

# PUBLIC INSPECTION COPY

EXTENDED TO NOVEMBER 15, 2022

Form **990**

## Return of Organization Exempt From Income Tax

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

OMB No. 1545-0047

2021

Department of the Treasury  
Internal Revenue Service

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

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

Open to Public  
Inspection

**A For the 2021 calendar year, or tax year beginning** \_\_\_\_\_ **and ending** \_\_\_\_\_

<b>B</b> Check if applicable:  <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C Name of organization</b> ST JOSEPH'S HEALTH SYSTEM SUBORDINATE <b>GROUP RETURN</b> <b>Doing business as</b> _____ <b>Number and street (or P.O. box if mail is not delivered to street address) Room/suite</b> 703 MAIN STREET _____ <b>City or town, state or province, country, and ZIP or foreign postal code</b> PATERSON, NJ 07503-2621 <b>F Name and address of principal officer: KEVIN J. SLAVIN</b> 703 MAIN STREET, PATERSON, NJ 07503-2621	<b>D Employer identification number</b> 27-1344467 <b>E Telephone number</b> 973-754-2000 <b>G Gross receipts \$</b> 1,031,452,270. <b>H(a) Is this a group return for subordinates?</b> STMT 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>H(b) Are all subordinates included?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions <b>H(c) Group exemption number</b> ▶ 5557
<b>I Tax-exempt status:</b> <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
<b>J Website:</b> ▶ WWW.STJOSEPHSHEALTH.ORG		
<b>K Form of organization:</b> <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		<b>L Year of formation:</b> _____ <b>M State of legal domicile:</b> _____

**Part I Summary**

<b>1</b>	Briefly describe the organization's mission or most significant activities: <u>TO PROVIDE QUALITY HEALTHCARE WITH A SPECIAL CONCERN FOR THE POOR AND UNDERSERVED.</u>		
<b>2</b>	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
<b>3</b>	Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	62
<b>4</b>	Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	50
<b>5</b>	Total number of individuals employed in calendar year 2021 (Part V, line 2a)	<b>5</b>	6375
<b>6</b>	Total number of volunteers (estimate if necessary)	<b>6</b>	132
<b>7 a</b>	Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	999,410.
<b>b</b>	Net unrelated business taxable income from Form 990-T, Part I, line 11	<b>7b</b>	623,086.
<b>8</b>	Contributions and grants (Part VIII, line 1h)	<b>8</b>	170,638,275.
<b>9</b>	Program service revenue (Part VIII, line 2g)	<b>9</b>	750,103,576.
<b>10</b>	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>10</b>	16,200,275.
<b>11</b>	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<b>11</b>	8,661,597.
<b>12</b>	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>12</b>	945,603,723.
<b>13</b>	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<b>13</b>	6,123,562.
<b>14</b>	Benefits paid to or for members (Part IX, column (A), line 4)	<b>14</b>	0.
<b>15</b>	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<b>15</b>	528,551,105.
<b>16a</b>	Professional fundraising fees (Part IX, column (A), line 11e)	<b>16a</b>	0.
<b>b</b>	Total fundraising expenses (Part IX, column (D), line 25) ▶ 1,709,514.	<b>16b</b>	0.
<b>17</b>	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<b>17</b>	367,611,095.
<b>18</b>	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<b>18</b>	902,285,762.
<b>19</b>	Revenue less expenses. Subtract line 18 from line 12	<b>19</b>	43,317,961.
<b>20</b>	Total assets (Part X, line 16)	<b>20</b>	1,092,329,735.
<b>21</b>	Total liabilities (Part X, line 26)	<b>21</b>	851,700,002.
<b>22</b>	Net assets or fund balances. Subtract line 21 from line 20	<b>22</b>	240,629,733.

