Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ **Do not enter Social Security numbers on this form as it may be made public.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning , 2018, and ending , 20

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) 703 MAIN STREET

Room/suite

City or town, state or province, country, and ZIP or foreign postal code PATERSON, NJ 07503-2621

D Employer identification number 27-1344467

E Telephone number (973) 754-2000

G Gross receipts $ 811,255,786.

F Name and address of principal officer: KEVIN J SLAVIN
703 MAIN STREET, PATERSON, NJ 07503-2621

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 ▶ 5557

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.STJOSEPHSHEALTH.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1872 **M** State of legal domicile: NJ

Part I Summary

1 Briefly describe the organization's mission or most significant activities: THE MISSION OF ST. JOSEPH'S HEALTH SYSTEM IS TO PROVIDE QUALITY HEALTHCARE WITH A SPECIAL CONCERN FOR THE POOR AND UNDERSERVED.

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	80.
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	67.
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	6,164.
6	Total number of volunteers (estimate if necessary)	**6**	374.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	1,157,877.
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	1,178,832.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	24,465,617.	27,693,733.
9	Program service revenue (Part VIII, line 2g)	760,516,105.	762,638,228.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	5,260,000.	8,441,457.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	7,904,077.	9,355,040.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	798,145,799.	808,128,458.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	2,342,635.	3,692,588.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	467,862,063.	457,481,990.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	36,250.	111,950.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 1,267,234.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	334,902,362.	341,871,346.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	805,143,310.	803,157,874.
19	Revenue less expenses. Subtract line 18 from line 12	-6,997,511.	4,970,584.

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		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	841,515,000.	827,128,926.
21	Total liabilities (Part X, line 26)	631,068,000.	630,743,919.
22	Net assets or fund balances. Subtract line 21 from line 20	210,447,000.	196,385,007.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date: 11/12/2019

▶ KEVIN J SLAVIN PRESIDENT/CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
LAURA KIELCZEWSKI	Laura Kielczewski	11-14-19		P00740769

Firm's name ▶ ERNST & YOUNG U.S. LLP — Firm's EIN ▶ 34-6565596

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

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2018)

JSA
8E1065 1.000

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:

ATTACHMENT 1

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

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

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

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

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

4a (Code:) (Expenses $ 684,877,121. including grants of $ 3,692,588.) (Revenue $ 768,085,500.)

ATTACHMENT 2

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

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

4d Other program services (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 684,877,121.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	380		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0.		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	

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

			Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. **2a** 6,164			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)	**2b**	X	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	**3a**	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	**3b**	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	**4a**	X	
b	If "Yes," enter the name of the foreign country: ▶ BERMUDA See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year **7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**		
9	**Sponsoring organizations maintaining donor advised funds.**			
a	Did the sponsoring organization make any taxable distributions under section 4966?	**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	**9b**		
10	**Section 501(c)(7) organizations.** Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12 **10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities **10b**			
11	**Section 501(c)(12) organizations.** Enter:			
a	Gross income from members or shareholders **11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) **11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year **12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**			
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.	**13a**		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans **13b**			
c	Enter the amount of reserves on hand **13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	**14b**		
15	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.	**15**	X	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	**16**		X

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year . . . . . 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.	1a 80		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 67		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

[X] Own website [ ] Another's website [X] Upon request [ ] Other *(explain in Schedule O)*

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶
CHRISTOPHER CAULFIELD 703 MAIN STREET PATERSON, NJ 07513 973-754-2000

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KATHLEEN M. BOOZANG	2.00									
TRUSTEE	0.	X						0.	0.	0.
(2) ANTOINETTE CECERE, M.D.	40.00									
TRUSTEE	0.	X						263,698.	0.	3,348.
(3) SR PATRICIA CODEY, S.C., ESQ	2.00									
SECRETARY	0.	X		X				0.	0.	0.
(4) BERNADETTE COUNTRYMAN	2.00									
VICE CHAIRPERSON	0.	X		X				0.	0.	0.
(5) WILFREDO FERNANDEZ	2.00									
TRUSTEE	0.	X						0.	0.	0.
(6) TALIA GRIEP	2.00									
TRUSTEE	0.	X						0.	0.	0.
(7) J. MICHAEL HOPKINS	2.00									
TREASURER	0.	X						0.	0.	0.
(8) REV. MSGR. GEORGE F. HUNDT	2.00									
TRUSTEE	0.	X						0.	0.	0.
(9) JAMES KRANZ	2.00									
TRUSTEE	0.	X						0.	0.	0.
(10) GUALBERTO MEDINA	2.00									
TRUSTEE	0.	X						0.	0.	0.
(11) SISTER NOREEN NEARY	2.00									
TRUSTEE	0.	X						0.	0.	0.
(12) JAI G. PAREKH, MD, MBA, FAAO	2.00									
TRUSTEE	1.00	X						64,250.	0.	0.
(13) SISTER JOAN REPKA	2.00									
TRUSTEE	0.	X						0.	0.	0.
(14) SISTER MARILYN THIE	2.00									
CHAIRPERSON	0.	X		X				0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) TIMOTHY WERKLEY	2.00									
TRUSTEE	0.	X						0.	0.	0.
(16) SR. JEANNE AGANS	2.00									
TRUSTEE	0.	X						0.	0.	0.
(17) JOSEPH AMICO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(18) ANNEMARIE APPLETON	2.00									
TRUSTEE	0.	X						0.	0.	0.
(19) MARIE BREUSS	2.00									
TRUSTEE	0.	X						0.	0.	0.
(20) PATRICIA DAVINO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(21) CRAIG FEINBERG	2.00									
TRUSTEE	0.	X						0.	0.	0.
(22) ERIC W. GROSS, ESQ	2.00									
TRUSTEE	0.	X						0.	0.	0.
(23) TIM HODGES	2.00									
TRUSTEE	0.	X						0.	0.	0.
(24) DAVID L. HUGHES	2.00									
TRUSTEE	0.	X						0.	0.	0.
(25) ROGER JOHNSON	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶								327,948.	0.	3,348.
c Total from continuation sheets to Part VII, Section A ▶								20,547,383.	0.	784,777.
d Total (add lines 1b and 1c) ▶								20,875,331.	0.	788,125.

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 3		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 63

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) JOANN KARAS	2.00									
TRUSTEE	0.	X						0.	0.	0.
(27) MARJORY LANGER, MD, FACEP	2.00									
TRUSTEE	0.	X						471,999.	0.	5,100.
(28) ANTOINETTE (TONI) LOYAS	2.00									
VICE CHAIR	0.	X						0.	0.	0.
(29) THOMAS G. MARINARO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(30) TIMOTHY J. MATTESON, ESQ	2.00									
TRUSTEE	0.	X						0.	0.	0.
(31) DOUGLAS F. OLSEN	2.00									
TRUSTEE	0.	X						0.	0.	0.
(32) CHARLES PEDRANI	2.00									
TRUSTEE	0.	X						0.	0.	0.
(33) BETH POLITO	2.00									
SECRETARY	0.	X						0.	0.	0.
(34) DAVID V. RASA, M.D.	2.00									
TRUSTEE	0.	X						14,625.	0.	0.
(35) SUSAN REED, CPA, CFP	2.00									
VICE CHAIR	0.	X						0.	0.	0.
(36) TERRY M. RYAN	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(37) MOSTAFA SALIMI, M.D.	2.00									
TRUSTEE	0.	X						0.	0.	0.
(38) SUSAN SPATT	40.00									
EXE. DIRECTOR (THRU 9/27/2018)	0.	X						165,749.	0.	2,393.
(39) SHELLI TAGGART	2.00									
TRUSTEE	0.	X						0.	0.	0.
(40) RICHARD J. ABBATE	2.00									
TRUSTEE	0.	X						0.	0.	0.
(41) KEVIN P. BRESLIN	2.00									
TRUSTEE	0.	X						0.	0.	0.
(42) ANTHONY M. BRUNO, CPA	2.00									
VICE CHAIR	0.	X						0.	0.	0.
(43) A. MICHAEL CANDIDO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(44) JOHN R. CIOLETTI	2.00									
TRUSTEE	0.	X						0.	0.	0.
(45) DONNA M. DE CANDIDO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(46) DEAN P. EMMOLO	2.00									
CHAIRMAN	0.	X						0.	0.	0.
(47) RONALD J. GARNER	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(48) NELSON GOMES	2.00									
TRUSTEE	0.	X						0.	0.	0.
(49) JOSEPH R. HAFTEK JR, ESQ	2.00									
TRUSTEE	0.	X						0.	0.	0.
(50) DAVID INCORVAIA	2.00									
TRUSTEE	0.	X						0.	0.	0.
(51) SR. JUNE MORRISSEY, S.C.	24.00									
TRUSTEE	2.00	X						30,730.	0.	10,145.
(52) GEORGE OLIPHANT II	2.00									
TRUSTEE	0.	X						0.	0.	0.
(53) DOLORES PAVLAK	2.00									
TRUSTEE	0.	X						0.	0.	0.
(54) ROBERT PAZ	2.00									
SECRETARY/TREASURER	0.	X		X				0.	0.	0.
(55) GLENN F. SCOTLAND	2.00									
TRUSTEE	0.	X						0.	0.	0.
(56) ELIZABETH REGULA	40.00									
EXE.DIR./TRUSTEE (THRU 5/2018)	0.	X						144,124.	0.	11,042.
(57) LAUREN SZUMITA	2.00									
TRUSTEE	0.	X						0.	0.	0.
(58) STACY TSAPATSARIS	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(59) KRISTY ZIONTZ, D.O., FACOEP	40.00									
MEMBER AT LARGE	0.	X						445,264.	0.	23,842.
(60) ELLEN WALSH	40.00									
COORD PT SAFETY/QUALITY	0.	X						120,831.	0.	10,747.
(61) SR. ELLEN CLIFFORD, MD	40.00									
TRUSTEE	0.	X						297,651.	0.	24,171.
(62) MICHAEL LAMACCHIA, MD	40.00									
TRUSTEE	0.	X						494,456.	0.	33,118.
(63) MICHAEL DELISI, MD	40.00									
TRUSTEE	0.	X						442,622.	0.	27,019.
(64) JOSEPH FARNESE, MD	2.00									
TRUSTEE	0.	X						0.	0.	0.
(65) VIKRAM GUPTA, MD	2.00									
TRUSTEE	0.	X						7,800.	0.	0.
(66) ANTHONY LOSARDO, MD	2.00									
TRUSTEE	0.	X						170,040.	0.	0.
(67) DENNIS MARCO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(68) GENNARO RUBINO	40.00									
TRUSTEE	0.	X						321,832.	0.	29,249.
(69) LORELANE TINDOC, MD	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(70) JOSEPH VITALE, JR., MD	2.00									
TRUSTEE	0.	X						7,400.	0.	0.
(71) ALFRED LEE	2.00									
TRUSTEE	0.	X						0.	0.	0.
(72) ANTHONY GRIFFO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(73) ANTHONY LOCONTE	2.00									
TRUSTEE	0.	X						0.	0.	0.
(74) ATHANASIA KONTOS	2.00									
TRUSTEE	0.	X						0.	0.	0.
(75) DONNA BOLES	2.00									
TRUSTEE	0.	X						0.	0.	0.
(76) GABRIELLA LOCONTE	2.00									
TRUSTEE	0.	X						0.	0.	0.
(77) J. MICHAEL ARMSTRONG	2.00									
TRUSTEE	0.	X						0.	0.	0.
(78) LOUIS ROMANO	2.00									
TRUSTEE	0.	X						0.	0.	0.
(79) MANJU GUPTA	2.00									
TRUSTEE	0.	X						0.	0.	0.
(80) MARTIN NEILAN MD	2.00									
TRUSTEE	0.	X						0.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(81) PATRICIA KOHLMAN	2.00									
TRUSTEE	0.	X						0.	0.	0.
(82) BERNADETTE TIERNAN	2.00									
TRUSTEE (THRU 4/25/2018)	0.	X						0.	0.	0.
(83) NALINI SHAH, MD	2.00									
TRUSTEE	0.	X						94,600.	0.	0.
(84) JOANNE DUNAY	53.00									
TRUSTEE (THRU 12/27/2018)	2.00	X						282,541.	0.	19,542.
(85) FR. MARTIN ROONEY	2.00									
TRUSTEE (THRU 3/30/2018)	0.	X						0.	0.	0.
(86) JOSEPH DUFFY, MD	55.00									
VP, CMO WAYNE	0.			X				178,376.	0.	3,662.
(87) KEVIN J SLAVIN	55.00									
PRESIDENT & CEO	0.			X				1,572,810.	0.	33,913.
(88) DENNIS ROEMER	55.00									
SVP OF FINANCE/CFO	0.			X				877,192.	0.	22,446.
(89) LINDA REED	55.00									
VP, CHIEF INFORMATION OFFICER	0.			X				525,980.	0.	30,949.
(90) LISA SCHMITTGALL	55.00									
SENIOR VICE PRESIDENT/COO	0.			X				856,801.	0.	14,000.
(91) JOHN P. BRUNO	55.00									
VP, HUMAN RESOURCES	0.			X				469,775.	0.	28,905.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(92) ROBERT C. HOOD	55.00									
SENIOR VP, POPULATION HEALTH	0.			X				367,316.	0.	26,299.
(93) JUDITH PADULA	55.00									
VP PATIENT CARE SVCS CNO	0.			X				394,591.	0.	15,454.
(94) MOIRA GIBBONS	53.00									
VP CCO & DIR. LEGAL AFFAIRS	2.00			X				309,128.	0.	21,292.
(95) SR. PATRICIA MENNOR	55.00									
VP MISSION	0.			X				337,294.	0.	13,205.
(96) KENNETH M. MORRIS, JR.	55.00									
VP EXTERNAL AFFAIRS	0.			X				307,325.	0.	20,418.
(97) JAMES HAYNES	55.00									
VP FACILITIES OPERATIONS	0.			X				326,867.	0.	34,231.
(98) STEVEN ALDERSON	55.00									
VP PHYSICIAN SERVICES	0.			X				399,265.	0.	14,714.
(99) MICHAEL ALWELL	55.00									
VP REVENUE CYCLE	0.			X				280,055.	0.	25,536.
(100) JENNIFER MENDYZCKI	53.00									
VP WAYNE SITE ADMINISTRATOR	2.00			X				462,458.	0.	35,769.
(101) THOMAS CASEY	55.00									
VP, MARKETING & PR	0.			X				286,795.	0.	2,210.
(102) DAVID ADINARO, MD	55.00									
VICE PRESIDENT, CMO	0.			X				603,664.	0.	33,221.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(103) TODD C. BROWER	55.00									
SENIOR VP, GENERAL COUNSEL	0.			X				645,526.	0.	38,207.
(104) JAMES LABAGNARA, JR, MD	55.00									
SVP AND SYSTEM CMO	0.			X				559,901.	0.	10,579.
(105) ROBERT BUDELMAN, III	55.00									
VP, CHIEF DEVELOPMENT OFFICER	0.			X				175,081.	0.	19,194.
(106) MARK CONNOLLY	55.00									
CHAIRMAN, DEPT. OF SURGERY	0.					X		3,192,987.	0.	26,358.
(107) DAVID PRINCIPE, MD	55.00									
PHYSICIAN	0.					X		1,095,070.	0.	27,725.
(108) ALDO KHOURY, MD	55.00									
PHYSICIAN	0.					X		1,278,303.	0.	36,819.
(109) SHAMOON FAYEZ, MD	55.00									
PHYSICIAN	0.					X		663,868.	0.	24,373.
(110) MARK ROSENBERG, MD	55.00									
CHAIR/CHIEF INNOVATION OFFICER	0.					X		664,539.	0.	25,759.
(111) THOMAS BARNES	0.									
FORMER OFFICER	0.						X	204,152.	0.	3,171.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 891

