)	383,000	8,750	25,429	11,459	14,638	443,276	0
STEVEN LEVINE MD PHYSICIAN	(i)	407,567	0	7,135	20,655	13,977	449,334	0
	(ii)	0	0	0	0	0	0	0
NICHOLAS QUANDAH MD PHYSICIAN	(i)	553,428	48,142	600	0	7,643	609,813	0
	(ii)	0	0	0	0	0	0	0
LASZLO FUZESI MD PHYSICIAN	(i)	806,252	0	1,914	12,623	859	821,648	0
	(ii)	0	0	0	0	0	0	0
ANNE CAHILL MD PHYSICIAN	(i)	631,251	0	667	13,750	859	646,527	0
	(ii)	0	0	0	0	0	0	0
FREDERICK JOYCE MC PHYSICIAN	(i)	579,808	0	63,837	13,750	19,001	676,396	0
	(ii)	0	0	0	0	0	0	0
MARIA GESUALDO FORMER DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	0	0	180,877	0	0	180,877	0

Schedule L

(Form 990 or 990-EZ)

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.  
▶ Attach to Form 990 or Form 990-EZ.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

Name of the organization  
ST ELIZABETH MEDICAL CENTER

Employer identification number  
15-0532245

Part I

Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2

Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . . ▶ \$

3

Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ \$

Part II

Loans to and/or From Interested Persons.  
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

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

Part III

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) MARIA GESUALDO	FORMER BOARD DIRECTOR	180,877	QUALITY CARE CONSULTANT		No

**Part V Supplemental Information**

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

Return Reference	Explanation
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**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury

Name of the organization

ST ELIZABETH MEDICAL CENTER

**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

**2018**

**Open to Public Inspection**

**Employer identification number**

15-0532245

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART III, LINE 3	CLOSURE OF PHYSICAL THERAPY SERVICES AT 4401 MIDDLE SETTLEMENT ROAD, NEW HARTFORD NY CLOSURE OF MEDICAL IMAGING SERVICES AT 4401 MIDDLE SETTLEMENT ROAD, NEW HARTFORD NY

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	MOHAWK VALLEY HEALTH SYSTEM AND PARTNERS IN FRANCISCAN MINISTRIES, INC