**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.

<b>Sign Here</b>	Signature of officer  KEVIN J. SLAVIN, PRESIDENT/CEO Type or print name and title	Date 11/15/2022
------------------	--	--------------------

<b>Paid Preparer Use Only</b>	Print/Type preparer's name ABBEY E. LEIBEL	Preparer's signature 	Date 11/15/22	Check if self-employed <input type="checkbox"/>	PTIN P01517527
	Firm's name ▶ ERNST & YOUNG U.S. LLP				Firm's EIN ▶ 34-6565596
	Firm's address ▶ 221 E. 4TH ST, SUITE 2900 CINCINNATI, OH 45202				Phone no. 513-612-1400

May the IRS discuss this return with the preparer shown above? See instructions  Yes  No

PUBLIC INSPECTION COPY

Form **8868**  
(Rev. January 2022)

**Application for Automatic Extension of Time To File an Exempt Organization Return**

OMB No. 1545-0047

Department of the Treasury  
Internal Revenue Service

▶ **File a separate application for each return.**  
▶ **Go to [www.irs.gov/Form8868](http://www.irs.gov/Form8868) for the latest information.**

**Electronic filing (e-file).** You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit [www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits](http://www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits).

**Automatic 6-Month Extension of Time.** Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

<b>Type or print</b>  <small>File by the due date for filing your return. See instructions.</small>	Name of exempt organization or other filer, see instructions. ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Taxpayer identification number (TIN)  27-1344467
	Number, street, and room or suite no. If a P.O. box, see instructions. 703 MAIN STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. PATERSON, NJ 07503-2621	

Enter the Return Code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12
Form 990-T (corporation)	07		

CHRISTOPHER CAULFIELD

• The books are in the care of ▶ 703 MAIN STREET - PATERSON, NJ 07513

Telephone No. ▶ 973-754-2000

Fax No. ▶ \_\_\_\_\_

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) 5557. If this is for the whole group, check this box . If it is for part of the group, check this box  and attach a list with the names and TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until NOVEMBER 15, 2022, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶  calendar year 2021 or

▶  tax year beginning \_\_\_\_\_, and ending \_\_\_\_\_.

2 If the tax year entered in line 1 is for less than 12 months, check reason:  Initial return  Final return  
 Change in accounting period

<b>3a</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>3a</b>	\$	0.
<b>b</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	<b>3b</b>	\$	0.
<b>c Balance due.</b> Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>3c</b>	\$	0.

**Caution:** If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-TE and Form 8879-TE for payment instructions.

LHA For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Form **8868** (Rev. 1-2022)

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page 2

## 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:  
WE ARE COMMITTED TO PROVIDING EXCEPTIONAL QUALITY CARE WHICH SUSTAINS  
AND IMPROVES BOTH INDIVIDUAL AND COMMUNITY HEALTH, WITH A SPECIAL  
CONCERN FOR THOSE WHO ARE POOR, VULNERABLE AND UNDERSERVED.

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 \$ 795,305,069. including grants of \$ 3,724,698. ) (Revenue \$ 849,941,308. )

SEE SCHEDULE O

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

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

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

4e Total program service expenses 795,305,069.

Form 990 (2021)

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **3**

**Part IV Checklist of Required Schedules**

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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Form 990 (2021)

27-1344467

Page **4**

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

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

**Note:** All Form 990 filers are required to complete Schedule O

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

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

		Yes	No
<b>1a</b> Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable .....	<b>1a</b>	386	
<b>b</b> Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable .....	<b>1b</b>	0	
<b>c</b> Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? .....	<b>1c</b>	X	

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **5**

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

		Yes	No
<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .....	<b>2a</b> 6375		
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? .....		X	
<b>Note:</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. See instructions. ....			
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? .....		X	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i> .....		X	
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? .....			X
<b>b</b> If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? .....			X
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? .....			X
<b>c</b> If "Yes" to line 5a or 5b, did the organization file Form 8886-T? .....			
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? .....			X
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? .....			
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>			
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? .....		X	
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? .....		X	
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? .....			X
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year .....	<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? .....			X
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? .....			X
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? ...			
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? .....			
<b>9 Sponsoring organizations maintaining donor advised funds.</b>			
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966? .....			
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? .....			
<b>10 Section 501(c)(7) organizations.</b> Enter:			
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 .....	<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities .....	<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter:			
<b>a</b> Gross income from members or shareholders .....	<b>11a</b>		
<b>b</b> Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) .....	<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? .....			
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year .....	<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>			
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? .....			
<b>Note:</b> See the instructions for additional information the organization must report on Schedule O.			
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans .....	<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand .....	<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? .....			X
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i> .....			
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? .....		X	
<i>If "Yes," see the instructions and file Form 4720, Schedule N.</i>			
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? .....			X
<i>If "Yes," complete Form 4720, Schedule O.</i>			
<b>17 Section 501(c)(21) organizations.</b> Did the trust, any disqualified person, or mine operator engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? .....			
<i>If "Yes," complete Form 6069.</i>			