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	453,139.			
	d	Related organizations	1d	1,900,889.			
	e	Government grants (contributions)	1e	12,297,301.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	13,042,404.			
	g	Noncash contributions included in lines 1a-1f: $ 0.					
	h	**Total.** Add lines 1a-1f ▶		27,693,733.			
Program Service Revenue			**Business Code**				
	2a	NET PATIENT SERVICE REVENUE	622110	713,469,165.	713,469,165.		
	b	PHYSICIANS BILLING	622110	49,169,063.	49,169,063.		
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		762,638,228.			
	3	Investment income (including dividends, interest, and other similar amounts) ▶		5,200,806.		3,668.	5,197,138.
	4	Income from investment of tax-exempt bond proceeds ▶		0.			
	5	Royalties ▶		0.			
			(i) Real / (ii) Personal				
	6a	Gross rents	2,681,103.				
	b	Less: rental expenses	1,252,094. / 0.				
	c	Rental income or (loss)	1,429,009.				
	d	Net rental income or (loss) ▶		1,429,009.		507,579.	921,430.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	4,499,312.				
	b	Less: cost or other basis and sales expenses	1,258,661.				
	c	Gain or (loss)	3,240,651.				
	d	Net gain or (loss) ▶		3,240,651.	3,240,651.		
Other Revenue	8a	Gross income from fundraising events (not including $ 453,139. of contributions reported on line 1c). See Part IV, line 18	a 983,309.				
	b	Less: direct expenses	b 608,223.				
	c	Net income or (loss) from fundraising events ▶		375,086.			375,086.
	9a	Gross income from gaming activities. See Part IV, line 19	a 16,700.				
	b	Less: direct expenses	b 8,350.				
	c	Net income or (loss) from gaming activities ▶		8,350.			8,350.
	10a	Gross sales of inventory, less returns and allowances	a 0.				
	b	Less: cost of goods sold	b 0.				
	c	Net income or (loss) from sales of inventory ▶		0.			
		Miscellaneous Revenue	**Business Code**				
	11a	PARKING	812930	3,484,479.			3,484,479.
	b	EDUCATION/TRAINING	900099	1,339,250.	1,339,250.		
	c	MANAGEMENT FEE	541611	867,371.	867,371.		
	d	All other revenue		1,851,495.		646,630.	1,204,865.
	e	**Total.** Add lines 11a-11d ▶		7,542,595.			
	12	**Total revenue.** See instructions. ▶		808,128,458.	768,085,500.	1,157,877.	11,191,348.

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
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	3,684,588.	3,684,588.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	8,000.	8,000.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	14,023,651.	11,897,585.	2,089,670.	36,396.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	226,986.	192,574.	33,823.	589.
7 Other salaries and wages	371,586,851.	315,270,950.	55,368,423.	947,478.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	7,530,838.	6,395,941.	1,134,897.	
9 Other employee benefits	38,296,833.	32,364,302.	5,761,710.	170,821.
10 Payroll taxes	25,816,831.	21,926,235.	3,890,596.	
11 Fees for services (non-employees):				
a Management	0.			
b Legal	3,190,602.	2,709,778.	480,824.	
c Accounting	661,214.	561,569.	99,645.	
d Lobbying	168,000.	142,682.	25,318.	
e Professional fundraising services. See Part IV, line 17	111,950.			111,950.
f Investment management fees	545,589.	463,369.	82,220.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	3,846,915.	3,267,185.	579,730.	
12 Advertising and promotion	1,244,795.	1,057,205.	187,590.	
13 Office expenses	15,720,747.	13,351,630.	2,369,117.	
14 Information technology	26,351,750.	22,380,542.	3,971,208.	
15 Royalties	0.			
16 Occupancy	85,370,103.	72,504,829.	12,865,274.	
17 Travel	322,849.	274,196.	48,653.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	11,218,500.	9,696,761.	1,521,739.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	33,879,113.	29,006,168.	4,872,945.	
23 Insurance	8,424,717.	7,155,112.	1,269,605.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLY EXPENSE	112,513,591.	95,557,793.	16,955,798.	
b PHYSICIAN FEES	22,592,792.	19,188,058.	3,404,734.	
c HEALTHCARE REFORM ACT ASSESS	4,678,260.	4,678,260.		
d EQUIP REPAIR/MAINT.	4,615,986.	4,615,986.		
e All other expenses	6,525,823.	6,525,823.		
25 **Total functional expenses.** Add lines 1 through 24e	803,157,874.	684,877,121.	117,013,519.	1,267,234.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	6,805,000.	1	2,323,000.
	2	Savings and temporary cash investments	83,939,000.	2	49,517,585.
	3	Pledges and grants receivable, net	12,890,000.	3	22,804,578.
	4	Accounts receivable, net	90,748,000.	4	83,185,646.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	380,294.	6	377,544.
	7	Notes and loans receivable, net	951,000.	7	1,036,000.
	8	Inventories for sale or use	9,902,000.	8	10,352,955.
	9	Prepaid expenses and deferred charges	3,973,000.	9	2,591,662.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 652,865,404.			
	b	Less: accumulated depreciation — 10b: 286,615,131.	335,966,000.	10c	366,250,273.
	11	Investments - publicly traded securities	77,871,000.	11	99,689,404.
	12	Investments - other securities. See Part IV, line 11	175,293,000.	12	143,819,604.
	13	Investments - program-related. See Part IV, line 11	0.	13	0.
	14	Intangible assets	2,110,000.	14	2,110,000.
	15	Other assets. See Part IV, line 11	40,686,706.	15	43,070,675.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	841,515,000.	16	827,128,926.
Liabilities	17	Accounts payable and accrued expenses	114,606,000.	17	128,872,741.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	314,000.	19	1,038,203.
	20	Tax-exempt bond liabilities	378,093,000.	20	371,418,593.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
	23	Secured mortgages and notes payable to unrelated third parties	0.	23	0.
	24	Unsecured notes and loans payable to unrelated third parties	0.	24	0.
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	138,055,000.	25	129,414,382.
	26	**Total liabilities.** Add lines 17 through 25	631,068,000.	26	630,743,919.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	188,506,000.	27	178,030,941.
	28	Temporarily restricted net assets	13,864,000.	28	10,885,486.
	29	Permanently restricted net assets	8,077,000.	29	7,468,580.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	210,447,000.	33	196,385,007.
	34	Total liabilities and net assets/fund balances	841,515,000.	34	827,128,926.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	808,128,458.
2	Total expenses (must equal Part IX, column (A), line 25)	2	803,157,874.
3	Revenue less expenses. Subtract line 2 from line 1	3	4,970,584.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	210,447,000.
5	Net unrealized gains (losses) on investments	5	-8,349,698.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-10,682,879.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	196,385,007.

Part XII Financial Statements and Reporting

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

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

Form **990** (2018)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

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 **section 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 1

g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
ATTACHMENT 1						
(A)						
(B)						
(C)						
(D)						
(E)						
Total					2,515,868.	

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)** (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization 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 grants.")	0.	0.	0.	0.	0.	0.
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0.
3 The value of services or facilities furnished by a governmental unit to the organization without charge						0.
4 **Total.** Add lines 1 through 3						0.
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)						0.
6 **Public support.** Subtract line 5 from line 4						0.

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						0.
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						0.
9 Net income from unrelated business activities, whether or not the business is regularly carried on						0.
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						0.
11 **Total support.** Add lines 7 through 10						0.

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

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

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 from 2017 Schedule A, Part II, line 14 . . . . . **15** %

16a **33 1/3 % support test - 2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3 % support test - 2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

a ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in* ***Part VI*** *how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI*** *the role played by the organization in this regard.*	3b		

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

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

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

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

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

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

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

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

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.)

SCHEDULE A, SUPPLEMENTAL INFORMATION

PUBLIC CHARITY STATUS

LISTED BELOW ARE THOSE GROUP MEMBERS THAT ARE NEITHER A HOSPITAL NOR A COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B)(1)(A)(III).

ST JOSEPH'S HOSPITAL & MEDICAL CENTER FOUNDATION, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST JOSEPH'S WAYNE HOSPITAL FOUNDATION, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

HARBOR HOUSE, INC., AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST.

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.)

JOSEPH'S UNIVERSITY MEDICAL CENTER.

200 HOSPITAL PLAZA, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST. JOSEPH'S EMERGENCY PHYSICIANS INC, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST. JOSEPH'S FACULTY PHYSICIANS INC, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST. JOSEPH'S PHYSICIANS INC, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), ORGANIZED AND OPERATED EXCLUSIVELY FOR THE BENEFIT OF, TO

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.)

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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST. JOSEPH'S PHYSICIANS HEALTHCARE GROUP INC, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

ST. JOSEPH'S SUBSPECIALTY PHYSICIANS INC, AN ORGANIZATION DESCRIBED IN SECTION 509(A)(3), 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). IT IS REPORTED AS TYPE I ON PART IV TO DIRECTLY SUPPORT ST. JOSEPH'S UNIVERSITY MEDICAL CENTER.

PASSAIC COUNTY COMPREHENSIVE ACCOUNTABLE CARE ORGANIZATION, INC. (PCCACO), AN ORGANIZATION DESCRIBED IN SECTION 170(B)(I)(A)(VI), 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). PART II REPRESENTS PCCACO.

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.)

SCHEDULE A, PART IV, LINE 1

THE ST. JOSEPH'S UNIVERSITY MEDICAL CENTER FOUNDATION IS ORGANIZED TO PROMOTE, BY DONATION, LOAN OR OTHERWISE, THE INTERESTS AND PROGRAMS OF ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (SJUMC). ITS SOLE MEMBER IS ST JOSEPH'S HEALTH, INC. AND THE SYSTEM HAS RIGHT AND POWER TO APPOINT BOARD MEMBERS, AMEND BYLAWS AND ARTICLES OF INCORPORATION.

ST. JOSEPH'S WAYNE HOSPITAL FOUNDATION IS ORGANIZED TO PROMOTE, BY DONATION, LOAN OR OTHERWISE, THE INTERESTS AND PROGRAMS OF ST. JOSEPH'S WAYNE HOSPITAL. ITS SOLE MEMBER IS THE SYSTEM AND THE SYSTEM HAS RIGHT AND POWER TO APPOINT BOARD MEMBERS, AMEND BYLAWS AND ARTICLES OF INCORPORATION.

HARBOR HOUSE, INC. IS ORGANIZED TO PROVIDE ELDERLY OR DISABLED PERSON WITH HOUSING FACILITIES AND SERVICES. THE BYLAWS DESIGNATE ITS TRUSTEES FROM THE TRUSTEES OF SJUMC OR NON-TRUSTEES WITH SJUMC BOARD APPROVAL. THE REMOVAL, APPROVAL OR RESIGNATION OF TRUSTEE IN SJUMC RESULTS IN AUTOMATIC TRUSTEE REVOCATION FOR HARBOR HOUSE, INC. THE SOLE MEMBER OF HARBOR HOUSE, INC. IS SJUMC.

200 HOSPITAL PLAZA IS ORGANIZED TO PROVIDE HOSPITAL HOUSING, PARKING, AND OTHER FACILITIES FOR EMPLOYEES, PATIENTS, VISITORS, DOCTORS, AND OTHERS AFFILIATED WITH SJUMC. THE SOLE MEMBER IS THE SYSTEM. THE SYSTEM DETERMINES WHEN BOARD ELECTIONS ARE HELD AND CAN REMOVE ANY TRUSTEE AND OFFICER AT ANY TIME IF IT IS IN THE BEST INTEREST OF 200 HOSPITAL PLAZA.

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.)

ST. JOSEPH'S EMERGENCY PHYSICIANS INC.'S SOLE MEMBER IS SJUMC. SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S EMERGENCY PHYSICIANS INC.

ST. JOSEPH'S FACULTY PHYSICIANS INC.'S SOLE MEMBER IS SJUMC. SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S FACULTY PHYSICIANS INC.

ST. JOSEPH'S PHYSICIANS INC.'S SOLE MEMBER IS SJUMC. SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S PHYSICIANS INC.

ST. JOSEPH'S SUBSPECIALTY PHYSICIANS INC.'S SOLE MEMBER IS SJUMC. SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S SUBSPECIALTY PHYSICIANS INC.

ST. JOSEPH'S PHYSICIANS HEALTHCARE GROUP INC.'S SOLE MEMBER IS SJUMC. SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S PHYSICIANS HEALTHCARE GROUP INC.

ATTACHMENT 1

SCHEDULE A, PART I - INFORMATION ABOUT SUPPORTED ORGANIZATIONS

(I) NAME OF SUPPORTED ORGANIZATION	(II) EIN	(III) TYPE OF ORGANIZATION	(IV) YES NO	(V) AMOUNT OF SUPPORT	(VI) OTHER SUPPORT AMOUNT
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER	22-1487602	3	X	2,515,868.	0.
TOTAL AMOUNT OF SUPPORT				2,515,868.	

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2018

Name of the organization
ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number
27-1344467

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year . . . . . ▶ $ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 17,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 6,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12		$ 12,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		$ 65,120.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16		$ 22,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
18		$ 14,980.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
20		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
21		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
22		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
23		$ 10,050.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
24		$ 75,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		$ 24,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
26		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
27		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
28		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
29		$ 62,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
30		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
32		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
33		$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
34		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
35		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
36		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
38		$ 37,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
39		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
40		$ 25,358.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
41		$ 16,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
42		$ 55,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
44		$ 6,630.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
45		$ 36,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
46		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
47		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
48		$ 66,441.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
50		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
51		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
52		$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
53		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
54		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55		$ 8,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
56		$ 35,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
57		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
58		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
59		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
60		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61		$ 1,900,889.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
62		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
63		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
64		$ 26,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
65		$ 374,244.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
66		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
67		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
68		$ 38,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
69		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
70		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
71		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
72		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
73		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
74		$ 8,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
75		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
76		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
77		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
78		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
79		$ 17,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
80		$ 16,982.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
81		$ 16,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
82		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
83		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
84		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
86		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
87		$ 65,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
88		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
89		$ 113,861.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
90		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
91		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
92		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
93		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
94		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
95		$ 8,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
96		$ 110,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
97		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
98		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
99		$ 17,350.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
100		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
101		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
102		$ 19,650.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
103		$ 52,875.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
104		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
105		$ 359,440.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
106		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
107		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
108		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
109		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
110		$ 7,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
111		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
112		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

Name of organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

Part III ***Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $ ____________
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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* 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 organization	Employer identification number
ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	27-1344467

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
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		168,000.
j Total. Add lines 1c through 1i			168,000.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

LOBBYING ACTIVITIES

SCHEDULE C, PART II-B, LINE 1

THE HOSPITAL DOES NOT CONDUCT ANY DIRECT LOBBYING ACTIVITIES; HOWEVER, THE HOSPITAL HAS HIRED INDEPENDENT CONSULTING FIRMS TO PURSUE LEGISLATIVE ENDEAVORS ON BEHALF OF THE HOSPITAL. IN 2018, THE HOSPITAL PAID WASHINGTON STRATEGIC CONSULTING,INC. $90,000, AND PUBLIC STRATEGIES IMPACT, LLC $78,000 FOR THEIR EFFORTS.