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	<p>RESERVED POWERS TO MOHAWK VALLEY HEALTH SYSTEM ("MVHS") IN ADDITION TO ALL OTHER RIGHTS AND POWERS OF MEMBERSHIP PRESCRIBED BY NEW YORK LAW, THE CERTIFICATE OF INCORPORATION AND/OR THE BYLAWS OF THE CORPORATION, THE FOLLOWING GOVERNANCE AND MANAGEMENT POWERS SHALL BE DELEGATED TO MVHS TO THE EXTENT PERMITTED BY THE NEW YORK NOT-FOR-PROFIT CORPORATION LAW (1) EXCEPT AS OTHERWISE SET FORTH HEREIN, TO APPROVE AND INTERPRET THE STATEMENT OF MISSION AND PHILOSOPHY ADOPTED BY THE CORPORATION, TO REQUIRE THAT THE CORPORATION OPERATE IN CONFORMANCE WITH ITS MISSION AND PHILOSOPHY AND TO COORDINATE THE MISSIONS, VISIONS, ACTIVITIES AND RESOURCES OF THE CORPORATION IN ORDER TO PROMOTE HIGH QUALITY, EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES IN ONEIDA COUNTY, NEW YORK, AND SURROUNDING AREAS. NOTWITHSTANDING THE FOREGOING, MVHS SHALL NOT HAVE THE POWER TO APPROVE OR INTERPRET THOSE ELEMENTS OF THE CORPORATION'S MISSION AND PHILOSOPHY THAT RELATE SPECIFICALLY TO ITS STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF THE CORPORATION'S CATHOLIC MISSION AND PHILOSOPHY, (2) TO ELECT OR APPOINT, FIX THE NUMBER OF, AND REMOVE, WITH OR WITHOUT CAUSE, THE DIRECTORS OF THE CORPORATION, AND TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, THE PRESIDENT/CHIEF EXECUTIVE OFFICER OF THE CORPORATION. NOTWITHSTANDING THE FOREGOING, PFM SHALL BE ENTITLED TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, THE ONE ADDITIONAL DIRECTOR DESIGNATED BY PFM TO THE CORPORATION'S BOARD OF DIRECTORS, (3) TO AMEND OR REPEAL THE CERTIFICATE AND BYLAWS, AND TO ADOPT ANY NEW OR RESTATED CERTIFICATE OF INCORPORATION OR BYLAWS, OF THE CORPORATION, (4) TO APPROVE ANY PLAN OF MERGER, CONSOLIDATION, DISSOLUTION OR LIQUIDATION OF THE CORPORATION, (5) TO APPROVE THE DEBT OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY MVHS, (6) TO APPROVE THE SALE, ACQUISITION, LEASE, TRANSFER, MORTGAGE, GUARANTEE OR PLEDGE OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY MVHS. NOTWITHSTANDING THE FOREGOING, THE APPROVAL OF PFM SHALL BE REQUIRED FOR THE SALE, TRANSFER, MORTGAGE, GUARANTEE, PLEDGE OR OTHER ALIENATION OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY PFM, TO MEET THE REQUIREMENTS OF THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, (7) TO APPROVE THE CAPITAL AND OPERATING BUDGETS OF THE CORPORATION, (8) TO APPROVE SETTLEMENTS OF LITIGATION WHEN SUCH SETTLEMENTS EXCEED APPLICABLE INSURANCE COVERAGE OR THE AMOUNT OF ANY APPLICABLE SELF-INSURANCE FUND AVAILABLE TO SUCH CORPORATION, (9) TO APPROVE ANY CORPORATE REORGANIZATION OF THE CORPORATION AND THE ESTABLISHMENT, MERGER, CONSOLIDATION, REORGANIZATION OR DISSOLUTION OF ANY ORGANIZATIONAL RELATIONSHIP OF THE CORPORATION, INCLUDING BUT NOT LIMITED TO SUBSIDIARY CORPORATIONS, PARTNERSHIPS, OR JOINT VENTURES OF THE CORPORATION, (10) TO APPROVE AND COORDINATE THE STRATEGIC PLANS OF THE CORPORATION, (11) TO THE EXTENT APPLICABLE</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	<p>BLE, TO APPROVE ALL CONTRACTS OF REIMBURSEMENT FOR THE CORPORATION FROM GOVERNMENTAL OR PRIVATE THIRD PARTY INSURERS, (12) TO THE EXTENT APPLICABLE, TO APPROVE ALL APPLICATIONS OF THE CORPORATION TO FEDERAL OR STATE GOVERNMENTAL AGENCIES FOR ESTABLISHMENT OR OPERATING LICENSURE, INCLUDING BUT NOT LIMITED TO CERTIFICATE OF NEED APPLICATIONS TO THE NEW YORK STATE DEPARTMENT OF HEALTH AS REQUIRED, (13) TO THE EXTENT APPLICABLE, TO APPROVE MANAGEMENT CONTRACTS FOR THE CORPORATION SUBJECT TO APPROVAL AND/OR REGULATION UNDER THE LAWS AND REGULATIONS OF THE STATE OF NEW YORK, (14) TO APPROVE ANY MATERIAL CHANGE IN THE SERVICES OFERED BY THE CORPORATION, (15) TO REQUIRE THE CORPORATION TO PARTICIPATE IN ANY AND ALL PROGRAMS AND SERVICES, AS DETERMINED BY MVHS IN ITS DISCRETION, PROVIDED, HOWEVER, THAT MVHS MAY NOT REQUIRE CORPORATION TO PARTICIPATE IN ANY PROGRAM OR SERVICE OR TAKE ANY ACTION THAT