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Form 990 (2021)

27-1344467

Page **6**

**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 on Schedule O. See instructions.

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

## Section A. Governing Body and Management

			Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year 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 on Schedule O.	<b>1a</b>	62		
<b>b</b> Enter the number of voting members included on line 1a, above, who are independent	<b>1b</b>	50		
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	<b>2</b>			X
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?	<b>3</b>			X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>			X
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>			X
<b>6</b> Did the organization have members or stockholders?	<b>6</b>		X	
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	<b>7a</b>		X	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>		X	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
<b>a</b> The governing body?	<b>8a</b>		X	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>		X	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O	<b>9</b>			X

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

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

**19** Describe on 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 - 973-754-2000  
 703 MAIN STREET, PATERSON, NJ 07513

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **7**

## 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 X

### 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 the 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, Form 1099-MISC, and/or box 1 of Form 1099-NEC) 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.
- See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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) MARK W. CONNOLLY, MD CHAIRMAN, DEPT. OF SURGERY	55.00 0.00					X		2,508,658.	0.	31,170.
(2) KEVIN J. SLAVIN PRESIDENT & CHIEF EXECUTIVE OFFICER	55.00 0.00			X				2,094,141.	0.	6,981.
(3) DENNIS ROEMER SR. VP, CFO THRU 11/20	0.00 0.00						X	1,122,643.	0.	4,016.
(4) JOHN M. DANKS, MD MEDICAL DOCTOR	55.00 0.00					X		1,097,981.	0.	13,689.
(5) LISA SCHMITTGALL EXEC VP, CHIEF ADMIN. OFFICER	55.00 0.00			X				1,057,970.	0.	14,066.
(6) ALDO D. KHOURY, MD MEDICAL DOCTOR	55.00 0.00					X		986,991.	0.	33,934.
(7) MATTHEW A. GROSSMAN MEDICAL DOCTOR	55.00 0.00					X		992,260.	0.	27,737.
(8) SILVIO PODDA, MD MEDICAL DOCTOR	55.00 0.00					X		952,280.	0.	26,972.
(9) TODD C. BROWER SENIOR VP, GENERAL COUNSEL	55.00 0.00				X			823,069.	0.	28,163.
(10) JENNIFER MENDRZYCKI SR. VP, SITE EXEC AND OUTPATIENT SER	53.00 2.00				X			714,480.	0.	34,533.
(11) JOSEPH DUFFY, MD SR. VP, CMO	55.00 0.00				X			735,313.	0.	4,765.
(12) CASWELL SAMMS SR. VP, CHIEF FINANCIAL OFFICER	55.00 0.00			X				684,826.	0.	27,345.
(13) ROBERTO SOLIS, MD TRUSTEE	2.00 0.00	X						662,184.	0.	402.
(14) LINDA A. REED VP, CHIEF INFORMATION OFFICER	55.00 0.00				X			595,700.	0.	28,993.
(15) MICHAEL LAMACCHIA, MD TRUSTEE	2.00 0.00	X						554,986.	0.	27,485.
(16) PIA HOUSE WALKER VP, CHIEF HUMAN RESOURCES OFFICER	55.00 0.00				X			514,315.	0.	28,532.
(17) ROBERT C. HOOD FMR. SR. VP, POP. HEALTH	0.00 0.00						X	512,962.	0.	21,346.