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* for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

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)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

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 Tax Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.
Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

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

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on 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					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

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

- a Board designated or quasi-endowment ▶ _____ %
- b Permanent endowment ▶ _____ %
- c Temporarily restricted endowment ▶ _____ %

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		12,008,443.		12,008,443.
b Buildings		454,039,578.	242,882,091.	211,157,486.
c Leasehold improvements		18,211,321.	13,431,216.	4,780,104.
d Equipment		152,519,933.	30,301,824.	122,218,109.
e Other		16,086,131.		16,086,131.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				366,250,273.

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) MUNICIPAL BONDS	4,878,611.	FMV
(B) CORPORATE OBLIGATIONS	138,940,993.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	143,819,604.	

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) INVESTMENT IN JOINT VENTURES	27,896,256.
(2) ESTIMATED INSURANCE RECOVERIES	1,049,000.
(3) OTHER ASSETS	8,592,419.
(4) BENEFICIAL INTEREST IN TRUST	5,530,000.
(5) UNCONDITIONAL PROMISES TO GIVE	3,000.
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	43,070,675.

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	
(2) ESTIMATED THIRD PARTY SETTLEMENTS	10,156,000.
(3) ACCRUED PENSION LIABILITY	100,278,161.
(4) ACCRUED MALPRACTICE INSURANCE	8,110,533.
(5) OTHER LONG TERM DEBT	10,869,688.
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	129,414,382.

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information.

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

Part XIII Supplemental Information *(continued)*

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE
GROUP RETURN

Employer identification number
27-1344467

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

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

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

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

	(a) Region	**(b)** Number of offices in the region	**(c)** Number of employees, agents, and independent contractors in the region	**(d)** Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	**(e)** If activity listed in (d) is a program service, describe specific type of service(s) in the region	**(f)** Total expenditures for and investments in the region
(1)	CENTRAL AMERICA/CARIBBEAN	0.	0.	PROGRAM SERVICES	CAPTIVE INSURANCE	5,156,000.
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
3a	Subtotal					5,156,000.
b	Total from continuation sheets to Part I					
c	**Totals** (add lines 3a and 3b)					5,156,000.

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

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

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

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

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

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

Part IV Foreign Forms

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

Part V **Supplemental Information**

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

PART I, LINE 3, COLUMN (F)

THE ORGANIZATION USES THE ACCRUAL METHOD OF ACCOUNTING TO ACCOUNT FOR ITS

FOREIGN EXPENDITURES.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization: ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number: 27-1344467

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

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

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

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

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
1	ATTACHMENT 1						
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total ▶						111,950.	

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

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

		(a) Event #1 CHARITY BALL (event type)	(b) Event #2 GOLF OUTING (event type)	(c) Other events 1. (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	878,040.	464,480.	93,928.	1,436,448.
	2 Less: Contributions	194,603.	231,447.	27,089.	453,139.
	3 Gross income (line 1 minus line 2)	683,437.	233,033.	66,839.	983,309.
Direct Expenses	4 Cash prizes		7,183.		7,183.
	5 Noncash prizes	7,200.	1,950.		9,150.
	6 Rent/facility costs		103,543.		103,543.
	7 Food and beverages	142,280.	117,708.	13,854.	273,842.
	8 Entertainment	32,020.		2,590.	34,610.
	9 Other direct expenses	107,131.	48,203.	24,561.	179,895.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				608,223.
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				375,086.

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue			16,700.	16,700.
Direct Expenses	2 Cash prizes			8,350.	8,350.
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☒ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				8,350.
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				8,350.

9 Enter the state(s) in which the organization conducts gaming activities: NJ,

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

b If "No," explain:

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

b If "Yes," explain:

11 Does the organization conduct gaming activities with nonmembers? [X] Yes [ ] No

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

13 Indicate the percentage of gaming activity conducted in:

a The organization's facility	13a	3.0000 %
b An outside facility	13b	97.0000 %

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

Name ▶ PATRICIA PAOLUCCI

Address ▶ 703 MAIN STREET PATERSON, NJ 07503

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

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

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

Name ▶

Address ▶

16 Gaming manager information:

Name ▶ PATRICIA PAOLUCCI

Gaming manager compensation ▶ $ 2,160.

Description of services provided ▶ PLAN AND EXECUTE FUNDRAISING EVENTS

[ ] Director/officer [X] Employee [ ] Independent contractor

17 Mandatory distributions:

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

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

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

ATTACHMENT 1

990, SCHEDULE G, PART I - HIGHEST PAID FUNDRAISER

NAME AND ADDRESS OF FUNDRAISER	ACTIVITY	DID FUNDRAISER HAVE CUSTODY OR CONTROL OF CONTRIBUTIONS? YES	NO	GROSS RECEIPTS FROM ACTIVITY	AMOUNT PAID TO (OR RETAINED BY FUNDRAISER	AMOUNT PAID TO (OR RETAINED BY ORGANIZATION
COMMUNITY COUNSELLING SERVICE CO., LLC 527 MADISON AVENUE 5TH FLOOR NEW YORK NY 10022	PROF. SVC. AGREEMENT		X		60,000.	
CORRINE, LLC 285 WEST SIDE AVENUE, SUITE 252 JERSEY CITY NJ 07305	ABSOLUTE EVENTS		X		51,950.	

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/Form990* for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

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	X	
b	If "Yes," was it a written policy?	1b	X	
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. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 300.0000 %	3a	X	
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: [ ] 200% [ ] 250% [X] 300% [ ] 350% [ ] 400% [ ] Other ____ %	3b	X	
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	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
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		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

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)			56,606,141.	38,274,600.	18,331,541.	2.28
b Medicaid (from Worksheet 3, column a)			231,207,196.	173,537,090.	57,670,106.	7.18
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			287,813,337.	211,811,690.	76,001,647.	9.46
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,074,107.	62,229.	3,011,878.	.38
f Health professions education (from Worksheet 5)			41,852,436.	18,537,653.	23,314,783.	2.90
g Subsidized health services (from Worksheet 6)			68,925,200.	50,148,734.	18,776,466.	2.34
h Research (from Worksheet 7)			1,222,554.	49,623.	1,172,931.	.15
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			115,074,297.	68,798,239.	46,276,058.	5.77
k **Total.** Add lines 7d and 7j			402,887,634.	280,609,929.	122,277,705.	15.23

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing			203,394.			.03
2 Economic development						
3 Community support			97,289.			.01
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			558,740.			.07
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			859,423.			.11

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

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2 88,648,271.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit 3 46,177,685.			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	243,169,000.	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	248,120,056.	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-4,951,056.	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: [X] Cost accounting system [ ] Cost to charge ratio [ ] Other			

Section C. Collection Practices

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

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

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	SJ REGIONAL CARDIOLO	CATH LAB MANAGEMENT	51.00000		49.00000
2	SJW CARDIOLOGY LLC	CATH LAB MANAGEMENT	51.00000		49.00000
3	SJ SURGERY MANAGEMEN	SURGERY CENTER MANAG	51.79000		44.00000
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 2

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 ST. JOSEPH'S UNIVERSITY MEDICAL CTR 703 MAIN STREET PATERSON NJ 07503 WWW.STJOSEPHSHEALTH.ORG SJUMC DBA SJHRC 22-1487602	11605 X	X	X	X	X	X	X			
2 SJUMC DBA ST. JOSEPH'S WAYNE MED. CTR 224 HAMBURG TURNPIKE WAYNE NJ 07470 WWW.STJOSEPHSHEALTH.ORG SJUMC DBA SJHRC 22-1487602	11603 X	X					X			
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S UNIVERSITY MEDICAL CTR

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

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE PART V, SECTION C			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2017			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to 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)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S WAYNE HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE PART V, SECTION C			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2017			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to 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)

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S UNIVERSITY MEDICAL CTR

			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	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.0000 % and FPG family income limit for eligibility for discounted care of 300.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] 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	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S WAYNE HOSPITAL

			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	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.0000 % and FPG family income limit for eligibility for discounted care of 300.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] 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	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S UNIVERSITY MEDICAL CTR

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☒ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☒ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S WAYNE HOSPITAL

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**19**		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☒ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☒ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S UNIVERSITY MEDICAL CTR

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	**23**		X
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.	**24**		X

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group ST. JOSEPH'S WAYNE HOSPITAL

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	**23**		X
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.	**24**		X

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

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

SUPPLEMENTAL INFORMATION -- ST. JOSEPH'S UNIVERSITY MEDICAL CTR

SCHEDULE H, PART V, SECTION B, LINE 5

TO SOLICIT INPUT FROM KEY INFORMANTS, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN THE HEALTH OF THE COMMUNITY, AN ONLINE KEY INFORMANT SURVEY WAS IMPLEMENTED FROM MARCH 2016 THROUGH JULY 2016. A LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY ST. JOSEPH'S HEALTH INC.; THIS LIST INCLUDED NAMES AND CONTACT INFORMATION FOR PHYSICIANS, PUBLIC HEALTH REPRESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS. POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS OF THE COMMUNITY OVERALL.

KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRODUCING THE PURPOSE OF THE SURVEY AND PROVIDING A LINK TO TAKE THE SURVEY ONLINE; REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION.

POPULATION AND SURVEY CHARACTERISTICS: 47.8% WERE MEN; 52.2% WERE WOMEN; 35.6% WERE BETWEEN 18 AND 39 YEARS; 44.3% WERE BETWEEN 40 AND 60 YEARS; 20.1% WERE 65 YEARS OR OLDER; 42.2% WERE WHITE; 40.1% HISPANIC; 17.0% OTHER AND 34.6% WERE BELOW 300% FPL. PERCENTAGES REPRESENT THE WEIGHTED SURVEY SAMPLE OF ACTUAL PARTICIPANTS.

IN ALL, 79 COMMUNITY STAKEHOLDERS IN PASSAIC COUNTY TOOK PART IN THE ONLINE KEY INFORMANT SURVEY, AS OUTLINED BELOW:

4CS OF PASSAIC COUNTY, INC.

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

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

A&S GENERAL PHYSICIAN LLC

AMANA MEDICAL GROUP

BISAN MEDICAL, INC.

CATHOLIC CHARITIES

CLIFTON HEALTH DEPARTMENT

CLIFTON MEDICAL CARE

CLIFTON PUBLIC SCHOOLS

COMMUNITY CHARTER SCHOOL OF PATERSON

DEPARTMENT OF SENIOR SERVICES PASSAIC COUNTY

DEPAUL PEDIATRICS

ELMWOOD PARK SENIOR CENTER

EVA'S VILLAGE

GMED HEALTHCARE

GREATER BERGEN COMMUNITY ACTION, INC.

HEART AND VASCULAR ASSOCIATES OF NJ

HOMECARE OPTIONS

NOTCHVIEW PEDIATRICS

OASIS A HAVEN FOR WOMEN AND CHILDREN

PASSAIC BOARD OF EDUCATION

PATERSON COMMUNITY CLINIC

PATERSON EDUCATION FUND

PATERSON TASK FORCE FOR COMMUNITY ACTION, INC

ST. JOSEPH'S CHILDREN'S HOSPITAL

ST. JOSEPH'S FAMILY MEDICINE

ST. JOSEPH'S HEALTH INC.

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

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

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC.

VITALE WOMEN'S HEALTH

WAFA HOUSE, INC.

WANAQUE HEALTH DEPARTMENT

WAYNE YMCA

WEST PATERSON FAMILY MEDICAL CENTER

WOMEN IN TRANSITION, WAYNE COUNSELING & FAMILY SERVICES

SCHEDULE H, PART V, SECTION B, LINE 6A

ST. JOSEPH'S WAYNE HOSPITAL

SCHEDULE H, PART V, SECTION B, LINES 7A & 10A

PLEASE FIND THE CHNA AND IMPLEMENTATION STRATEGY HERE:

WWW.STJOSEPHSHEALTH.ORG/GENERAL-INFORMATION/ABOUT-ST-JOSEPHS-HEALTHCARE-SY

STEM/ITEM/1848-COMMUNITY

SCHEDULE H, PART V, SECTION B, LINE 11

WITH TWO ACUTE CARE CAMPUSES LOCATED IN PATERSON AND WAYNE, NEW JERSEY,

ST. JOSEPH'S HEALTH, INC. (SJH) COMPLETED COMMUNITY HEALTH NEEDS

ASSESSMENTS IN COLLABORATION WITH COMMUNITY, GOVERNMENT AND OTHER SOCIAL

SERVICE PARTNERS SERVING THOSE COMMUNITIES. THIS IMPLEMENTATION STRATEGY

ACTION PLAN HAS BEEN FORMULATED BASED ON THE FINDINGS AND PRIORITIES

ESTABLISHED BY THE NEEDS ASSESSMENTS. THE ACTION PLAN DELINEATES THE

FOCUS OF SJHS'S COMMUNITY OUTREACH AND HEALTH IMPROVEMENT EFFORTS OVER

IMPROVED HEALTH THROUGH BETTER QUALITY OF CARE AT LOWER COSTS WITH

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

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

POSITIVE PATIENT AND FAMILY EXPERIENCES WITH FOCUS ON ADDRESSING

THE HIGHEST PRIORITY ISSUES IDENTIFIED IN THE NEEDS ASSESSMENT.

APPROPRIATE RESOURCES WILL BE ALLOCATED TO ACHIEVE HEALTH IMPROVEMENT

GOALS RELATED TO THE PRIORITY ISSUES.

GOAL 1: IMPROVE THE WELL-BEING OF COMMUNITY RESIDENTS THROUGH INCREASED

KNOWLEDGE ABOUT AND ACCESS TO HEALTHY FOODS AND PARTICIPATION IN PHYSICAL

ACTIVITY PROGRAMS

1. PARTNER WITH THE HEALTH COALITION OF PASSAIC COUNTY AND AREA

ORGANIZATIONS TO PROMOTE HEALTH AND WELLNESS IN THE COMMUNITY RELATED TO

NUTRITION, PHYSICAL AND HEALTHY WEIGHT ACTIVITIES

2. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

TO NUTRITION, PHYSICAL ACTIVITY AND HEALTHY WEIGHT INITIATIVES

3. PROVIDE AND EXPAND EDUCATION TO BARIATRIC SUPPORT GROUPS, EMPLOYEES

FOCUSED ON WEIGHT MANAGEMENT OR WEIGHT LOSS, AND INDIVIDUALS WITH

CONDITIONS EXACERBATED BY UNHEALTHY LIFESTYLES

4. EXPAND NUTRITIONAL EDUCATION PARTNERSHIPS WITH COMMUNITY SCHOOLS TO

FOSTER HEALTHY HABITS DURING CHILDHOOD

5. EXTEND LEARNING FROM SJHS EMPLOYEE WELLNESS PROGRAMS TO COMMUNITY

PARTNERS

GOAL 2: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE MANAGEMENT ACROSS

THE CONTINUUM FOR HEART DISEASE AND STROKE

1. HEART DISEASE

A. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

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

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

TO HEART DISEASE PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE

AMERICAN HEART ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS

B. CONTINUE AND EXPAND EDUCATION OF FIRST RESPONDERS IN STATE OF THE ART

CARDIAC LIFE-SAVING TECHNOLOGY AND PRACTICES

C. SUSTAIN AHA MISSION LIFELINE GOLD STATUS IN RECOGNITION OF EXCELLENCE

IN COMMUNITY RESPONSE TO AND TREATMENT OF CARDIAC CONDITIONS

D. BECOME A CHEST PAIN CENTER ACCREDITED BY THE AMERICAN COLLEGE OF

CARDIOLOGY

E. EXPAND CARDIAC REHABILITATION TO THE WAYNE COMMUNITY

F. PROVIDE COMMUNITY EDUCATION RELATED TO PREVENTION, TREATMENT AND

NON-TRADITIONAL WARNING SIGNS OF HEART DISEASE IN WOMEN

2. STROKE

A. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

TO STROKE PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE

AMERICAN HEART ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS.