WOULD CONSTITUTE A DEFAULT OR EVENT OF DEFAULT UNDER ANY MORTGAGE, INDENTURE OR OTHER MATERIAL AGREEMENT OR INSTRUMENT TO WHICH THE CORPORATION IS A PARTY AND BY WHICH IT IS BOUND, AND MAY NOT REQUIRE THE CORPORATION'S PARTICIPATION IN ANY PROGRAM OR SERVICE WHICH WOULD BE CONTRARY TO ITS STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF ITS CATHOLIC MISSION OR PHILOSOPHY, AND (16) TO ACCEPT DELEGATIONS OF AUTHORITY ON BEHALF OF THE CORPORATION PURSUANT TO SECTION 701 OF THE NOT-FOR PROFIT CORPORATION LAW AND EXERCISE ON BEHALF OF THE CORPORATION, THE AUTHORITY TO ACCEPT, UTILIZE, TRANSFER AND SHARE IN THE ASSETS, REVENUES AND INCOME OF THE CORPORATION AND TO MAINTAIN A SINGLE CONSOLIDATED SET OF BOOKS AND FINANCIAL RECORDS, AS MAY BE NECESSARY OR DESIRABLE TO CARRY OUT THE OBLIGATIONS OF THE CORPORATION PURSUANT TO ANY MASTER TRUST INDENTURE OR SIMILAR INSTRUMENT AND, PROVIDED, HOWEVER, THAT NO SUCH AUTHORITY SHALL BE ACCEPTED OR EXERCISED EXCEPT PURSUANT TO THE NOT-FOR-PROFIT CORPORATION LAW AND UNTIL ALL APPROVALS REQUIRED BY LAW HAVE FIRST BEEN OBTAINED, INCLUDING, WITHOUT LIMITATION, THE PRIOR APPROVAL OF THE DEPARTMENT OF HEALTH AS MAY BE REQUIRED FOR OBLIGATED GROUP FINANCINGS FOR THE PURPOSES OF THE FOREGOING, MVHS SHALL HAVE (I) THE POWER TO INITIATE AND DIRECT ACTION BY THE CORPORATION WITHOUT A PRIOR RECOMMENDATION OF THE CORPORATION'S BOARD OF DIRECTORS, AND (II) THE POWER TO ACCEPT, REJECT OR MODIFY THE RECOMMENDATION OF THE CORPORATION'S BOARD OF DIRECTORS AND TO DIRECT ACTION BY THE CORPORATION OR TO RETURN THE MATTER TO THE BOARD OF DIRECTORS OF THE CORPORATION FOR RECONSIDERATION, WITH REASONS FOR REJECTION AND/OR SUGGESTED CHANGE NOTWITHSTANDING THE FOREGOING, IN THE CASE OF THE CORPORATION, MVHS SHALL NOT DIRECT ANY ACTION WITH RESPECT TO THE CORPORATION THAT REQUIRES THE APPROVAL OF PFM WITHOUT PRIOR APPROVAL OF SUCH ACTION BY PFM THE BOARD OF DIRECTORS AND OFFICERS OF THE CORPORATION SHALL NOT IMPLEMENT ANY ACTION REQUIRING THE APPROVAL OF MVHS UNTIL MVHS SHALL HAVE EXERCISED ITS RESERVE POWERS AND COMMUNICATED ITS DETERMINATIONS IN</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	<p>WRITING TO THE CORPORATION'S BOARD OF DIRECTORS AND, IN THE CASE OF ANY POWERS OVER THE CORPORATION THAT ARE ALSO RESERVED TO PFM, TO PFM RESERVED POWERS TO PARTNERS IN FRANCISCAN MINISTRIES, INC ("PFM") THE FOLLOWING POWERS SHALL BE RESERVED EXCLUSIVELY TO PFM (1) TO APPROVE AND INTERPRET THOSE ELEMENTS OF THE CORPORATION'S STATEMENT OF MISSION AND PHILOSOPHY ADOPTED BY THE CORPORATION THAT RELATE TO THE CORPORATION'S STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF THE CORPORATION'S CATHOLIC MISSION AND PHILOSOPHY, AND ANY AMENDMENTS THEREOF, AND TO REQUIRE THE CORPORATION TO OPERATE IN CONFORMANCE WITH ITS CATHOLIC MISSION AND PHILOSOPHY, THIS POWER SHALL INCLUDE APPROVAL OF THE INDIVIDUAL WHO WILL SERVE IN A POSITION TO OVERSEE MISSION, WHICH POSITION WILL REPORT DIRECTLY TO THE PRESIDENT/ CEO AND SHALL NOT BE ELIMINATED WITHOUT THE PRIOR APPROVAL OF PFM (2) TO APPROVE ANY AMENDMENT OF THE CORPORATION'S PURPOSES OR POWERS IN ITS CERTIFICATE OF INCORPORATION THAT WOULD TERMINATE THE CORPORATION'S STATUS AS A CATHOLIC ORGANIZATION OR DIMINISH ITS COMMITMENT OR ABILITY TO OPERATE IN A MANNER CONSISTENT WITH THE ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTHCARE SERVICES, AND (3) TO APPROVE THE SALE, TRANSFER, MORTGAGE, GUARANTY, PLEDGE OR OTHER ALIENATION OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY THE PFM TO MEET THE REQUIREMENTS OF THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (4) TO APPROVE AND REJECT APPOINTMENTS TO THE PENSI ON COMMITTEE FOR THE SEMC CHURCH PLAN (5) TO APPROVE ANY AMENDMENTS OR MODIFICATIONS TO, OR THE TERMINATION OF, THE SEMC CHURCH PLAN, AND (6) TO ELECT OR APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, ONE DIRECTOR OF THE CORPORATION WHO DOES NOT CURRENTLY SERVE ON THE BOARD OF MVHS</p>