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **8**

**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 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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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			
(18) MICHAEL DELISI, MD TRUSTEE/CO-CHAIR	40.00 0.00	X						487,894.	0.	19,757.
(19) JUDITH PADULA VP, CHIEF NURSING OFFICER THRU 12/21	55.00 0.00				X			488,441.	0.	15,804.
(20) MICHAEL ALWELL VICE PRESIDENT, REVENUE CYCLE	55.00 0.00				X			469,438.	0.	28,756.
(21) NILESH PATEL, MD TRUSTEE	2.00 0.00	X						446,616.	0.	22,190.
(22) JAMES HAYNES VP, FACILITIES OPERATIONS THRU 10/21	55.00 0.00				X			439,640.	0.	28,301.
(23) JONATHAN BARKHORN FMR. VP, PHYS. SVCS. THRU 10/20	0.00 0.00						X	450,000.	0.	0.
(24) MARJORY LANGER, MD TRUSTEE THRU 6/21	2.00 0.00	X						402,504.	0.	29,705.
(25) KENNETH M. MORRIS, JR. VP, EXTERNAL AFFAIRS	55.00 0.00				X			400,627.	0.	23,311.
(26) JAMES LABAGNARA JR., MD VP, MED. AFFAIRS THRU 12/21	55.00 0.00				X			375,893.	0.	10,458.
<b>1b Subtotal</b>								20,571,812.	0.	538,411.
<b>c Total from continuation sheets to Part VII, Section A</b>								4,086,672.	0.	157,219.
<b>d Total (add lines 1b and 1c)</b>								24,658,484.	0.	695,630.

**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 1,219

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director, trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	X	
<b>4</b> For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	X	
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>		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
PROLINK HEALTHCARE, 4600 MONTGOMERY RD, STE 300, CINCINNATI, OH 45212	TEMPORARY STAFFING	7,173,144.
CARDIOLOGY ASSOCIATES, 999 MCBRIDE AVE, STE B204, WEST PATERSON, NJ 07424	CARDIOLOGY	3,960,751.
SYMMETRY WORKFORCE SOLUTIONS, LLC 220 MONMOUTH RD, OAKHURST, NJ 07755	TEMPORARY STAFFING	3,629,459.
ADVANCED CARDIOLOGY PRACTICE LLC 246 HAMBURG TPKE, STE 201, WAYNE, NJ 07470	CARDIOLOGY	3,461,716.
NORTH AMERICAN PARTNERS IN ANESTHESIA 68 SOUTH SERVICE RD, MELVILLE, NY 11747	ANAESTHESIOLOGY	2,725,339.

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 64

SEE PART VII, SECTION A CONTINUATION SHEETS

Form **990** (2021)

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Form 990

27-1344467

**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 line)	(C) Position (check all that apply)						(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			
(27) ROBERT BUDELMAN, III TRUSTEE & VP CDO	55.00 0.00	X						356,681.	0.	26,844.
(28) SISTER PATRICIA MENNOR VP, MISSION	55.00 0.00				X			369,713.	0.	13,668.
(29) PADMAJA UPADYA, MD VP, CHIEF MEDICAL OFFICER, SJWMC	55.00 0.00				X			382,227.	0.	940.
(30) THOMAS CASEY VP, MARKETING AND PUBLIC RELATIONS	55.00 0.00				X			359,671.	0.	1,778.
(31) SWATI PAREKH TRUSTEE	2.00 0.00	X						309,384.	0.	2,911.
(32) MOIRA CONNOLLY, ESQ. VP, CHIEF COMP. OFF. THRU 9/21	53.00 2.00				X			298,418.	0.	3,302.
(33) MICHAEL AGNELLI, MD TRUSTEE	2.00 0.00	X						296,827.	0.	3,952.
(34) JANE WHITE VP ONCOLOGY	55.00 0.00				X			256,384.	0.	40,969.
(35) GENNARO RUBINO, MD TRUSTEE	40.00 0.00	X						275,582.	0.	17,273.
(36) MICHAEL CAIROLI VP, WAYNE SITE ADMIN.	55.00 0.00				X			242,105.	0.	28,557.
(37) CHRISTOPHER TROTZ, MD VP, PHYSICIAN SERVICES	55.00 0.00				X			256,384.	0.	10,715.
(38) JOHN P. BRUNO FORMER VP, HUMAN RESOURCES	0.00 0.00						X	217,474.	0.	3,236.
(39) SAMI ABDULMASSIH, MD TRUSTEE	2.00 0.00	X						217,599.	0.	3,074.
(40) ANTHONY LOSARDO, MD TRUSTEE	2.00 0.00	X						171,265.	0.	0.
(41) JAI PAREKH, MD, MBA, FPAO TRUSTEE	2.00 1.00	X						65,000.	0.	0.
(42) JOSEPH VITALE JR, MD TRUSTEE	2.00 0.00	X						11,325.	0.	0.
(43) MANJU GUPTA TRUSTEE THRU 6/21	2.00 0.00	X						633.	0.	0.
(44) ALBERT CANDIDO SECRETARY	2.00 0.00	X		X				0.	0.	0.
(45) ALFRED LEE TRUSTEE	2.00 0.00	X						0.	0.	0.
(46) ANNEMARIE APPLETON TRUSTEE	2.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c .....										