B. ACHIEVE NJ DEPARTMENT OF HEALTH PRIMARY STROKE DESIGNATION FOR THE

WAYNE CAMPUS/COMMUNITY

C. ENHANCE TRANSITIONS OF CARE FOR STROKE PATIENTS TO ENSURE CONNECTION

WITH APPROPRIATE POST-ACUTE RESOURCES

D. CONTINUE AND EXPAND EDUCATION OF FIRST RESPONDERS ON CONTEMPORARY

TECHNOLOGY AND PRACTICES IN THE DETECTION AND TREATMENT OF STROKES IN THE

FIELD

GOAL 3: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE MANAGEMENT ACROSS

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

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

THE CONTINUUM FOR DIABETES

1. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED TO DIABETES PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE AMERICAN DIABETES ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS

2. EXPAND DIABETES EDUCATION PROGRAM ON THE WAYNE CAMPUS AND EXPAND SERVICES TO PATERSON COMMUNITY

3. SHARE EXPERIENCES AND LEARNINGS FROM SJHS INTERNAL DIABETES AWARENESS AND PREVENTION PROGRAM WITH COMMUNITY PARTNERS

THE HOSPITAL IS CURRENTLY ADDRESSING ALL NEEDS THAT WERE IDENTIFIED BY THE MOST RECENT COMMUNITY NEEDS ASSESSMENT.

SCHEDULE H, PART V, SECTION B, LINE 16A-C

PLEASE FIND THE WEB ADDRESS FOR THE FINANCIAL ASSISTANCE POLICY (FAP) HERE:

HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/SJH_FINANCIAL_ASSISTANCE_POLICY.PDF

PLEASE FIND THE WEB ADDRESS FOR THE FINANCIAL ASSISTANCE APPLICATION HERE:

HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/APPLICATION_FOR_PARTICPATION_CARE_ASSISTANCE.PDF

PLEASE FIND THE WEB ADDRESS FOR THE PLAIN LANGUAGE SUMMARY HERE:

HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/SJH_FA_PLAINLANGUAGE.PDF

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

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

SUPPLEMENTAL INFORMATION -- ST. JOSEPH'S WAYNE HOSPITAL

SCHEDULE H, PART V, SECTION B, LINE 5

TO SOLICIT INPUT FROM KEY INFORMANTS, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN THE HEALTH OF THE COMMUNITY, AN ONLINE KEY INFORMANT SURVEY WAS IMPLEMENTED FROM MARCH 2016 THROUGH JULY 2016. A LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY ST. JOSEPH'S HEALTH, INC.; THIS LIST INCLUDED NAMES AND CONTACT INFORMATION FOR PHYSICIANS, PUBLIC HEALTH REPRESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS. POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS OF THE COMMUNITY OVERALL. KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRODUCING THE PURPOSE OF THE SURVEY AND PROVIDING A LINK TO TAKE THE SURVEY ONLINE; REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION.

POPULATION AND SURVEY CHARACTERISTICS: 47.8% WERE MEN; 52.2% WERE WOMEN; 35.6% WERE BETWEEN 18 AND 39 YEARS; 44.3% WERE BETWEEN 40 AND 60 YEARS; 20.1% WERE 65 YEARS OR OLDER; 42.2% WERE WHITE; 40.1% HISPANIC; 17.0% OTHER AND 34.6% WERE BELOW 200% FPL. PERCENTAGES REPRESENT THE WEIGHTED SURVEY SAMPLE OF ACTUAL PARTICIPANTS.

IN ALL, 79 COMMUNITY STAKEHOLDERS IN PASSAIC COUNTY TOOK PART IN THE ONLINE KEY INFORMANT SURVEY, AS OUTLINED BELOW:

4CS OF PASSAIC COUNTY, INC.

A&S GENERAL PHYSICIAN LLC

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

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

AMANA MEDICAL GROUP

BISAN MEDICAL, INC.

CATHOLIC CHARITIES

CLIFTON HEALTH DEPARTMENT

CLIFTON MEDICAL CARE

CLIFTON PUBLIC SCHOOLS

COMMUNITY CHARTER SCHOOL OF PATERSON

DEPARTMENT OF SENIOR SERVICES PASSAIC COUNTY

DEPAUL PEDIATRICS

ELMWOOD PARK SENIOR CENTER

EVA'S VILLAGE

GMED HEALTHCARE

GREATER BERGEN COMMUNITY ACTION, INC.

HEART AND VASCULAR ASSOCIATES OF NJ

HOMECARE OPTIONS

NOTCHVIEW PEDIATRICS

OASIS A HAVEN FOR WOMEN AND CHILDREN

PASSAIC BOARD OF EDUCATION

PATERSON COMMUNITY CLINIC

PATERSON EDUCATION FUND

PATERSON TASK FORCE FOR COMMUNITY ACTION, INC.

ST. JOSEPH'S CHILDREN'S HOSPITAL

ST. JOSEPH'S FAMILY MEDICINE

ST. JOSEPH'S HEALTH, INC.

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC.

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

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

VITALE WOMEN'S HEALTH WAFA HOUSE, INC.

WANAQUE HEALTH DEPARTMENT

WAYNE YMCA

WEST PATERSON FAMILY MEDICAL CENTER

WOMEN IN TRANSITION, WAYNE COUNSELING & FAMILY SERVICES

SCHEDULE H, PART V, SECTION B, LINE 6A

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (FORMERLY KNOWN AS ST. JOSEPH'S REGIONAL MEDICAL CENTER)

SCHEDULE H, PART V, SECTION B, LINES 7A & 10A

PLEASE FIND THE CHNA AND IMPLEMENTATION STRATEGY HERE:

WWW.STJOSEPHSHEALTH.ORG/GENERAL-INFORMATION/ABOUT-ST-JOSEPHS-HEALTHCARE-SYSTEM/ITEM/1848-COMMUNITY

SCHEDULE H, PART V, SECTION B, LINE 11

WITH TWO ACUTE CARE CAMPUSES LOCATED IN PATERSON AND WAYNE, NEW JERSEY, ST. JOSEPH'S HEALTH, INC. (SJH) COMPLETED COMMUNITY HEALTH NEEDS ASSESSMENTS IN COLLABORATION WITH COMMUNITY, GOVERNMENT AND OTHER SOCIAL SERVICE PARTNERS SERVING THOSE COMMUNITIES. THIS IMPLEMENTATION STRATEGY ACTION PLAN HAS BEEN FORMULATED BASED ON THE FINDINGS AND PRIORITIES ESTABLISHED BY THE NEEDS ASSESSMENTS. THE ACTION PLAN DELINEATES THE FOCUS OF SJHS'S COMMUNITY OUTREACH AND HEALTH IMPROVEMENT EFFORTS OVER IMPROVED HEALTH THROUGH BETTER QUALITY OF CARE AT LOWER COSTS WITH POSITIVE PATIENT AND FAMILY EXPERIENCES WITH FOCUS ON ADDRESSING

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

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

THE HIGHEST PRIORITY ISSUES IDENTIFIED IN THE NEEDS ASSESSMENT.

APPROPRIATE RESOURCES WILL BE ALLOCATED TO ACHIEVE HEALTH IMPROVEMENT

GOALS RELATED TO THE PRIORITY ISSUES.

GOAL 1: IMPROVE THE WELL-BEING OF COMMUNITY RESIDENTS THROUGH INCREASED

KNOWLEDGE ABOUT AND ACCESS TO HEALTHY FOODS AND PARTICIPATION IN PHYSICAL

ACTIVITY PROGRAMS

1. PARTNER WITH THE PASSAIC COUNTY HEALTH COALITION AND AREA

ORGANIZATIONS TO PROMOTE HEALTH AND WELLNESS IN THE COMMUNITY RELATED TO

NUTRITION, PHYSICAL AND HEALTHY WEIGHT ACTIVITIES

2. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

TO NUTRITION, PHYSICAL ACTIVITY AND HEALTHY WEIGHT INITIATIVES

3. PROVIDE AND EXPAND EDUCATION TO BARIATRIC SUPPORT GROUPS, EMPLOYEES

FOCUSED ON WEIGHT MANAGEMENT OR WEIGHT LOSS, AND INDIVIDUALS WITH

CONDITIONS EXACERBATED BY UNHEALTHY LIFESTYLES

4. EXPAND NUTRITIONAL EDUCATION PARTNERSHIPS WITH COMMUNITY SCHOOLS TO

FOSTER HEALTHY HABITS DURING CHILDHOOD

5. EXTEND LEARNING FROM SJHS EMPLOYEE WELLNESS PROGRAMS TO COMMUNITY

PARTNERS

GOAL 2: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE MANAGEMENT ACROSS

THE CONTINUUM FOR HEART DISEASE AND STROKE

1. HEART DISEASE

A. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

TO HEART DISEASE PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE

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

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

AMERICAN HEART ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS

B. CONTINUE AND EXPAND EDUCATION OF FIRST RESPONDERS IN STATE OF THE ART CARDIAC LIFE-SAVING TECHNOLOGY AND PRACTICES

C. SUSTAIN AHA MISSION LIFELINE GOLD STATUS IN RECOGNITION OF EXCELLENCE IN COMMUNITY RESPONSE TO AND TREATMENT OF CARDIAC CONDITIONS

D. BECOME A CHEST PAIN CENTER ACCREDITED BY THE AMERICAN COLLEGE OF CARDIOLOGY

E. EXPAND CARDIAC REHABILITATION TO THE WAYNE COMMUNITY

F. PROVIDE COMMUNITY EDUCATION RELATED TO PREVENTION, TREATMENT AND NON-TRADITIONAL WARNING SIGNS OF HEART DISEASE IN WOMEN

2. STROKE

A. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED TO STROKE PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE AMERICAN HEART ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS.

B. ACHIEVE NJ DEPARTMENT OF HEALTH PRIMARY STROKE DESIGNATION FOR THE WAYNE CAMPUS/COMMUNITY

C. ENHANCE TRANSITIONS OF CARE FOR STROKE PATIENTS TO ENSURE CONNECTION WITH APPROPRIATE POST-ACUTE RESOURCES

D. CONTINUE AND EXPAND EDUCATION OF FIRST RESPONDERS ON CONTEMPORARY TECHNOLOGY AND PRACTICES IN THE DETECTION AND TREATMENT OF STROKES IN THE FIELD

GOAL 3: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE MANAGEMENT ACROSS THE CONTINUUM FOR DIABETES

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

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

1. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS RELATED

TO DIABETES PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE

AMERICAN DIABETES ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS

2. EXPAND DIABETES EDUCATION PROGRAM ON THE WAYNE CAMPUS AND EXPAND

SERVICES TO PATERSON COMMUNITY

3. SHARE EXPERIENCES AND LEARNINGS FROM SJHS INTERNAL DIABETES AWARENESS

AND PREVENTION PROGRAM WITH COMMUNITY PARTNERS

SCHEDULE H, PART V, SECTION B, LINE 16A-C

PLEASE FIND THE WEB ADDRESS FOR THE FINANCIAL ASSISTANCE POLICY (FAP)

HERE:

HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/SJH_FINANCIAL_ASSISTANCE_POLICY.PDF

PLEASE FIND THE WEB ADDRESS FOR THE FINANCIAL ASSISTANCE APPLICATION

HERE:

HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/APPLICATION_FOR_PARTICPATION_CARE_ASSIS

TANCE.PDF

PLEASE FIND THE WEB ADDRESS FOR THE PLAIN LANGUAGE SUMMARY HERE:

HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/SJH_FA_PLAINLANGUAGE.PDF

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 3

	Name and address	Type of Facility (describe)
1	ST. JOSEPH'S HEALTHCARE AND REHAB CENTER 315 EAST LINDSLEY ROAD CEDAR GROVE NJ 07009	LONGTERM CARE AND SUBACUTE SERVICES
2	ST. JOSEPH'S PHYSICIANS HEALTHCARE GRP 703 MAIN STREET PATERSON NJ 07503	FACULTY PRACTICE
3	ST. JOSEPH'S HEALTHCARE, INC. 703 MAIN STREET PATERSON NJ 07503	FACULTY PRACTICE
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Provide the following information.

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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.

PART I, LINE 3C

ST. JOSEPH'S HEALTH, INC. USES THE FOLLOWING SLIDING SCALE TO DETERMINE

FREE AND DISCOUNTED CARE BASED ON INCOME:

-LESS THAN OR EQUAL TO 200% FPL - 100% DISCOUNT

-GREATER THAN 200% THROUGH 225% FPL - 80% DISCOUNT

-GREATER THAN 225% THROUGH 250% FPL - 60% DISCOUNT

-GREATER THAN 250% THROUGH 275% FPL - 40% DISCOUNT

-GREATER THAN 275% THROUGH 300% FPL - 20% DISCOUNT

-GREATER THAN 300% FPL - NO DISCOUNT

IN ADDITION TO THE ABOVE INCOME CRITERIA, INDIVIDUAL ASSETS CANNOT EXCEED

$7,500 AND FAMILY ASSETS CANNOT EXCEED $15,000. BOTH CRITERIA MUST BE MET

TO QUALIFY FOR FREE OR DISCOUNTED CARE.

PART II - COMMUNITY BUILDING ACTIVITIES

ACTIVELY PARTNERS THE EXECUTIVE LEADERSHIP TEAM, ADMINISTRATIVE AND

CLINICAL DIRECTORS WITH SOCIAL SERVICE AGENCIES AND RESIDENTS IN

LOW/MODERATE INCOME AREAS THROUGHOUT PASSAIC COUNTY TO MEANINGFULLY

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ADDRESS THE SOCIAL DETERMINANTS OF HEALTH. THESE PROJECTS INCLUDE ADDRESSING ISSUES RELATED TO AFFORDABLE HOUSING, HEALTHY FOOD ACCESS, DEVELOPING PATHWAYS TO ENSURE GRANDPARENTS WHO HAVE CUSTODIAL CARE OF THEIR GRANDCHILDREN HAVE ACCESS TO PRIMARY CARE PHYSICIANS, BEHAVIORAL HEALTH SERVICES, AND PROJECTS THAT CREATE SAFE NEIGHBORHOOD CORRIDORS. ST. JOSEPH'S STAFF VOLUNTEERS TO WORK WITH THE HEALTH COALITION OF PASSAIC COUNTY TO IMPROVE THE HEALTH OF THE UNDERSERVED OF THE CITY OF PATERSON WITH A SPECIAL FOCUS ON THE MEDICAID AND MEDICAID MCO LOW-INCOME COMMUNITY. EFFORTS TARGET LOW-INCOME HIGH-UTILIZATION POPULATIONS SUCH AS INDIVIDUALS WITH ASTHMA WITH HIGH EMERGENCY ROOM USAGE.