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>RESERVED POWERS TO MOHAWK VALLEY HEALTH SYSTEM ("MVHS") IN ADDITION TO ALL OTHER RIGHTS AND POWERS OF MEMBERSHIP PRESCRIBED BY NEW YORK LAW, THE CERTIFICATE OF INCORPORATION AND/OR THE BYLAWS OF THE CORPORATION, THE FOLLOWING GOVERNANCE AND MANAGEMENT POWERS SHALL BE DELEGATED TO MVHS TO THE EXTENT PERMITTED BY THE NEW YORK NOT-FOR-PROFIT CORPORATION LAW (1) EXCEPT AS OTHERWISE SET FORTH HEREIN, TO APPROVE AND INTERPRET THE STATEMENT OF MISSION AND PHILOSOPHY ADOPTED BY THE CORPORATION, TO REQUIRE THAT THE CORPORATION OPERATE IN CONFORMANCE WITH ITS MISSION AND PHILOSOPHY AND TO COORDINATE THE MISSIONS, VISIONS, ACTIVITIES AND RESOURCES OF THE CORPORATION IN ORDER TO PROMOTE HIGH QUALITY, EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES IN ONEIDA COUNTY, NEW YORK, AND SURROUNDING AREAS NOTWITHSTANDING THE FOREGOING, MVHS SHALL NOT HAVE THE POWER TO APPROVE OR INTERPRET THOSE ELEMENTS OF THE CORPORATION'S MISSION AND PHILOSOPHY THAT RELATE SPECIFICALLY TO ITS STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF THE CORPORATION'S CATHOLIC MISSION AND PHILOSOPHY, (2) TO ELECT OR APPOINT, FIX THE NUMBER OF, AND REMOVE, WITH OR WITHOUT CAUSE, THE DIRECTORS OF THE CORPORATION, AND TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, THE PRESIDENT/CHIEF EXECUTIVE OFFICER OF THE CORPORATION NOTWITHSTANDING THE FOREGOING, PFM SHALL BE ENTITLED TO APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, THE ONE ADDITIONAL DIRECTOR DESIGNATED BY PFM TO THE CORPORATION'S BOARD OF DIRECTORS, (3) TO AMEND OR REPEAL THE CERTIFICATE AND BYLAWS, AND TO ADOPT ANY NEW OR RESTATED CERTIFICATE OF INCORPORATION OR BYLAWS, OF THE CORPORATION, (4) TO APPROVE ANY PLAN OF MERGER, CONSOLIDATION, DISSOLUTION OR LIQUIDATION OF THE CORPORATION, (5) TO APPROVE THE DEBT OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY MVHS, (6) TO APPROVE THE SALE, ACQUISITION, LEASE, TRANSFER, MORTGAGE, GUARANTEE OR PLEDGE OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY MVHS NOTWITHSTANDING THE FOREGOING, THE APPROVAL OF PFM SHALL BE REQUIRED FOR THE SALE, TRANSFER, MORTGAGE, GUARANTEE, PLEDGE OR OTHER ALIENATION OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY PFM, TO MEET THE REQUIREMENTS OF THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, (7) TO APPROVE THE CAPITAL AND OPERATING BUDGETS OF THE CORPORATION, (8) TO APPROVE SETTLEMENTS OF LITIGATION WHEN SUCH SETTLEMENTS EXCEED APPLICABLE INSURANCE COVERAGE OR THE AMOUNT OF ANY APPLICABLE SELF-INSURANCE FUND AVAILABLE TO SUCH CORPORATION, (9) TO APPROVE ANY CORPORATE REORGANIZATION OF THE CORPORATION AND THE ESTABLISHMENT, MERGER, CONSOLIDATION, REORGANIZATION OR DISSOLUTION OF ANY ORGANIZATIONAL RELATIONSHIP OF THE CORPORATION, INCLUDING BUT NOT LIMITED TO SUBSIDIARY CORPORATIONS, PARTNERSHIPS, OR JOINT VENTURES OF THE CORPORATION, (10) TO APPROVE AND COORDINATE THE STRATEGIC PLANS OF THE CORPORATION, (11) TO THE EXTENT APPLICABLE</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>BLE, TO APPROVE ALL CONTRACTS OF REIMBURSEMENT FOR THE CORPORATION FROM GOVERNMENTAL OR PRIVATE THIRD PARTY INSURERS, (12) TO THE EXTENT APPLICABLE, TO APPROVE ALL APPLICATIONS OF THE CORPORATION TO FEDERAL OR STATE GOVERNMENTAL AGENCIES FOR ESTABLISHMENT OR OPERATING LICENSURE, INCLUDING BUT NOT LIMITED TO CERTIFICATE OF NEED APPLICATIONS TO THE NEW YORK STATE DEPARTMENT OF HEALTH AS REQUIRED, (13) TO THE EXTENT APPLICABLE, TO APPROVE MANAGEMENT CONTRACTS FOR THE CORPORATION SUBJECT TO APPROVAL AND/OR REGULATION UNDER THE LAWS AND REGULATIONS OF THE STATE OF NEW YORK, (14) TO APPROVE ANY MATERIAL CHANGE IN THE SERVICES OFERED BY THE CORPORATION, (15) TO REQUIRE THE CORPORATION TO PARTICIPATE IN ANY AND ALL PROGRAMS AND SERVICES, AS DETERMINED BY MVHS IN ITS DISCRETION, PROVIDED, HOWEVER, THAT MVHS MAY NOT REQUIRE CORPORATION TO PARTICIPATE IN ANY PROGRAM OR SERVICE OR TAKE ANY ACTION THAT WOULD CONSTITUTE