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Form 990

27-1344467

<b>Part VII</b> Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees <i>(continued)</i>										
(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(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			
(47) ANTHONY GRIFFO, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(48) ANTOINETTE LOYAS VICE CHAIR	2.00 0.00	X		X				0.	0.	0.
(49) ANTOINETTE CECERE, MD TRUSTEE THRU 2/21	40.00 0.00	X						0.	0.	0.
(50) ATHANASIA KONTOS TRUSTEE	2.00 0.00	X						0.	0.	0.
(51) BERNADETTE COUNTRYMAN TRUSTEE	2.00 0.00	X						0.	0.	0.
(52) BETH POLITO TRUSTEE	2.00 0.00	X						0.	0.	0.
(53) CATHERINE KIERNAN TRUSTEE	2.00 0.00	X						0.	0.	0.
(54) CECILIA MCKENNEY TRUSTEE	2.00 0.00	X						0.	0.	0.
(55) DAVID INCORVAIA TRUSTEE	2.00 0.00	X						0.	0.	0.
(56) DEAN EMMOLO CHAIRMAN	2.00 0.00	X		X				0.	0.	0.
(57) DENNIS MARCO, MD TRUSTEE/SECRETARY/TREASURER	2.00 0.00	X		X				0.	0.	0.
(58) DOLORES PAVLAK TRUSTEE	2.00 0.00	X						0.	0.	0.
(59) DONNA BOLES TRUSTEE	2.00 0.00	X						0.	0.	0.
(60) DONNA M DE CANDIDO TRUSTEE	2.00 0.00	X						0.	0.	0.
(61) GABRIELLA LOCONTE TRUSTEE	2.00 0.00	X						0.	0.	0.
(62) GAMIL MAKER, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(63) GUALBERTO MEDINA TRUSTEE	2.00 0.00	X						0.	0.	0.
(64) JAMES KRANZ TRUSTEE	2.00 0.00	X						0.	0.	0.
(65) JOANN KARASIEWICZ TRUSTEE	2.00 0.00	X						0.	0.	0.
(66) JOHN MORONE, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c .....										

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Form 990

27-1344467

<b>Part VII</b> Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees <i>(continued)</i>										
(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(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			
(67) JOHN R. CIOLETTI TRUSTEE	2.00 0.00	X					0.	0.	0.	
(68) JOHN SUTTER, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(69) JOSEPH AMICO TRUSTEE	2.00 0.00	X					0.	0.	0.	
(70) JOSEPH FARNESE, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(71) LORELANE TINDOC, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(72) LOUIS ROMANO TRUSTEE	2.00 0.00	X					0.	0.	0.	
(73) MANNAN RAZZAK, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(74) MARIE BREUSS TRUSTEE	2.00 0.00	X					0.	0.	0.	
(75) MARTIN NEILAN, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(76) MARY MEEHAN TRUSTEE	2.00 0.00	X					0.	0.	0.	
(77) MICHAEL J. ARMSTRONG TRUSTEE	2.00 0.00	X					0.	0.	0.	
(78) MICHAEL MAINERO, MD TRUSTEE	2.00 0.00	X					0.	0.	0.	
(79) NELSON GOMES TRUSTEE	2.00 0.00	X					0.	0.	0.	
(80) PATRICIA DAVINO TRUSTEE	2.00 0.00	X					0.	0.	0.	
(81) REV. MSGR. GEORGE F. HUNDT TRUSTEE THRU 9/21	2.00 0.00	X					0.	0.	0.	
(82) RICHARD J. ABBATE TRUSTEE THRU 9/21	2.00 0.00	X					0.	0.	0.	
(83) ROBERT PAZ TRUSTEE	2.00 0.00	X					0.	0.	0.	
(84) ROGER JOHNSON TRUSTEE	2.00 0.00	X					0.	0.	0.	
(85) ROMAN OBEN TRUSTEE	2.00 0.00	X					0.	0.	0.	
(86) RONALD J. GARNER TRUSTEE	2.00 0.00	X					0.	0.	0.	
Total to Part VII, Section A, line 1c .....										