PART III, LINE 2 - BAD DEBT EXPENSE

THE AMOUNT REPORTED IS THE UNCOLLECTIBLE AMOUNTS FOR SELF-PAY PATIENTS.

PART III, LINE 3 - THE MEDICAL CENTER'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS DECREASED FROM 84% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2017 TO 65% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2018.

Part VI Supplemental Information

Provide the following information.

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PART III, LINE 4 - AFS FOOTNOTE

THERE IS NO BAD DEBT FOOTNOTE IN THE AUDITED FINANCIAL STATEMENTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE SYSTEM ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYER SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE SYSTEM ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, THE SYSTEM RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS

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CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

THE MEDICAL CENTER'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS DECREASED FROM 84% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2017 TO 65% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2018. IN ADDITION, THE MEDICAL CENTER'S SELF-PAY WRITE-OFFS NET OF RECOVERIES INCREASED FROM $81.3 MILLION FOR 2017 TO $88.6 MILLION FOR 2018. THE MEDICAL CENTER HAS NOT CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL YEARS 2017 OR 2018.

PART III, LINE 8 - MEDICARE SHORTFALL

THE HOSPITAL UTILIZED THE AMOUNTS REPORTED ON THE MEDICARE COST REPORT TO DETERMINE THE MEDICARE ALLOWABLE COSTS. ST. JOSEPH'S IS COMMITTED TO PROVIDING QUALITY HEALTHCARE TO ALL PATIENTS. THIS COST OF CARE TO OUR MEDICARE POPULATION RESULTED IN A LOSS. WE CONSIDER THIS NET LOSS TO SERVE MEDICARE PATIENTS TO BE ANOTHER FORM OF COMMUNITY BENEFIT. THE SERVICES PROVIDED INCLUDED PRIMARY CARE, EMERGENCY CARE, DENTAL SERIVCES, SUB-SPECIALITY CARE AND INPATIENT AND LONG TERM CARE SERVICES.

Part VI Supplemental Information

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PART III, LINE 9B - WRITTEN DEBT COLLECTION POLICY

WHEN A PATIENT IS KNOWN TO QUALIFY AND APPROVED FOR FINANCIAL ASSISTANCE, A SPECIFIC INSURANCE CODE IS ASSIGNED. THESE BILLS ARE ELECTRONICALLY TRANSMITTED TO THE MEDICAID FISCAL INTERMEDIARY. THE INTERMEDIARY PRICES AND PROCESSES THE CLAIMS. PATIENTS THAT WERE APPROVED FOR 100% ASSISTANCE, AND MADE A PAYMENT WILL BE CREDITED. SIMILARLY, A PATIENT THAT IS APPROVED FOR THE SLIDING SCALE THAT OVERPAID, WILL BE CREDITED.

PART VI, LINE 2 - NEEDS ASSESSMENT

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER CONVENED A GROUP OF INTERNAL AND COMMUNITY STAKEHOLDERS (REPRESENTING A CROSS-SECTION OF COMMUNITY-BASED AGENCIES AND ORGANIZATIONS) TO EVALUATE, DISCUSS AND PRIORITIZE HEALTH ISSUES FOR COMMUNITY, BASED ON FINDINGS OF THIS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC) BEGAN THE MEETING WITH A PRESENTATION OF KEY FINDINGS FROM THE CHNA, HIGHLIGHTING THE SIGNIFICANT HEALTH ISSUES IDENTIFIED FROM THE RESEARCH (SEE AREAS OF OPPORTUNITY ABOVE).

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FOLLOWING THE DATA REVIEW, PRC ANSWERED ANY QUESTIONS AND FACILITATED A GROUP DIALOGUE, ALLOWING PARTICIPANTS TO ADVOCATE FOR ANY OF THE HEALTH ISSUES DISCUSSED. A HOSPITAL REPRESENTATIVE ALSO PROVIDED GUIDANCE TO THE GROUP, DESCRIBING EXISTING ACTIVITIES, INITIATIVES, RESOURCES, ETC., RELATING TO THE AREAS OF OPPORTUNITY. FINALLY, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF THE PRIORITIZATION EXERCISE THAT FOLLOWED.

IN ORDER TO ASSIGN PRIORITY TO THE IDENTIFIED HEALTH NEEDS (I.E., AREAS OF OPPORTUNITY), A WIRELESS AUDIENCE RESPONSE SYSTEM WAS USED IN WHICH EACH PARTICIPANT WAS ABLE TO REGISTER HIS/HER RATINGS USING A SMALL REMOTE KEYPAD. THE PARTICIPANTS WERE ASKED TO EVALUATE EACH HEALTH ISSUE ALONG TWO CRITERIA:

SCOPE & SEVERITY - THE FIRST RATING WAS TO GAUGE THE MAGNITUDE OF THE PROBLEM IN CONSIDERATION OF THE FOLLOWING:

- HOW MANY PEOPLE ARE AFFECTED?

- HOW DOES THE LOCAL COMMUNITY DATA COMPARE TO STATE OR NATIONAL LEVELS, OR HEALTHY PEOPLE 2020 TARGETS?

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- TO WHAT DEGREE DOES EACH HEALTH ISSUE LEAD TO DEATH OR DISABILITY,

IMPAIR QUALITY OF LIFE, OR IMPACT OTHER HEALTH ISSUES?

RATINGS WERE ENTERED ON A SCALE OF 1 (NOT VERY PREVALENT AT ALL, WITH

ONLY MINIMAL HEALTH CONSEQUENCES) TO 10 (EXTREMELY PREVALENT, WITH VERY

SERIOUS HEALTH CONSEQUENCES).

ABILITY TO IMPACT - A SECOND RATING WAS DESIGNED TO MEASURE THE PERCEIVED

LIKELIHOOD OF THE HOSPITAL HAVING A POSITIVE IMPACT ON EACH HEALTH ISSUE,

GIVEN AVAILABLE RESOURCES, COMPETENCIES, SPHERES OF INFLUENCE, ETC.

RATINGS WERE ENTERED ON A SCALE OF 1 (NO ABILITY TO IMPACT) TO 10 (GREAT

ABILITY TO IMPACT).

INDIVIDUALS' RATINGS FOR EACH CRITERIA WERE AVERAGED FOR EACH TESTED

HEALTH ISSUE, AND THEN THESE COMPOSITE CRITERIA SCORES WERE AVERAGED TO

PRODUCE AN OVERALL SCORE. THIS PROCESS YIELDED THE FOLLOWING PRIORITIZED

LIST OF COMMUNITY HEALTH NEEDS:

1. NUTRITION, PHYSICAL ACTIVITY & WEIGHT

2. HEART DISEASE & STROKE

3. DIABETES

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4. MENTAL HEALTH

5. CANCER

6. SUBSTANCE ABUSE

7. ACCESS TO HEALTHCARE SERVICES

8. HIV/AIDS

9. IMMUNIZATION & INFECTIOUS DISEASES

10. HOUSING

11. ORAL HEALTH

12. INJURY & VIOLENCE

13. RESPIRATORY DISEASES

14. SEXUALLY TRANSMITTED DISEASES

15. POTENTIALLY DISABLING CONDITIONS

PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

FINANCIAL ASSISTANCE INFORMATION IS PROVIDED AND POSTED IN FOUR LANGUAGES IN ALL PATIENT REGISTRATION AREAS. PATIENTS IN NEED OF FINANCIAL ASSISTANCE HAVE AN OPPORTUNITY TO SCHEDULE AN APPOINTMENT WITH A FINANCIAL COUNSELOR TO ASK QUESTIONS AND APPLY FOR FINANCIAL ASSISTANCE.

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FINANCIAL COUNSELOR TO ASK QUESTIONS AND APPLY FOR FINANCIAL ASSISTANCE.

PART VI, LINE 4 - COMMUNITY INFORMATION

COMPARISON AND GENERAL COMMUNITY DESCRIPTION: PASSAIC COUNTY, NEW JERSEY

WILL BE UTILIZED TO DEFINE ST. JOSEPH'S UNIVERSITY MEDICAL CENTER'S

COMMUNITY.

SJUMC SISTER HOSPITAL, ST. JOSEPH'S WAYNE HOSPITAL IS ALSO LOCATED IN

PASSAIC COUNTY, APPROXIMATELY 7 MILES TO THE NORTH OF PATERSON IN WAYNE,

NEW JERSEY. WAYNE IS A SUBURBAN COMMUNITY WITH 55,000 RESIDENTS. THE

MEDIAN HOUSEHOLD INCOME IS $100,853; 5% OF HOUSEHOLDS HAD INCOME BELOW

$15,000 A YEAR, WITH 4% IN POVERTY; 29% REPORTED INCOME GREATER THAN

$150,000. MEDIAN AGE WAS 43.4 YEARS; 21% PERCENT OF THE POPULATION IS

UNDER 18 YEARS; 17 PERCENT OF THE POPULATION IS OVER 65 YEARS OF AGE. 93%

OF THE POPULATION HAS HEALTH INSURANCE COVERAGE WITH 10% OF THE

POPULATION REPORTING A DISABILITY.

PASSAIC COUNTY IS A DIVERSE YOUNG COMMUNITY WITH 501,226 RESIDENTS WITH

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APPROXIMATELY 85% OF ITS RESIDENTS RESIDING IN THE SOUTHERN HALF OF THE COUNTY. THE MEDIAN AGE OF A PASSAIC COUNTY RESIDENT IS 36.2 YEARS, WITH 25% PERCENT OF THE POPULATION UNDER 18 YEARS AND 12% OVER THE AGE OF 65 YEARS. RACIALLY, 62% PERCENT OF THE RESIDENTS IDENTIFY THEMSELVES AS WHITE, 14% AS BLACK OR AFRICAN AMERICAN, 4% ASIAN AND 17% AS OTHER. ETHNICALLY, 29.9 % IDENTIFY THEMSELVES AS HISPANIC OR LATINO.

NATIVE RESIDENTS OF THE UNITED STATES ACCOUNT FOR 72% OF PASSAIC COUNTY'S POPULATION; 28% OF THE PEOPLE LIVING IN PASSAIC COUNTY WERE FOREIGN BORN. OF THE FOREIGN BORN POPULATION 48 PERCENT ARE NATURALIZED U.S. CITIZENS.

PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH

THE DEPARTMENT OF URBAN & COMMUNITY HEALTH LEADS THE COMMUNITY ENGAGEMENT ACTIVITIES ON BEHALF OF THE SYSTEM. STAFF MEMBERS HOLD LEADERSHIP POSITIONS ON VARIOUS COMMUNITY BOARDS, INCLUDING THE TRI-COUNTY CHAMBER OF COMMERCE, PATERSON ROTARY, PATERSON ALLIANCE, UNITED WAY OF PASSAIC COUNTY, MINORITY CONCERNS COMMITTEE OF THE PASSAIC COUNTY VICINAGE, AND BOTH THE PATERSON AND WAYNE YMCAS. ACTIVITIES INCLUDE BUT ARE NOT LIMITED

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TO:

1/20/18 - FREE COMMUNITY HEALTH FAIR

ISLAMIC CONGREGATION OF NORTH JERSEY

300-306 PREAKNESS AVE, PATERSON

2/1/18 - STROKE: WHAT YOU SHOULD KNOW

FOUR SEASONS AT GREAT NOTCH

101 FOUR SEASONS BLVD., WOODLAND PARK

3/27/18 - CHILDREN'S HEALTH SERIES: JUVENILE DIABETES

WILLIAM PATERSON UNIVERSITY SCHOOL OF CONTINUING EDUCATION

1600 VALLEY ROAD, WAYNE, NJ 07470

3/29/18 - GOOD NUTRITION FOR INFANTS & TODDLERS

YOUTH BUILD/NJCDC

302 MAIN STREET, PATERSON, NJ

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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.

4/21/18 - CHRISTOPHER COLUMBUS MIDDLE SCHOOL HEALTH & VENDOR

FAIRCHRISTOPHER COLUMBUS MIDDLE SHOOL

350 PIAGET AVE., CLIFTON

4/21/18 - HEALTHY KIDS DAY (WAYNE)

YMCA OF WAYNE

1 PIKE DR, WAYNE, NJ 07470

4/21/18 - HEALHTY KIDS DAY (PATERSON)

YMCA OF PATERSON

128 WARD ST., PATERSON, NJ 07505

4/26/18 - REPORT CARD NIGHT & HEALTH FAIR

SCHOOL #13

690 E 23RD ST, PATERSON

4/28/18 - HEALTH FAIR & COMMUNITY DAY

COMMUNITY CHARTER SCHOOL OF PATERSON

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.

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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.

75 SPRUCE STREET, PATERSON

5/1/18 - CHILDREN'S HEALTH SERIES: ADHD

WILLIAM PATERSON UNIVERSITY SCHOOL OF CONTINUING EDUCATION

1600 VALLEY ROAD, WAYNE, NJ 07470

5/3/18 - MEDICATION SAFETY SEQUOIA SENIOR CENTER

ADAS ISRAEL,

565 BROADWAY, PASSAIC, NJ

5/12/18 - WEST MILFORD 6TH ANNUAL HEALTH FAIR

WEST MILFORD RECREATION CENTER

PAL DRIVE, WEST MILFORD

5/16/18 - EMPLOYEE HEALTH FAIR

BAE SYSTEMS

150 PARISH DRIVE, WAYNE

Part VI Supplemental Information

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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.

6/1/18 - CPR/DEFIBRILLATOR PRESENTATION

KONTOS FOODS

100 6TH AVE., PATERSON

6/3/18 - PEQUANNOCK TOWNSHIP STREET FESTIVAL

PEQUANNOCK TOWNSHIP

NEWARK POMPTON TURNPIKE

6/6/18 - RAMADAN IFTAR

SJUMC

703 MAIN STREET, PATERSON

6/10/18 - ANNUAL WAYNE DAY

WAYNE TOWNSHIP

WAYNE VALLEY HS, 551 VALLEY RD., WAYNE

7/14/18 - DIABETES IN YOUNG CHILDREN

NJCDC

Part VI Supplemental Information

Provide the following information.

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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.

32 SPRUCE STREET, PATERSON

7/14/18 - DOING IT IN THE PARK COMMUNITY FAIR & BASKETBALL TOURNAMENT

DOING IT IN THE PARK ORGANIZATION

390 GREGORY AVE., PASSAIC

7/21/18 - ALEXANDER HAMILTON PROJECTS ASSOCIATION REUNION

AHP ASSOCIATION

EASTSIDE PARK, PATERSON

7/25/18 - WHAT YOU NEED TO KNOW ABOUT COLORECTAL CANCER

VALLEY NATIONAL BANK

1720 RT 23, WAYNE

7/28/18 - COMMUNITY DAY & FOOD FESTIVAL

FOUNDATION OF SALVATION CHURCH

221 MYRTLE AVENUE, PASSAIC

Part VI Supplemental Information

Provide the following information.

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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.

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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.

7/31/18 - MICU/PARAMEDICS PRESENTATION

BOYS & GIRLS CLUB OF PATERSON

264 21ST AVE., PATERSON

8/4/18 - CAR SEAT SAFETY

CITY OF PASSAIC WIC

333 PASSAIC ST., PASSAIC

8/7/18 - NATIONAL NIGHT OUT

SJUMC

703 MAIN STREET, PATERSON

8/16 - 8/19 - PASSAIC COUNTY FAIR

PASSAIC COUNTY

GARRET MOUNTAIN RESERVATION

9/1-9/3 PATERSON GREAT FALLS FESTIVAL

CITY OF PATERSON

Part VI Supplemental Information

Provide the following information.