A DEFAULT OR EVENT OF DEFAULT UNDER ANY MORTGAGE, INDENTURE OR OTHER MATERIAL AGREEMENT OR INSTRUMENT TO WHICH THE CORPORATION IS A PARTY AND BY WHICH IT IS BOUND, AND MAY NOT REQUIRE THE CORPORATION'S PARTICIPATION IN ANY PROGRAM OR SERVICE WHICH WOULD BE CONTRARY TO ITS STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF ITS CATHOLIC MISSION OR PHILOSOPHY, AND (16) TO ACCEPT DELEGATIONS OF AUTHORITY ON BEHALF OF THE CORPORATION PURSUANT TO SECTION 701 OF THE NOT-FOR PROFIT CORPORATION LAW AND EXERCISE ON BEHALF OF THE CORPORATION, THE AUTHORITY TO ACCEPT, UTILIZE, TRANSFER AND SHARE IN THE ASSETS, REVENUES AND INCOME OF THE CORPORATION AND TO MAINTAIN A SINGLE CONSOLIDATED SET OF BOOKS AND FINANCIAL RECORDS, AS MAY BE NECESSARY OR DESIRABLE TO CARRY OUT THE OBLIGATIONS OF THE CORPORATION PURSUANT TO ANY MASTER TRUST INDENTURE OR SIMILAR INSTRUMENT AND, PROVIDED, HOWEVER, THAT NO SUCH AUTHORITY SHALL BE ACCEPTED OR EXERCISED EXCEPT PURSUANT TO THE NOT-FOR-PROFIT CORPORATION LAW AND UNTIL ALL APPROVALS REQUIRED BY LAW HAVE FIRST BEEN OBTAINED, INCLUDING, WITHOUT LIMITATION, THE PRIOR APPROVAL OF THE DEPARTMENT OF HEALTH AS MAY BE REQUIRED FOR OBLIGATED GROUP FINANCINGS FOR THE PURPOSES OF THE FOREGOING, MVHS SHALL HAVE (I) THE POWER TO INITIATE AND DIRECT ACTION BY THE CORPORATION WITHOUT A PRIOR RECOMMENDATION OF THE CORPORATION'S BOARD OF DIRECTORS, AND (II) THE POWER TO ACCEPT, REJECT OR MODIFY THE RECOMMENDATION OF THE CORPORATION'S BOARD OF DIRECTORS AND TO DIRECT ACTION BY THE CORPORATION OR TO RETURN THE MATTER TO THE BOARD OF DIRECTORS OF THE CORPORATION FOR RECONSIDERATION, WITH REASONS FOR REJECTION AND/OR SUGGESTED CHANGE NOTWITHSTANDING THE FOREGOING, IN THE CASE OF THE CORPORATION, MVHS SHALL NOT DIRECT ANY ACTION WITH RESPECT TO THE CORPORATION THAT REQUIRES THE APPROVAL OF PFM WITHOUT PRIOR APPROVAL OF SUCH ACTION BY PFM THE BOARD OF DIRECTORS AND OFFICERS OF THE CORPORATION SHALL NOT IMPLEMENT ANY ACTION REQUIRING THE APPROVAL OF MVHS UNTIL MVHS SHALL HAVE EXERCISED ITS RESERVE POWERS AND COMMUNICATED ITS DETERMINATIONS IN</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>WRITING TO THE CORPORATION'S BOARD OF DIRECTORS AND, IN THE CASE OF ANY POWERS OVER THE CORPORATION THAT ARE ALSO RESERVED TO PFM, TO PFM RESERVED POWERS TO PARTNERS IN FRANCISCAN MINISTRIES, INC ("PFM") THE FOLLOWING POWERS SHALL BE RESERVED EXCLUSIVELY TO PFM (1) TO APPROVE AND INTERPRET THOSE ELEMENTS OF THE CORPORATION'S STATEMENT OF MISSION AND PHILOSOPHY ADOPTED BY THE CORPORATION THAT RELATE TO THE CORPORATION'S STATUS AS A CATHOLIC ORGANIZATION OR THE PURSUIT OF THE CORPORATION'S CATHOLIC MISSION AND PHILOSOPHY, AND ANY AMENDMENTS THEREOF, AND TO REQUIRE THE CORPORATION TO OPERATE IN CONFORMANCE WITH ITS CATHOLIC MISSION AND PHILOSOPHY, THIS POWER SHALL INCLUDE APPROVAL OF THE INDIVIDUAL WHO WILL SERVE IN A POSITION TO OVERSEE MISSION, WHICH POSITION WILL REPORT DIRECTLY TO THE PRESIDENT/ CEO AND SHALL NOT BE ELIMINATED WITHOUT THE PRIOR APPROVAL OF PFM (2) TO APPROVE ANY AMENDMENT OF THE CORPORATION'S PURPOSES OR POWERS IN ITS CERTIFICATE OF INCORPORATION THAT WOULD TERMINATE THE CORPORATION'S STATUS AS A CATHOLIC ORGANIZATION OR DIMINISH ITS COMMITMENT OR ABILITY TO OPERATE IN A MANNER CONSISTENT WITH THE ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTHCARE SERVICES, AND (3) TO APPROVE THE SALE, TRANSFER, MORTGAGE, GUARANTY, PLEDGE OR OTHER ALIENATION OF REAL OR PERSONAL PROPERTY OF THE CORPORATION IN EXCESS OF AN AMOUNT TO BE FIXED FROM TIME TO TIME BY THE PFM TO MEET THE REQUIREMENTS OF THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (4) TO APPROVE AND REJECT APPOINTMENTS TO THE PENSI ON COMMITTEE FOR THE SEMC CHURCH PLAN (5) TO APPROVE ANY AMENDMENTS OR MODIFICATIONS TO, OR THE TERMINATION OF, THE SEMC CHURCH PLAN, AND (6) TO ELECT OR APPOINT AND REMOVE, WITH OR WITHOUT CAUSE, ONE DIRECTOR OF THE CORPORATION WHO DOES NOT CURRENTLY SERVE ON THE BOARD OF MVHS</p>