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **9**

**Part VIII Statement of Revenue**

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1 a</b> Federated campaigns .....	<b>1a</b>					
	<b>b</b> Membership dues .....	<b>1b</b>					
	<b>c</b> Fundraising events .....	<b>1c</b>	371,715.				
	<b>d</b> Related organizations .....	<b>1d</b>	3,665,314.				
	<b>e</b> Government grants (contributions) .....	<b>1e</b>	77,489,353.				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above ...	<b>1f</b>	4,535,739.				
	<b>g</b> Noncash contributions included in lines 1a-1f	<b>1g</b>	\$ 33,960.				
	<b>h Total.</b> Add lines 1a-1f .....		86,062,121.				
	<b>Program Service Revenue</b>	<b>2 a</b> NET PATIENT SRVC REV.	<b>Business Code</b>				
		621110	777,874,376.	777,874,376.			
<b>b</b> PHYSICIAN BILLING		621110	55,455,264.	55,455,264.			
<b>c</b> .....							
<b>d</b> .....							
<b>e</b> .....							
<b>f</b> All other program service revenue .....							
<b>g Total.</b> Add lines 2a-2f .....		833,329,640.					
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) .....		17,590,428.			17,590,428.	
	<b>4</b> Income from investment of tax-exempt bond proceeds .....						
	<b>5</b> Royalties .....						
	<b>6 a</b> Gross rents .....	<b>6a</b>	(i) Real				
			(ii) Personal				
				2,625,399.			
	<b>b</b> Less: rental expenses ...	<b>6b</b>	755,254.				
	<b>c</b> Rental income or (loss)	<b>6c</b>	1,870,145.				
	<b>d</b> Net rental income or (loss) .....		1,870,145.		598,695.	1,271,450.	
	<b>7 a</b> Gross amount from sales of assets other than inventory	<b>7a</b>	(i) Securities				
			(ii) Other				
				67,469,779.	4,183,450.		
	<b>b</b> Less: cost or other basis and sales expenses .....	<b>7b</b>	66,665,089.	0.			
	<b>c</b> Gain or (loss) .....	<b>7c</b>	804,690.	4,183,450.			
	<b>d</b> Net gain or (loss) .....		4,988,140.			4,988,140.	
<b>8 a</b> Gross income from fundraising events (not including \$ 371,715. of contributions reported on line 1c). See Part IV, line 18 .....	<b>8a</b>		405,589.				
		<b>b</b> Less: direct expenses .....	<b>8b</b>	223,506.			
		<b>c</b> Net income or (loss) from fundraising events .....		182,083.			182,083.
<b>9 a</b> Gross income from gaming activities. See Part IV, line 19 .....	<b>9a</b>		35,780.				
		<b>b</b> Less: direct expenses .....	<b>9b</b>	8,850.			
		<b>c</b> Net income or (loss) from gaming activities .....		26,930.			26,930.
<b>10 a</b> Gross sales of inventory, less returns and allowances .....	<b>10a</b>						
		<b>b</b> Less: cost of goods sold .....	<b>10b</b>				
		<b>c</b> Net income or (loss) from sales of inventory .....					
<b>Miscellaneous Revenue</b>	<b>11 a</b> PHARMACY	<b>Business Code</b>					
		446110	4,971,945.	4,945,736.	26,209.		
	<b>b</b> PARKING	812930	2,737,701.			2,737,701.	
	<b>c</b> EDUCATION/TRAINING	900099	1,639,745.	1,639,745.			
	<b>d</b> All other revenue .....	900099	10,400,693.	10,026,187.	374,506.		
<b>e Total.</b> Add lines 11a-11d .....		19,750,084.					
<b>12 Total revenue.</b> See instructions .....		963,799,571.	849,941,308.	999,410.	26,796,732.		