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GREAT FALLS NATIONAL PARK

9/5/18 - WHEN TO VISIT THE ED

ST. TIMOTHY'S LUTERAN CHURCH "PRIME TIMERS" SENIORS GROUP

395 VALLEY ROAD, WAYNE

9/8/18 - PROSPECT PARK DAY

BOROUGH OF PROSPECT PARK

106 BROWN AVENUE, PROSPECT PARK

9/8/18 - COMMUNITY FEST

CHRISTIAN COMMUNITY OF PRAISE

183-185 20TH AVE, PATERSON

9/29/18 - SUSAN G. KOMEN PASSAIC COUNTY WOMEN'S WELLNESS EXPO

SUSAN G. KOMEN AND PASSAIC COUNTY HEALTH DEPARTMENT

PCTI

45 REINHARDT RD, WAYNE, NJ 07470

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.

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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.

10/26/18 - PASSAIC COUNTY CANCER FAIR

PASSAIC COUNTY VICINAGE

77 HAMILTON ST, PATERSON

11/17/18 - FALL FESTIVAL AT CLIFTON SCHOOL #12

CLIFTON SCHOOL #12

165 CLIFTON AVE., CLIFTON

12/6/18 - WAYNE CHRISTMAS TREE LIGHTING

SJWH

224 HAMBURG TPKE, WAYNE

12/11/18 - PATERSON CHRISTMAS TREE LIGHTING

SJUMC

703 MAIN STREET, PATERSON

NUMBER OF PEOPLE SERVED/ENCOUNTERED: 20

Part VI Supplemental Information

Provide the following information.

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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.

PART VI, LINE 6

SAINT JOSEPH'S HEALTH INC., THE PARENT ORGANIZATION, IS SPONSORED BY THE SISTERS OF CHARITY OF SAINT ELIZABETH AND ITS AFFILIATES.

AFFILIATED MEMBERS OF THE PARENT INCLUDE ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. AND SUBSIDIARIES, ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER FOUNDATION, INC. (THE MEDICAL CENTER FOUNDATION), ST. JOSEPH'S WAYNE HOSPITAL FOUNDATION, INC. (THE WAYNE FOUNDATION), 200 HOSPITAL PLAZA CORPORATION (200 HOSPITAL PLAZA), SJHS INSURANCE LIMITED (THE INSURANCE CAPTIVE), AND VHS MANAGEMENT, INC. AND SUBSIDIARY (VHS).

SAINT JOSEPH'S UNIVERSITY MEDICAL CENTER (THE UNIVERSITY MEDICAL CENTER) WAS FOUNDED IN 1867 AND IS LOCATED IN PATERSON, NEW JERSEY. IT IS AN ACUTE-CARE HOSPITAL WITH 651 LICENSED BEDS AND 30 NEWBORN BASSINETS. THE UNIVERSITY MEDICAL CENTER IS A STATE-DESIGNATED TRAUMA CENTER AND PROVIDES A FULL RANGE OF HEALTH CARE SERVICES. EFFECTIVE JANUARY 1, 2010, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. D/B/A ST. JOSEPH'S WAYNE MEDICAL CENTER AND SUBSIDIARY (WAYNE MEDICAL CENTER) WAS MERGED WITH THE UNIVERSITY MEDICAL CENTER AND COLLECTIVELY THE ENTITIES ARE REFERRED TO

Part VI Supplemental Information

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HEREIN AS THE MEDICAL CENTER. WAYNE MEDICAL CENTER IS LOCATED IN WAYNE,

NEW JERSEY, AND IS AN ACUTE-CARE HOSPITAL WITH 229 LICENSED BEDS. WAYNE

MEDICAL CENTER PROVIDES COMPREHENSIVE MEDICAL AND SURGICAL CARE, AND

EMERGENCY AND DIAGNOSTIC SERVICES FOR ITS COMMUNITY.

THE MEDICAL CENTER ALSO OPERATES ST. JOSEPH'S UNIVERSITY MEDICAL CENTER,

INC. D/B/A ST. JOSEPH'S HEALTHCARE AND REHAB CENTER, A 151 BED SKILLED

NURSING FACILITY LOCATED IN CEDAR GROVE, NEW JERSEY. IN ADDITION, THE

MEDICAL CENTER INCLUDES THE FOLLOWING WHOLLY OWNED SUBSIDIARIES:

-ST. JOSEPH'S HOSPITAL HOUSING CORP. (THE HOUSING CORP.) AND ITS

SUBSIDIARIES, GENESIS PROPERTY DEVELOPMENT HOLDING, LLC AND GENESIS

PROPERTY DEVELOPMENT, LLC (COLLECTIVELY, GENESIS), PROVIDE

PROPERTY-MANAGEMENT SERVICES FOR NONHOSPITAL-RELATED REAL ESTATE

HOLDINGS. THE HOUSING CORP. CEASED ITS OPERATIONS IN 2009.

-ST. JOSEPH'S HEALTHCARE, INC.; ST. JOSEPH'S EMERGENCY PHYSICIANS, INC.;

ST. JOSEPH'S FACULTY PHYSICIANS, INC.; AND ST. JOSEPH'S PHYSICIAN'S, INC.

MANAGE THE MEDICAL CENTER'S FACULTY STAFF BILLING SERVICES.

-HARBOR HOUSE, INC. AND ITS SUBSIDIARIES, HARBORSIDE APARTMENTS, INC. AND

Part VI Supplemental Information

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HARBORVIEW

THE MEDICAL CENTER IS ALSO THE MAJORITY MEMBER OF THE FOLLOWING CONSOLIDATED SUBSIDIARIES: ST. JOSEPH'S REGIONAL CARDIOLOGY, LLC (PATERSON CARDIOLOGY); ST. JOSEPH'S WAYNE CARDIOLOGY, LLC (WAYNE CARDIOLOGY); BLUE MOON PROPERTIES, LLC (BLUE MOON); AND ST. JOSEPH'S SURGERY MANAGEMENT, LLC (SURGERY MANAGEMENT). PATERSON CARDIOLOGY AND WAYNE CARDIOLOGY ARE LIMITED LIABILITY CORPORATIONS THAT EACH OPERATE A CARDIAC CATHETERIZATION LABORATORY. BLUE MOON IS A LIMITED LIABILITY CORPORATION THAT PROVIDES RADIOLOGY-MANAGEMENT SERVICES. SURGERY MANAGEMENT IS A LIMITED LIABILITY CORPORATION ESTABLISHED TO MANAGE THE SURGICAL SERVICES AT THE UNIVERSITY MEDICAL CENTER.

THE PATERSON FOUNDATION AND THE WAYNE FOUNDATION ARE PUBLIC CHARITIES WHOSE PRIMARY PURPOSE IS TO RAISE FUNDS FOR THE MEDICAL CENTER AND WAYNE MEDICAL CENTER, RESPECTIVELY, AND THEIR AFFILIATED ORGANIZATIONS, AND OTHER AREA CHARITABLE ORGANIZATIONS.

200 HOSPITAL PLAZA IS A NOT-FOR-PROFIT ORGANIZATION WHOSE PURPOSE IS TO

Part VI Supplemental Information

Provide the following information.

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FURTHER THE OPERATIONS OF THE MEDICAL CENTER BY OWNING, MANAGING, AND OPERATING PARKING FACILITIES AND ANY OTHER FACILITIES THAT MAY BE DEEMED USEFUL OR NECESSARY FOR EMPLOYEES, PATIENTS, VISITORS, DOCTORS, AND OTHER PERSONS AFFILIATED WITH THE MEDICAL CENTER.

THE INSURANCE CAPTIVE, WHICH IS A WHOLLY OWNED CAPTIVE INSURANCE COMPANY DOMICILED IN BERMUDA, WAS ESTABLISHED IN 2007 TO PROVIDE THE SYSTEM WITH GENERAL LIABILITY AND PROFESSIONAL MEDICAL LIABILITY INSURANCE.

VHS IS A NOT-FOR-PROFIT CORPORATION INCORPORATED IN THE STATE OF NEW JERSEY AND IS THE HOLDING COMPANY OF VISITING HEALTH SERVICES OF NEW JERSEY, INC. (THE AGENCY). THE AGENCY IS LOCATED IN TOTOWA, NEW JERSEY, AND IS A NOT-FOR-PROFIT HOME HEALTH AGENCY THAT SERVED PASSAIC, BERGEN, AND MORRIS COUNTIES IN NEW JERSEY. IN MAY 2017, THE SYSTEM SOLD CERTAIN ASSETS AND BUSINESS OPERATIONS RELATED TO VHS TO A NEWLY FORMED JOINT VENTURE, VHSNJ AT HOME, LLC, A JOINT VENTURE BETWEEN A RECENTLY FORMED SUBSIDIARY OF THE SYSTEM, ST. JOSEPH'S HOME HEALTH, LLC, AND HACKENSACK MERIDIAN HOME CARE SERVICES, INC. THE SYSTEM HOLDS 50% OWNERSHIP INTEREST

Part VI Supplemental Information

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IN THE VHSNJ AT HOME, LLC JOINT VENTURE.

PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT

NEW JERSEY

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

▶ **Go to *www.irs.gov/Form990* for the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE
GROUP RETURN

Employer identification number 27-1344467

Part I General Information on Grants and Assistance

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

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC 503 MAIN STREET PATERSON, NJ 07503	22-1487602	501(C)(3)	1,746,505.				GENERAL SUPPORT
(2) ST. JOSEPH'S HOSPITAL AND MEDICAL CTR FND 810 MAIN ST PATERSON, NJ 07470	22-2448138	501(C)(3)	1,933,743.				GENERAL SUPPORT
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 2.

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1	SCHOLARSHIPS	7.	8,000.			
2						
3						
4						
5						
6						
7						

Part IV **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b); and any other additional information.

SCHEDULE I, PART I, LINE 2

GRANT IS MADE TO A RELATED TAX-EXEMPT ORGANIZATION AND MONITORING IS NOT

REQUIRED AS FUNDS ARE USED TO FURTHER ITS EXEMPT PURPOSE.

SCHOLARSHIPS ARE AWARDED BY THE SCHOLARSHIP COMMITTEE THROUGH A FORMAL

APPLICATION PROCESS.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization: ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number: 27-1344467

Part I Questions Regarding Compensation

			Yes	No
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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**	X	
b	Any related organization?	**6b**		X
	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 on lines 5 and 6? If "Yes," describe in Part III	**7**	X	
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	**8**	X	
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**	X	

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	ANTOINETTE CECERE, M.D.	(i)	241,686.	20,000.	2,012.	0.	3,348.	267,046.	0.
	TRUSTEE	(ii)	0.	0.	0.	0.	0.	0.	0.
2	JOSEPH DUFFY, MD	(i)	165,468.	11,523.	1,385.	3,124.	538.	182,038.	0.
	VP, CMO WAYNE	(ii)	0.	0.	0.	0.	0.	0.	0.
3	KEVIN J SLAVIN	(i)	1,169,836.	383,468.	19,506.	3,943.	29,970.	1,606,723.	0.
	PRESIDENT & CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
4	MARJORY LANGER, MD, FAC	(i)	456,305.	15,032.	662.	0.	5,100.	477,099.	0.
	TRUSTEE	(ii)	0.	0.	0.	0.	0.	0.	0.
5	SUSAN SPATT	(i)	119,538.	13,807.	32,404.	1,489.	904.	168,142.	0.
	EXE. DIRECTOR (THRU 9/27/2018)	(ii)	0.	0.	0.	0.	0.	0.	0.
6	ELIZABETH REGULA	(i)	100,583.	18,034.	25,507.	2,065.	8,977.	155,166.	0.
	EXE.DIR./TRUSTEE (THRU 5/2018)	(ii)	0.	0.	0.	0.	0.	0.	0.
7	KRISTY ZIONTZ, D.O., FA	(i)	431,093.	11,585.	2,586.	3,611.	20,231.	469,106.	0.
	MEMBER AT LARGE	(ii)	0.	0.	0.	0.	0.	0.	0.
8	DENNIS ROEMER	(i)	693,504.	176,164.	7,524.	3,899.	18,547.	899,638.	0.
	SVP OF FINANCE/CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
9	LINDA REED	(i)	425,666.	93,864.	6,450.	7,579.	23,370.	556,929.	0.
	VP, CHIEF INFORMATION OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
10	LISA SCHMITTGALL	(i)	708,528.	145,651.	2,622.	3,238.	10,762.	870,801.	0.
	SENIOR VICE PRESIDENT/COO	(ii)	0.	0.	0.	0.	0.	0.	0.
11	JOHN P. BRUNO	(i)	382,100.	83,944.	3,731.	3,236.	25,669.	498,680.	0.
	VP, HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
12	ROBERT C. HOOD	(i)	254,926.	96,176.	16,214.	3,869.	22,430.	393,615.	0.
	SENIOR VP, POPULATION HEALTH	(ii)	0.	0.	0.	0.	0.	0.	0.
13	JUDITH PADULA	(i)	320,834.	69,153.	4,604.	3,826.	11,628.	410,045.	0.
	VP PATIENT CARE SVCS CNO	(ii)	0.	0.	0.	0.	0.	0.	0.
14	MOIRA GIBBONS	(i)	252,159.	55,575.	1,394.	2,886.	18,406.	330,420.	0.
	VP CCO & DIR. LEGAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.
15	SR. PATRICIA MENNOR	(i)	273,307.	60,021.	3,966.	3,781.	9,424.	350,499.	0.
	VP MISSION	(ii)	0.	0.	0.	0.	0.	0.	0.
16	KENNETH M. MORRIS, JR.	(i)	248,774.	54,953.	3,598.	3,444.	16,974.	327,743.	0.
	VP EXTERNAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	JAMES HAYNES VP FACILITIES OPERATIONS	(i)	265,638.	60,021.	1,208.	4,699.	29,532.	361,098.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
2	STEVEN ALDERSON VP PHYSICIAN SERVICES	(i)	323,305.	72,248.	3,712.	5,171.	9,543.	413,979.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3	MICHAEL ALWELL VP REVENUE CYCLE	(i)	253,770.	25,000.	1,285.	0.	25,536.	305,591.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
4	JENNIFER MENDYZCKI VP WAYNE SITE ADMINISTRATOR	(i)	377,799.	83,363.	1,296.	4,212.	31,557.	498,227.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
5	MARK CONNOLLY CHAIRMAN, DEPT. OF SURGERY	(i)	1,842,955.	1,338,383.	11,649.	3,859.	22,499.	3,219,345.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
6	DAVID PRINCIPE, MD PHYSICIAN	(i)	1,090,983.	0.	4,087.	3,742.	23,983.	1,122,795.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
7	ALDO KHOURY, MD PHYSICIAN	(i)	1,268,644.	0.	9,659.	3,883.	32,936.	1,315,122.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
8	THOMAS CASEY VP, MARKETING & PR	(i)	233,509.	51,129.	2,157.	655.	1,555.	289,005.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
9	DAVID ADINARO, MD VICE PRESIDENT, CMO	(i)	528,143.	71,728.	3,793.	3,720.	29,501.	636,885.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
10	TODD C. BROWER SENIOR VP, GENERAL COUNSEL	(i)	516,233.	109,816.	19,477.	7,579.	30,628.	683,733.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
11	JAMES LABAGNARA, JR, MD SVP AND SYSTEM CMO	(i)	455,501.	97,874.	6,526.	8,748.	1,831.	570,480.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
12	SR. ELLEN CLIFFORD, MD TRUSTEE	(i)	261,779.	29,470.	6,402.	14,508.	9,663.	321,822.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
13	MICHAEL LAMACCHIA, MD TRUSTEE	(i)	451,904.	37,050.	5,502.	3,857.	29,261.	527,574.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
14	MICHAEL DELISI, MD TRUSTEE	(i)	399,561.	37,050.	6,011.	5,113.	21,906.	469,641.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
15	ANTHONY LOSARDO, MD TRUSTEE	(i)	170,040.	0.	0.	0.	0.	170,040.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
16	GENNARO RUBINO TRUSTEE	(i)	299,820.	20,000.	2,012.	508.	28,741.	351,081.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	ROBERT BUDELMAN, III VP, CHIEF DEVELOPMENT OFFICER	(i)	174,488.	0.	593.	0.	19,194.	194,275.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
2	SHAMOON FAYEZ, MD PHYSICIAN	(i)	619,294.	37,050.	7,524.	2,100.	22,273.	688,241.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3	MARK ROSENBERG, MD CHAIR/CHIEF INNOVATION OFFICER	(i)	616,951.	37,050.	10,538.	3,051.	22,708.	690,298.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
4	THOMAS BARNES FORMER OFFICER	(i)	0.	0.	204,152.	3,171.	0.	207,323.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
5	JOANNE DUNAY TRUSTEE (THRU 12/27/2018)	(i)	251,268.	27,666.	3,607.	5,310.	14,232.	302,083.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
6		(i)							
		(ii)							
7		(i)							
		(ii)							
8		(i)							
		(ii)							
9		(i)							
		(ii)							
10		(i)							
		(ii)							
11		(i)							
		(ii)							
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

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.