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	INFORMATION IS GATHERED FROM THE ACCOUNTING AND PAYROLL DEPARTMENTS, WHICH IS USED BY THE SENIOR ACCOUNTANT TO PREPARE WORKSHEETS USED TO POPULATE THE FORM 990. MEMBERS OF AN EXTERNAL AUDIT AND TAX FIRM (CURRENTLY FUST CHARLES CHAMBERS LLP) INITIALLY DISCUSS, PREPARE AND REVIEW THE RETURN WITH THE SENIOR ACCOUNTANT. THE SEMC MANAGEMENT TEAM REVIEWS THE DRAFT AND HAS THE OPPORTUNITY TO ASK QUESTIONS AND DISCUSS THE RETURN WITH THE TAX STAFF. AFTER THE MANAGEMENT TEAM'S APPROVAL, THE FORM 990 IS DISTRIBUTED TO THE GOVERNING BODY FOR THEIR REVIEW AND COMMENT PRIOR TO THE FILING OF THE FORM 990.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>CONFLICT OF INTEREST POLICY FIRST, EACH BOARD OF TRUSTEE MEMBER, THE PRESIDENT/CEO, CHIEF OPERATING OFFICER, AND EACH VICE PRESIDENT COMPLETE AN ANNUAL CONFLICT OF INTEREST QUESTIONNAIRE THE RESULTS OF THE QUESTIONNAIRE ARE REVIEWED BY THE AUDIT COMMITTEE OF THE BOARD OF TRUSTEES WHICH IDENTIFIES ANY POTENTIAL CONFLICTS AS PART OF THE POLICY, BOARD MEMBERS THAT HAVE A CONFLICT ARE UNABLE TO VOTE WHEN A SUBJECT THAT THEY HAVE A CONFLICT OF INTEREST IN COMES UP FOR A VOTE AT A BOARD MEETING BOARD MEMBERS ARE NOT ALLOWED TO BE INVOLVED IN THE DISCUSSIONS RELATED TO THE ISSUE OTHER THAN TO MAKE A BRIEF COMMENT SINCE 2010, THE MEDICAL CENTER BEGAN TO REQUIRE ALL DEPARTMENT MANAGERS TO COMPLETE A CONFLICT OF INTEREST QUESTIONNAIRE ON AN ANNUAL BASIS SINCE 2010, ALL MEMBERS OF THE MEDICAL STAFF ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST QUESTIONNAIRE ONCE EVERY TWO YEARS, AS PART OF THE CREDENTIALING PROCESS FOR ALL OTHER EMPLOYEES, A POLICY IS IN PLACE AS PART OF THE COMPLIANCE PLAN THAT REQUIRES EMPLOYEES TO DISCLOSE ANY CONFLICT OF INTEREST TO THEIR SUPERVISOR THE SUPERVISOR IS THEN REQUIRED TO DISCLOSE THE INFORMATION TO THE COMPLIANCE OFFICER BOARD MEMBERS OF SUBSIDIARIES ARE ALSO REQUIRED TO COMPLETE CONFLICT OF INTEREST QUESTIONNAIRES</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	<p>COMPENSATION POLICY THE BOARD OF DIRECTORS HAS ESTABLISHED AN EXECUTIVE COMPENSATION COMMITTEE THAT IS COMPOSED OF THE CHAIRPERSON AND AT LEAST FOUR (4) ADDITIONAL DIRECTORS RECOMMENDED BY THE CHAIRPERSON AND APPROVED BY THE BOARD. ALL MEMBERS OF THE EXECUTIVE COMPENSATION COMMITTEE SHALL BE "INDEPENDENT DIRECTORS" AS THAT TERM IS DEFINED IN SECTION 4958 OF THE INTERNAL REVENUE CODE AND SUPPORTING REGULATIONS. IN THE EVENT THAT THE CHAIRPERSON IS NOT AN "INDEPENDENT DIRECTOR", THE BOARD SHALL APPOINT ANOTHER INDEPENDENT DIRECTOR TO SERVE IN THE PLACE OF THE CHAIRPERSON. THE PRESIDENT/CEO MAY SERVE AS AN