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **10**

**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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</i>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...	3,714,698.	3,714,698.		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 .....	10,000.	10,000.		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 .....				
<b>4</b> Benefits paid to or for members .....				
<b>5</b> Compensation of current officers, directors, trustees, and key employees .....	17,406,875.	14,878,343.	2,469,219.	59,313.
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) .....	2,331,667.	1,992,968.	330,754.	7,945.
<b>7</b> Other salaries and wages .....	430,957,677.	368,356,526.	61,132,685.	1,468,466.
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	12,530,522.	10,805,069.	1,725,453.	
<b>9</b> Other employee benefits .....	45,340,712.	38,950,589.	6,237,002.	153,121.
<b>10</b> Payroll taxes .....	29,851,583.	25,741,020.	4,110,563.	
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management .....				
<b>b</b> Legal .....	1,687,743.	1,455,341.	232,402.	
<b>c</b> Accounting .....	654,052.	563,989.	90,063.	
<b>d</b> Lobbying .....	259,949.	224,113.	35,836.	
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees .....	1,272,434.	1,077,417.	174,348.	20,669.
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	3,761,555.	3,243,589.	517,966.	
<b>12</b> Advertising and promotion .....	962,214.	829,717.	132,497.	
<b>13</b> Office expenses .....	32,784,062.	28,269,738.	4,514,324.	
<b>14</b> Information technology .....	22,679,182.	19,556,259.	3,122,923.	
<b>15</b> Royalties .....				
<b>16</b> Occupancy .....	61,114,693.	52,699,200.	8,415,493.	
<b>17</b> Travel .....	955,133.	823,611.	131,522.	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
<b>19</b> Conferences, conventions, and meetings .....				
<b>20</b> Interest .....	14,963,037.	13,049,669.	1,913,368.	
<b>21</b> Payments to affiliates .....				
<b>22</b> Depreciation, depletion, and amortization .....	36,863,195.	31,867,581.	4,995,614.	
<b>23</b> Insurance .....	14,544,305.	12,541,554.	2,002,751.	
<b>24</b> Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES EXP.	123,285,513.	101,445,887.	21,839,626.	
<b>b</b> PHYSICIAN FEES	19,959,879.	17,211,404.	2,748,475.	
<b>c</b> HEALTHCARE REFORM ACT	5,173,122.	5,173,122.		
<b>d</b> EQUIP REPAIR/MAINT.	5,085,134.	5,085,134.		
<b>e</b> All other expenses	35,738,531.	35,738,531.		
<b>25</b> Total functional expenses. Add lines 1 through 24e	923,887,467.	795,305,069.	126,872,884.	1,709,514.
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here  if following SOP 98-2 (ASC 958-720)