SCHEDULE J, PART I, LINE 4A

SEVERANCE PAYMENTS WERE MADE IN 2018 TO THE FOLLOWING INDIVIDUALS:

THOMAS BARNES $207,324

DAN KLINE $19,662

SUSAN SPATT $27,065

ELIZABETH REGULA $24,962

SCHEDULE J, PART I, LINE 6A

DURING 2018, DRS. KHOURY AND PRINCIPE RECEIVED ADDITIONAL COMPENSATION EQUAL TO A PERCENTAGE OF NET PATIENT REVENUE GENERATED THROUGH THEIR EXTRAORDINARY EFFORTS RELATED TO SPECIFIC ST JOSEPH'S SERVICE LOCATIONS.

SCHEDULE J, PART I, LINE 7

THE ST. JOSEPH'S HEALTH SYSTEM HAS A MANAGEMENT INCENTIVE PLAN IN PLACE THAT IS INTENDED TO ENCOURAGE AND REWARD ELIGIBLE PLAN PARTICIPANTS FOR ACHIEVING DEFINED OBJECTIVES THAT ARE SUPPORTIVE OF ST. JOSEPH'S HEALTHCARE SYSTEM'S MISSION AND STRATEGY. THE PROGRAM IS DESIGNED TO PROVIDE A MAXIMUM INCENTIVE OPPORTUNITY TO PARTICIPANTS WHOM ACHIEVE THE MAXIMUM PERFORMANCE AND EXPECTATIONS IN MEASUREABLE AREAS. ELIGIBLE

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.

PARTICIPANTS SHALL BE THOSE INCUMBENTS IN MANAGEMENT POSITIONS IN WHICH DECISION AND ACTIONS IMPACT THE OPERATIONS OF ST. JOSEPH'S HEALTHCARE SYSTEM AND/OR IT BUSINESSES AND SUBSIDIARIES. ELIGIBILITY REQUIREMENTS MAY BE MODIFIED FROM YEAR TO YEAR. THE AWARD OPPORTUNITIES WILL BE BASED ON ATTAINMENT OF PRACTICAL PERFORMANCE MEASURES IN THE AREAS OF FINANCIAL, QUALITY PERFORMANCE, PATIENT SATISFACTION AND INDIVIDUAL GOALS. THE AWARD IS THE AMOUNT PAID TO PARTICIPANTS FOR THE ACTUAL PERFORMANCE THAT MEETS THE EXPECTATIONS OF THE CRITERIA ESTABLISHED. AT THE CLOSE OF EACH PLAN YEAR, PARTICIPANTS WILL BE EVALUATED TO DETERMINE IF PERFORMANCE IN SPECIFIC GOALS HAVE BEEN ACHIEVED.

SHEDULE J, PART I, LINE 8

DURING 2018, THE HOSPITAL'S CEO AND CFO WERE COMPENSATED AND PROVIDED WITH BENEFITS PURSUANT TO AN EMPLOYMENT AGREEMENT SATISFYING THE INITIAL CONTRACT EXCEPTION DESCRIBED IN REGS. SECTION 53.4958-1(A)(3).

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE
GROUP RETURN

Employer identification number 27-1344467

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	NJ HEALTH CARE FACILITIES FINANCING AUTHORITY	22-2845542	645790CB0	08/24/2016	274,348,264.	SEE SCHEDULE K, PART VI		X		X		X
B	THE PASSAIC COUNTY IMPROVEMENT AUTHORITY	05-0569671	702754CY6	12/29/2017	26,760,514.	SEE SCHEDULE K, PART VI		X		X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	8,805,000.	800,000.		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	274,352,050.	25,911,699.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows		25,340,699.		
7	Issuance costs from proceeds	2,842,983.	504,287.		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	50,003,786.			
11	Other spent proceeds	221,505,281.	66,713.		
12	Other unspent proceeds				
13	Year of substantial completion	2017	2011		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X				
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	X		X					
16	Has the final allocation of proceeds been made?		X		X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

THE PASSAIC COUNTY IMPROVEMENT AUTHORITY

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X	X					
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X	X					
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?			X					
c	Are there any research agreements that may result in private business use of bond-financed property?				X				
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6	Total of lines 4 and 5		%		%		%		%
7	Does the bond issue meet the private security or payment test?		X		X				
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X				

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X					
b	Exception to rebate?		X		X				
c	No rebate due?		X		X				
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X				

Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X				
7 Has the organization established written procedures to monitor the requirements of section 148?		X		X				

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?		X		X				

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

FORM 990, SCHEDULE K, PART I:

BOND A, COLUMN (A): ISSUER NAME: NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY

BOND A, COLUMN (F): DESCRIPTION OF PURPOSE: EQUIPMENT, REFUNDING OF BONDS ISSUED 8/13/2008

BOND B, COLUMN (A): ISSUER NAME: THE PASSAIC COUNTY IMPROVEMENT AUTHORITY

BOND B, COLUMN (F): DESCRIPTION OF PURPOSE: ADVANCED REFUNDING OF THE 10/22/2010 BOND ISSUE

PART II, LINE 3: THE DIFFERENCE BETWEEN THE ISSUE PRICE PROVIDED IN PART I, COLUMN (E) AND THE TOTAL PROCEEDS IN PART II, LINE 3 FOR BOND A AND BOND B RESULTS FROM INVESTMENT EARNINGS.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 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* for instructions and the latest information.**

OMB No. 1545-0047

2018

Open To Public Inspection

Name of the organization: ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number: 27-1344467

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	(d) Corrected? No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the 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? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? No
	ATTACHMENT 1												
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total							▶ $ 376,794.						

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

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)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information

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

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)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V **Supplemental Information**

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

ATTACHMENT 1

SCHEDULE L, PART II

NAME	DR. JAMES LABAGNARA
RELATIONSHIP WITH ORGANIZATION	VP, MEDICAL AFFAIRS
PURPOSE OF LOAN	PHYSICIAN RECRUITMT
LOAN TO OR FROM THE ORG.?	TO X FROM
ORIGINAL PRINCIPAL AMOUNT	393,932.
BALANCE DUE	376,794.
IN DEFAULT?	YES X NO
APPROVED BY BOARD OR COMMITTEE	YES X NO
WRITTEN AGREEMENT?	X YES NO

FORM 990, PART VI, SECTION A, LINE 6

ST. JOSEPH'S HEALTH, INC. (FORMERLY KNOWN AS ST. JOSEPH'S HEALTHCARE SYSTEM) IS THE SOLE MEMBER OF ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (FORMERLY KNOWN AS ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER), ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER FOUNDATION, INC., ST. JOSEPH'S WAYNE HOSPITAL FOUNDATION, INC., AND 200 HOSPITAL PLAZA CORP. FOUR PERSONS, WHO ARE MEMBERS OF THE SPONSOR, THE SISTERS OF CHARITY OF SAINT ELIZABETH, ARE THE MEMBERS OF THE ST. JOSEPH'S HEALTH, INC.

THE SOLE MEMBER OF HARBOR HOUSE, INC., ST. JOSEPH'S EMERGENCY PHYSICIANS, INC., ST. JOSEPH'S FACULTY PHYSICIANS, INC., ST. JOSEPH'S PHYSICIANS, INC., AND ST. JOSEPH'S SUBSPECIALTY PHYSICIANS, INC. IS ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (FORMERLY KNOWN AS ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER).

FORM 990, PART VI, SECTION A, LINE 7A

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER SHARES A MIRROR BOARD WITH ITS MEMBER ORGANIZATION, ST. JOSEPH'S HEALTH, INC. (THE SYSTEM IS AN OBLIGATED GROUP). UNDER SECTION 2.2 OF THE SYSTEM'S BYLAWS, THE POWER TO ELECT AND REMOVE TRUSTEES FROM THE SYSTEM'S BOARD (AND BY EXTENSION, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER'S BOARD) IS RESERVED TO THE SYSTEM'S SPONSOR ORGANIZATION - THE SISTERS OF CHARITY OF SAINT ELIZABETH.

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

FORM 990, PART VI, SECTION A, LINE 7B

CERTAIN RIGHTS AND POWERS ARE RESERVED TO THE MEMBER PURSUANT TO THE BY-LAWS OF THE CORPORATIONS. THESE INCLUDE: APPROVAL OF THE STATEMENT OF THE MISSION OF THE INSTITUTION AND ANY SUBSEQUENT CHANGES; THE RIGHT TO ELECT AND REMOVE TRUSTEES OF THE BOARD OF THE CORPORATION AND ITS SUBSIDIARIES OTHER THAN THOSE PERSONS WHO ARE TRUSTEES BY REASON OF BEING APPOINTED BY THE SPONSOR; APPROVAL OF AMENDMENTS TO ST. JOSEPH'S CERTIFICATE OF INCORPORATION; AND THE RIGHT TO APPROVE SIGNIFICANT CORPORATE TRANSACTIONS (E.G. MERGERS, CONSOLIDATIONS, DISSOLUTION).

FORM 990, PART VI, SECTION B, LINE 11

A COPY OF THE FORM 990 WAS PRESENTED TO THE ST. JOSEPH'S HEALTH, INC.'S FINANCE COMMITTEE OF THE BOARD OF TRUSTEES IN NOVEMBER 2019 BY THE ORGANIZATION'S TAX RETURN PREPARERS, ERNST & YOUNG LLP. COMMENTS AND FEEDBACK WERE SOLICITED PRIOR TO FILING AND A FINAL COPY OF THE 990 WAS PROVIDED TO EACH OF THE BOARD MEMBERS VIA ELECTRONIC MEANS. THE SYSTEM HAS ESTABLISHED AN ELABORATE ON-LINE WORK-ROOM FOR ALL BOARD MATERIALS THAT CAN BE ACCESSED BY THE ENTIRE BOARD FROM ANY INTERNET-ACCESSIBLE LOCATION. THE FORM 990 FOR THE YEAR ENDING DECEMBER 31, 2018 IS A DOCUMENT WITHIN THAT DATABASE.

FORM 990, PART VI, SECTION B, LINE 12C

ST. JOSEPH'S HEALTH, INC. REQUIRES ALL BOARD OF TRUSTEES MEMBERS, MANAGER LEVEL AND HIGHER EMPLOYEES, OFFICERS AND MEDICAL STAFF COMMITTEE MEMBERS (REPORTING PARTIES) TO COMPLETE ANNUAL CONFLICT OF INTEREST DISCLOSURE

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

STATEMENTS (COIDS) THAT CONSIST OF QUESTIONS DESIGNED TO UNCOVER POTENTIAL CONFLICTS. THE ANNUAL SOLICITATION AND COMPLETION OF COIDS IS CONDUCTED ELECTRONICALLY. UPON COMPLETION AND SUBMISSION OF COIDS BY REPORTING PARTIES, AFFIRMATIVE RESPONSES TO THESE QUESTIONS ARE REVIEWED BY THE GENERAL COUNSEL AND THE CHIEF COMPLIANCE OFFICER. ANY POTENTIAL CONFLICT DISCLOSED IS IDENTIFIED AND RESOLVED IF NECESSARY. ALL DISCLOSURES AND RECOMMENDATIONS FOR RESOLUTION ARE THEN REVIEWED BY THE AUDIT & COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES. THE CHAIR OF THE AUDIT AND COMPLIANCE COMMITTEE PROVIDES A SUMMARY REPORT TO THE SYSTEM BOARD OF TRUSTESS. IN 2018, NO MATERIAL CONFLICTS WERE IDENTIFIED.

FORM 990, PART VI, SECTION B, LINE 15

ST. JOSEPH'S HEALTH, INC. UNDERTAKES A RIGOROUS PROCESS TO ENSURE THAT THE EXECUTIVE COMPENSATION IT PAYS TO ITS TOP MANAGEMENT OFFICIAL AND ALL OFFICERS OF THE ORGANIZATION IS REASONABLE. IN RELEVANT PART, THE BOARD OF TRUSTEES HAS ESTABLISHED A COMPENSATION COMMITTEE COMPRISED OF INDEPENDENT PERSONS THAT HAVE NO PERSONAL INTEREST IN THE PROPOSED COMPENSATION ARRANGEMENT.

THE BOARD OF TRUSTEES USES AN INDEPENDENT COMPENSATION CONSULTANT TO HELP ADVISE ON THE APPROPRIATE COMPENSATION LEVELS FOR THE AFOREMENTIONED INDIVIDUALS. THAT COMPENSATION CONSULTANT WILL USE COMPARABILITY OR BENCHMARKING DATA (BASED ON INDUSTRY SURVEYS) THAT DOCUMENTS THE COMPENSATION OF PERSONS HOLDING SIMILAR POSITIONS IN SIMILAR ORGANIZATIONS. ONCE THE COMPENSATION CONSULTANT HAS MADE ITS

RECOMMENDATIONS, THE SYSTEM'S COMPENSATION COMMITTEE MUST APPROVE THE COMPENSATION, WITHOUT INPUT OR VOTING PARTICIPATION BY THE PERSON WHOSE COMPENSATION IS BEING APPROVED OR BY ANY OTHER INDIVIDUAL WITH A CONFLICT OF INTEREST. THE FINAL DETERMINATION IS THEN DOCUMENTED IN COMMITTEE MINUTES. THOSE MINUTES WILL CONTAIN THE TERMS OF THE PROPOSED COMPENSATION, THE DECISIONS OF THOSE INDIVIDUALS WHO VOTED ON THE COMPENSATION, AND THE COMPARABILITY DATA THAT WAS RELIED UPON. OF INTEREST. THE FINAL DETERMINATION IS THEN DOCUMENTED IN COMMITTEE MINUTES. THOSE MINUTES WILL CONTAIN THE TERMS OF THE PROPOSED COMPENSATION, THE DECISIONS OF THOSE INDIVIDUALS WHO VOTED ON THE COMPENSATION, AND THE COMPARABILITY DATA THAT WAS RELIED UPON.