ADVISOR TO THE COMMITTEE AS LONG AS HE OR SHE IS EXCUSED WHEN THE COMMITTEE IS REVIEWING THE CEO'S COMPENSATION PACKAGE. THE EXECUTIVE COMPENSATION COMMITTEE IS APPOINTED TO DISCHARGE THE DUTY OF THE BOARD TO FULFILL ITS OVERSIGHT RESPONSIBILITY IN DETERMINING THE ADEQUACY AND REASONABLENESS OF THE COMPENSATION PAID TO THE PRESIDENT/CEO AND OTHER EMPLOYEES OR INDIVIDUALS THAT THE COMMITTEE BELIEVES ARE IN A POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER THE AFFAIRS OF THE CORPORATION, OR ITS AFFILIATES OR SUBSIDIARIES, ALL AS OUTLINED IN SECTION 4958 OF THE INTERNAL REVENUE CODE AND SUPPORTING REGULATIONS ("DISQUALIFIED PERSONS"). THE COMMITTEE (1) ESTABLISHES, MONITORS, REVIEWS AND REVISES, AT LEAST ANNUALLY, PERFORMANCE GUIDELINES FOR THE CEO, (2) ASSISTS THE BOARD IN ASSESSING AND EVALUATING THE CEO'S PERFORMANCE, (3) REVIEWS AND RECOMMENDS TO THE FULL BOARD THE CEO'S COMPENSATION, INCLUDING SALARY, INCENTIVES, BENEFITS AND OTHER PREREQUISITES, (4) REGULARLY ESTABLISHES, REVIEWS AND MONITORS SUCCESSION PLANS (INCLUDING EMERGENCY SUCCESSION PLANS) FOR ALL KEY MANAGEMENT PERSONNEL, (5) AT LEAST ANNUALLY, REVIEWS EXECUTIVE COMPENSATION TO ENSURE THAT IT IS APPROPRIATE IN VIEW OF CORPORATION'S TAX-EXEMPT STATUS AND TAKES THE REQUIRED STEPS TO ESTABLISH A "REBUTTABLE PRESUMPTION OF REASONABLENESS" [UNDER I.R.C. SECTION 4958] OF THE EXECUTIVE COMPENSATION, WHICH MAY INCLUDE EVALUATING A. THE COMPENSATION PAID BY SIMILAR ORGANIZATIONS, BOTH EXEMPT AND TAXABLE, FOR EQUIVALENT POSITIONS IN THE SAME OR SIMILAR COMMUNITY OR GEOGRAPHIC AREA, B. THE UNIQUENESS OF THE PERSON'S BACKGROUND, EDUCATION, TRAINING, EXPERIENCE, AND RESPONSIBILITIES, C. THE SIZE AND COMPLEXITY OF THE CORPORATION'S INCOME AND ASSETS AND THE NUMBER OF CORPORATIONS EMPLOYEES, D. CEO'S JOB PERFORMANCE, E. RELATIONSHIP OF THE CEO'S COMPENSATION TO THE COMPENSATION PAID TO CORPORATION'S OTHER EMPLOYEES, AND F. THE NUMBER OF HOURS THE CEO SPENDS PERFORMING HIS OR HER JOB. (6) REVIEW AND APPROVE THE COMPENSATION PACKAGE OF THE CHIEF OPERATING, MEDICAL, NURSING AND FINANCIAL OFFICERS, AS RECOMMENDED BY THE CEO. THE COMMITTEE IS PROVIDED SUCH RESOURCES AND AUTHORITY AS IT DEEMS APPROPRIATE TO DISCHARGE ITS DUTIES AND RESPONSIBILITIES, INCLUDING THE AUTHORITY TO DIRECTLY SELECT, ENGAGE AND SUPERVISE ANY CONSULTANT, ACCOUNTANT, LEGAL COUNSEL OR OTHER ADVISOR HIRED BY THE CORPORATION TO</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	ADVISE THE COMMITTEE ON EXECUTIVE COMPENSATION AND RELATED MATTERS IN CARRYING OUT ITS RESPONSIBILITIES, THE COMMITTEE MAY RELY UPON REASONED, WRITTEN OPINIONS OF CONSULTANTS AND /OR LEGAL COUNSEL

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	PUBLIC DISCLOSURE THE GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST THE ORGANIZATION'S FORM 990 IS POSTED ON WWW GUIDESTAR ORG



# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, LINE 1A	SEMC DOES NOT COMPENSATE THE BOARD OF DIRECTORS FOR THEIR SERVICES AS BOARD MEMBERS ANY COMPENSATION PAID TO BOARD MEMBERS IS NOT RELATED TO BOARD MEMBER'S SERVICE TO THE BOARD

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN INTEREST IN FOUNDATION -571,276 PENSION RELATED CHANGES -2,727,206

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THERE HAS BEEN NO CHANGE IN THE PROCESS BY WHICH THE ORGANIZATION OVERSEES ITS AUDIT OR THE PROCESS BY WHICH THE ORGANIZATION SELECTS ITS INDEPENDENT ACCOUNTANT

efile GRAPHIC print - DO NOT PROCESS

As Filed Data -

DLN: 93493317030569

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
ST ELIZABETH MEDICAL CENTER

Employer identification number  
15-0532245

Part I Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

Part II Identification of Related Tax-Exempt Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1)FAXTON- ST LUKE'S HEALTHCARE PO BOX 479  UTICA, NY 13502 16-1576637	ACCUTE CARE HOSPITAL	NY	501 (C) (3)	3	MOHAWK VALLEY HEALTH SYSTEM INC		No
(2)SR OF ST FRANCIS OF THE NEUMANN COMMUNITY 2500 GRANT BLVD  SYRACUSE, NY 13208 20-4292535	RELIGIOUS ORDER	NY	501 (C) (3)	LINE 1	N/A		No
(3)PARTNERS IN FRANCISCAN MINISTRIES 2500 GRANT BLVD  SYRACUSE, NY 13208 45-2279986	SPONSOR MINISTRIES	NY	501 (C) (3)	LINE 12A, I	N/A		No
(4)VISITING NURSES ASSOCIATION OF UTICA AND ONEIDA COUNTY 2608 GENESEE STREET  UTICA, NY 13502 15-0532259	HOME HEALTH NURSING	NY	501 (C) (3)	LINE 10	MOHAWK VALLEY HEALTH SYSTEM INC		No
(5)ST ELIZABETH MEDICAL CENTER FOUNDATION 2209 GENESEE STREET  UTICA, NY 13501 22-2562170	FUNDRAISING	NY	501 (C) (3)	LINE 12B, II	ST ELIZABETH MEDICAL CENTER	Yes	
(6)MOHAWK VALLEY HEALTH SYSTEM PO BOX 4308  UTICA, NY 13504 22-3124162	PROMOTE HEALTHCARE	NY	501 (C) (3)	3	N/A		No
(7)MOHAWK VALLEY HEALTH SYSTEM FOUNDATION 1676 SUNSET AVENUE  UTICA, NY 13502 22-3078768	FUNDRAISING	NY	501 (C) (3)	LINE 12B, II	MVHS		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.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
<b>(1)</b> HEALTHCARE UNDERWRITERS MUTUAL RISK MA NY (UNINCORPORATED)  5687 MAIN STREET WILLIAMSVILLE, NY 14221 16-1484203	SELF-INSURANCE GROUP	NY	N/A	T					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**1** 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?

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) ST ELIZABETH MEDICAL CENTER FOUNDATION INC	A	16,263	FAIR MARKET VALUE
(2) ST ELIZABETH MEDICAL CENTER FOUNDATION INC	N	62,521	FAIR MARKET VALUE
(3) ST ELIZABETH MEDICAL CENTER FOUNDATION INC	M	205,103	FAIR MARKET VALUE

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.

[illegible]

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

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

Return Reference	Explanation