FORM 990, PART VI, SECTION C, LINE 19
ST. JOSEPH'S HEALTH, INC. MAKES ITS FORM 990 AVAILABLE TO THE PUBLIC BY POSTING A COPY ON THE HOSPITAL'S WEBSITE. THE ORGANIZATION'S GOVERNING DOCUMENTS, FINANCIAL STATEMENTS, AND CONFLICT OF INTEREST POLICY ARE AVAILABLE TO THE PUBLIC UPON REQUEST AND AT MANAGEMENT'S DISCRETION.

FORM 990, PART VII, SECTION A
THE HOURS REPORTED FOR NALINI SHAH, ANTHONY LOSARDO, VIKRAM GUPTA, JOSEPH VITALE, MARJORY LANGER, MD FACEP, JAI G. PAREKH, MD, AND DAVID RASA, MD ARE RELATED TO TIME DEVOTED AS A TRUSTEE OF THE FILING ORGANIZATION. COMPENSATION IS RELATED TO THE INDIVIDUALS' ROLES AS INDEPENDENT CONTRACTORS AND DOES NOT REPRESENT COMPENSATION FOR BOARD DUTIES.

SISTER JUNE MORRISSEY AND SISTER PATRICA MENNOR, AS MEMBERS OF A

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

RELIGIOUS ORDER, ARE EXEMPT FROM FEDERAL AND STATE INCOME TAX AND THEREFORE DO NOT RECEIVE A W-2. IN THE INTEREST OF FULL DISCLOSURE, AMOUNTS PAID TO THE SISTERS ARE REPORTED IN PART VII, SECTION A, COLUMN (F) AND SCHEDULE J, PART II, COLUMN (D).

FORM 990, PART XI, LINE 9 - OTHER CHANGES IN NET ASSETS

PENSION-RELATED ADJUSTMENTS	$(6,443,008)
DISSOLUTION OF JV'S	$(5,000,000)
CHANGE IN BENEFICIAL INTEREST	$(608,928)
NET TRANSFERS FROM AFFILIATES	$ 1,369,057
TOTAL:	$(10,682,879)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

ST. JOSEPH'S HEALTH, INC. IS A HEALING MINISTRY OF THE CATHOLIC CHURCH SPONSORED BY THE SISTERS OF CHARITY OF SAINT ELIZABETH. WE ARE COMMITTED TO PROVIDE EXCEPTIONAL QUALITY CARE WHICH SUSTAINS AND IMPROVES BOTH INDIVIDUAL AND COMMUNITY HEALTH, WITH A SPECIAL CONCERN FOR THOSE WHO ARE POOR, VULNERABLE AND UNDERSERVED.

ATTACHMENT 2

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (SJUMC) PROVIDES COMPREHENSIVE ACUTE CARE SERVICES IN PATERSON, NEW JERSEY, SKILLED

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

ATTACHMENT 2 (CONT'D)

NURSING SERVICES THROUGH ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. D/B/A ST. JOSEPH'S HEALTHCARE AND REHAB CENTER (A DIVISION OF SJUMC) IN CEDAR GROVE, AND AMBULATORY CARE SERVICES AT EIGHT FREE-STANDING AMBULATORY SITES. SJUMC IS A NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES DESIGNATED LEVEL II TRAUMA CENTER, A CHILDREN'S HOSPITAL, A REGIONAL CARDIAC SURGERY CENTER, AND A REGIONAL PERINATAL CENTER WITH APPROXIMATELY 5,332 EMPLOYEES AND PHYSICIANS, THE MEDICAL CENTER IS BOTH THE LARGEST HEALTH CARE PROVIDER AND NON-GOVERNMENT EMPLOYER IN PASSAIC COUNTY. SJUMC OPERATES A 651-LICENSED-BED ACUTE CARE TERTIARY CARE HOSPITAL OF APPROXIMATELY 1.2 MILLION SQUARE FEET, SITUATED ON 25 ACRES. SJUMC IS A NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES DESIGNATED LEVEL II TRAUMA CENTER THAT OFFERS A FULL COMPLEMENT OF SPECIALTY AND SUBSPECIALTY SERVICES INCLUDING A:

1 CANCER CENTER,

2 COMMUNITY EDUCATION SERVICES,

3 COMPREHENSIVE NEURO-STROKE CENTER,

4 DIALYSIS CENTER,

5 EMERGENCY SERVICES,

6 LABOR & DELIVERY AND MOTHER/BABY UNITS,

7 REGIONAL PERINATAL CENTER,

8 SAME-DAY SURGERY,

9 SPECIALIZED SURGERY,

10 TELEMEDICINE,

11 THE HEART CENTER AT ST. JOSEPH'S, AND

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

ATTACHMENT 2 (CONT'D)

12 THE ORTHOPEDIC INSTITUTE.

SJUMC IS ALSO A STATE DESIGNATED FULL-SERVICE CHILDREN'S HOSPITAL, OPERATED UNDER THE NAME "ST. JOSEPH'S CHILDREN'S HOSPITAL," WHICH PROVIDES TERTIARY CARE FOR CHILDREN FROM BIRTH TO 21 YEARS OF AGE. SJUMC OFFERS SPECIALIZED CHILDREN'S SERVICES SUCH AS A NEONATAL INTENSIVE CARE, PEDIATRIC INTENSIVE CARE, AND A DEDICATED PEDIATRIC EMERGENCY ROOM. ADDITIONALLY, SJUMC PROVIDES A:

1 REGIONAL CRANIOFACIAL CENTER,

2 PEDIATRIC CENTER FOR FEEDING AND SWALLOWING DISORDERS,

3 CHILD DEVELOPMENT CENTER,

4 REGIONAL CYSTIC FIBROSIS CENTER, AND

5 A FULL SPECTRUM OF PEDIATRIC SPECIALTY AND SUBSPECIALTY SERVICES

SJUMC CURRENTLY OPERATES 559 BEDS WITHIN THE FOLLOWING 629-LICENSED BED COMPLEMENT:

MEDICAL/SURGICAL - 383

INTENSIVE/CORONARY CARE - 64

OBSTETRICS/GYNECOLOGY - 54

PEDIATRICS - 54

PSYCHIATRY - 24

NEONATAL INTENSIVE CARE - 50

TOTAL (EXCLUDES 30 NEWBORN BASSINETS) - 629

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

ATTACHMENT 2 (CONT'D)

SJUMC ALSO OPERATES THE FOLLOWING AMBULATORY FACILITY SITES WITHIN CLOSE PROXIMITY TO THE MAIN SJUMC CAMPUS:

1. COMPREHENSIVE CARE CENTER, AN AMBULATORY PRIMARY CARE FACILITY FOR HIV PATIENTS IN PATERSON, NJ;

2. CLIFTON FAMILY PRACTICE, AN AMBULATORY PRIMARY CARE FACILITY IN CLIFTON, NJ;

3. ST. JOSEPH'S PEDIATRIC SUB SPECIALTIES AT FAIRFIELD, A PEDIATRIC SUBSPECIALTY FACULTY PRACTICE FACILITY IN FAIRFIELD, NJ;

4. THE MEDICAL CENTER AT WILLOWBROOK ("WILLOWBROOK") IN WAYNE, NJ, A FACULTY PRACTICE FACILITY PROVIDING PEDIATRIC, OBSTETRIC AND MEDICAL SUBSPECIALTY SERVICES AND A 20 STATION DIALYSIS CENTER: AND

5. ST. JOSEPH'S UNIVERSITY MEDICAL CENTER AMBULATORY IMAGING CENTER, A FULL SERVICE DIAGNOSTIC AND WOMEN'S IMAGING CENTER IN CLIFTON, NJ. ST. JOSEPH'S HEALTHCARE AND REHAB CENTER IS LOCATED IN ESSEX COUNTY, APPROXIMATELY FIVE MILES FROM SJUMC. THIS CENTER PROVIDES 24/7 NURSING CARE, MEDICAL, PSYCHO-SOCIAL, NUTRITIONAL, THERAPEUTIC RECREATION, AND SPIRITUAL CARE IN ITS 151-BED LONG-TERM CARE AND SUBACUTE SERVICES CENTER.

CLINICAL SERVICES:

AS PART OF ST. JOSEPH'S HEALTH INC., SJUMC COORDINATES COMPREHENSIVE BASIC AND TERTIARY SERVICES ACROSS CAMPUSES WITH ITS SISTER HOSPITAL ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. D/B/A

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

ATTACHMENT 2 (CONT'D)

ST. JOSEPH'S WAYNE MEDICAL CENTER LOCATED IN WAYNE, NJ THROUGH ITS CLINICAL SERVICE LINE "CENTERS OF EXCELLENCE" MANAGEMENT MATRIX.

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. D/B/A ST. JOSEPH'S WAYNE MEDICAL CENTER (SJWMC) IS A 229-LICENSED BED ACUTE CARE COMMUNITY HOSPITAL FACILITY LOCATED IN WAYNE, NJ. THE HOSPITAL, A MEMBER OF ST. JOSEPH'S HEALTH INC., OFFERS INPATIENT AND ACUTE REHABILITATION SERVICES WITH SPECIALIZED SERVICES OFFERED IN ITS FULL SERVICE CARDIAC CATHETERIZATION LAB, DEDICATED COMPREHENSIVE ACUTE CARE REHABILITATION NURSING UNIT AND A GERIATRIC NURSING UNIT. OUTPATIENT SERVICES INCLUDE DIAGNOSTIC RADIOLOGY, PHYSICAL THERAPY SERVICES, SAME-DAY SURGERY, SLEEP CARE CENTER, AND THE JOHN VICTOR MACHUGA DIABETES EDUCATION CENTER.

CERTAIN ADDITIONAL SPACE IS CURRENTLY LEASED TO A NON-PROFIT LONG TERM ACUTE CARE SERVICES PROVIDER. SJW CURRENTLY OPERATES 138 BEDS WITHIN THE FOLLOWING 229 LICENSED BED COMPLEMENT:

MEDICAL/SURGICAL 193

INTENSIVE/CORONARY CARE 16

COMPREHENSIVE REHABILITATION 20

TOTAL - 229

CLINICAL SERVICES:

INTEGRAL TO ITS SERVICE DELIVERY, SJW COORDINATES COMPREHENSIVE BASIC AND TERTIARY SERVICES ACROSS CAMPUSES WITH ITS SISTER HOSPITAL, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, LOCATED IN

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN

Employer identification number 27-1344467

ATTACHMENT 2 (CONT'D)

PATERSON, NJ THROUGH A CLINICAL SERVICE LINE "CENTERS OF EXCELLENCE" MANAGEMENT MATRIX.

ATTACHMENT 3

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
CARDIOLOGY ASSOCIATES 999 MCBRIDE AVE, STE B204 WEST PATERSON, NJ 07424	CARDIOLOGY	3,970,185.
ADVANCED CARDIOLOGY PRACTICE LLC 246 HAMBURG TURNPIKE STE 201 WAYNE, NJ 07470	CARDIOLOGY	3,313,866.
SOUND PHYSICIANS 30 PROSPECT AVE #4621 HACKENSACK, NJ 07601	HOSPITALIST	2,413,358.
CROTHALL HEALTHCARE 13028 COLLECTION CENTER DRIVE CHICAGO, IL 60693	BIO-MED/IMAG EQUIP	2,382,630.
LORETTA GALLAGHER 16 CRACCO LANE WAYNE, NJ 07470	CONSULTING	2,310,134.

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* for instructions and the latest information.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization ST. JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Employer identification number 27-1344467

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
(1) ST. JOSEPH'S HOME HEALTH, LLC 82-1236513 703 MAIN STREET PATERSON, NJ 07503	SHELL	NJ	0.	0.	N/A
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) VHS MANAGEMENT, INC. 22-2681681 783 RIVERVIEW DRIVE TOTOWA, NJ 07512	HOLDING CO	NJ	501(C)(3)	12C	N/A		X
(2) HARBORSIDE APARTMENTS, INC 22-3373890 703 MAIN STREET PATERSON, NJ 07503	HOUSING	NJ	501(C)(3)	10	N/A		X
(3) HARBORVIEW APARTMENTS, INC. 22-3797055 703 MAIN STREET PATERSON, NJ 07503	HOUSING	NJ	501(C)(3)	10	N/A		X
(4)							
(5)							
(6)							
(7)							

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? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) ST. JOSEPH'S WAYNE CARDIOLOGY 224 HAMBURG TURNPIKE WAYNE, NJ	HEALTHCARE	NJ	SJW	RELATED	349,640.	0.		X	0.		X	
(2) ST. JOSEPH'S REGIONAL CARDIOLO 703 MAIN STREET PATERSON, NJ 0	HEALTHCARE	NJ	SJUMC	RELATED	4,397,451.	0.		X	0.		X	
(3) BLUE MOON PROPERTIES 26-417626 468 PARISH DRIVE WAYNE, NJ 074	RADIOLOGY	NJ	SJUMC	RELATED	80,966.	0.		X	0.		X	100.0000
(4) VHSNJ AT HOME, LLC 81-4612753 C/O TAX DEPT., 1350 CAMPUS PAR	HEALTHCARE	NJ	SJUMC	RELATED	99,899.	5,591,248.		X	0.		X	50.0000
(5) ST. JOSEPH'S SURGERY MANAGEMEN 703 MAIN STREET PATERSON, NJ 0	MGMT SERVICES	NJ	N/A	RELATED	516,892.	0.		X	0.		X	51.7900
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) SJHS INSURANCE LIMITED C/O LAS (INTL ADV 44 CHURCH BERMUDA, BERMUDA BD HM 12	CAPTIVE INSUR	BD	N/A	C CORP					X
(2) ST. JOSEPH'S HOSPITAL HOUSING CORP 22-2145893 703 MAIN STREET PATERSON, NJ 07503	HOUSING	NJ	SJUMC	C CORP				X	
(3) GENESIS PROPERTY DEVELOPMENT, LLC 20-3932322 703 MAIN STREET PATERSON, NJ 07503	INACTIVE	NJ	N/A	C CORP					X
(4) GENESIS PROPERTY DEVELOPMENT HOLDING LLC 20-3930063 703 MAIN STREET PATERSON, NJ 07503	INACTIVE	NJ	N/A	C CORP					X
(5) ST. JOSEPH'S HEALTH PHARMACY, LLC 83-3649808 703 MAIN ST PATERSON, NJ 07503	PHARMACY	NJ	SJUMC	C CORP				X	
(6)									
(7)									

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

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

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)	BLUE MOON PROPERTIES LIMITED	I	1,203,550.	FMV
(2)	BLUE MOON PROPERTIES LIMITED	J	581,452.	FMV
(3)	ST JOSEPH REGIONAL CARDIOLOGY	J	12,553,905.	FMV
(4)	SJHS LIMITED	R	5,177,228.	FMV
(5)	ST JOSEPH REGIONAL CARDIOLOGY	J	289,044.	FMV
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
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(16)													

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.