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **11**

**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
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	31,479,572.	<b>1</b>	34,500,555.
	<b>2</b> Savings and temporary cash investments .....	19,740,369.	<b>2</b>	17,032,394.
	<b>3</b> Pledges and grants receivable, net .....	19,514,715.	<b>3</b>	13,160,689.
	<b>4</b> Accounts receivable, net .....	77,261,891.	<b>4</b>	80,209,783.
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....	371,544.	<b>5</b>	268,794.
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....	1,621,809.	<b>7</b>	1,703,188.
	<b>8</b> Inventories for sale or use .....	13,953,587.	<b>8</b>	25,161,689.
	<b>9</b> Prepaid expenses and deferred charges .....	4,537,112.	<b>9</b>	13,822,979.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	962,900,491.		
	<b>10a</b>			
	<b>b</b> Less: accumulated depreciation .....	589,995,287.		
	<b>10b</b>		<b>10c</b>	372,905,204.
	<b>11</b> Investments - publicly traded securities .....	90,250,121.	<b>11</b>	93,315,330.
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	384,589,372.	<b>12</b>	334,014,881.
	<b>13</b> Investments - program-related. See Part IV, line 11 .....		<b>13</b>	
<b>14</b> Intangible assets .....	2,110,000.	<b>14</b>	2,110,000.	
<b>15</b> Other assets. See Part IV, line 11 .....	66,734,438.	<b>15</b>	93,389,729.	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	1,092,329,735.	<b>16</b>	1,081,595,215.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	179,551,781.	<b>17</b>	180,059,269.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....	61,762,389.	<b>19</b>	28,416,000.
	<b>20</b> Tax-exempt bond liabilities .....	355,691,986.	<b>20</b>	249,955,000.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....	28,015.	<b>23</b>	81,200,000.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	254,665,831.	<b>25</b>	198,994,014.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	851,700,002.	<b>26</b>	738,624,283.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions .....	219,052,316.	<b>27</b>	299,641,083.
	<b>28</b> Net assets with donor restrictions .....	21,577,417.	<b>28</b>	43,329,849.
	<b>Organizations that do not follow FASB ASC 958, check here</b> <input type="checkbox"/> <b>and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds .....		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>31</b>	
	<b>32</b> Total net assets or fund balances .....	240,629,733.	<b>32</b>	342,970,932.
<b>33</b> Total liabilities and net assets/fund balances .....	1,092,329,735.	<b>33</b>	1,081,595,215.	

Form **990** (2021)



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Form 990 (2021)

GROUP RETURN

27-1344467

Page **12**

## Part XI Reconciliation of Net Assets

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

<b>1</b> Total revenue (must equal Part VIII, column (A), line 12) .....	<b>1</b>	963,799,571.
<b>2</b> Total expenses (must equal Part IX, column (A), line 25) .....	<b>2</b>	923,887,467.
<b>3</b> Revenue less expenses. Subtract line 2 from line 1 .....	<b>3</b>	39,912,104.
<b>4</b> Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A)) .....	<b>4</b>	240,629,733.
<b>5</b> Net unrealized gains (losses) on investments .....	<b>5</b>	-1,191,917.
<b>6</b> Donated services and use of facilities .....	<b>6</b>	
<b>7</b> Investment expenses .....	<b>7</b>	
<b>8</b> Prior period adjustments .....	<b>8</b>	
<b>9</b> Other changes in net assets or fund balances (explain on Schedule O) .....	<b>9</b>	63,621,012.
<b>10</b> Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B)) .....	<b>10</b>	342,970,932.

## Part XII Financial Statements and Reporting

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

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

Form **990** (2021)

**SCHEDULE A**  
**(Form 990)**

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

OMB No. 1545-0047

**2021**

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).)
- 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 on 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?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER	22-1487602	3	X		3,665,314.	
<b>Total</b>					3,665,314.	0.

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

27-1344467

Page 2

Schedule A (Form 990) 2021

**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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> .....						<input type="checkbox"/>

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

<b>14</b> Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)) .....	<b>14</b>	
<b>15</b> Public support percentage from 2020 Schedule A, Part II, line 14 .....	<b>15</b>	
<b>16a 33 1/3% support test - 2021.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....	<input type="checkbox"/>	
<b>b 33 1/3% support test - 2020.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....	<input type="checkbox"/>	
<b>17a 10% -facts-and-circumstances test - 2021.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....	<input type="checkbox"/>	
<b>b 10% -facts-and-circumstances test - 2020.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....	<input type="checkbox"/>	
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....	<input type="checkbox"/>	

Schedule A (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule A (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

## 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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose .....						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year .....						
<b>c</b> Add lines 7a and 7b .....						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

### Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>9</b> Amounts from line 6 .....						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....						
<b>11</b> Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

**14 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

### Section C. Computation of Public Support Percentage

<b>15</b> Public support percentage for 2021 (line 8, column (f), divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2020 Schedule A, Part III, line 15 .....	<b>16</b>	%

### Section D. Computation of Investment Income Percentage

<b>17</b> Investment income percentage for <b>2021</b> (line 10c, column (f), divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2020</b> Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2021.** 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 - 2020.** 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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule A (Form 990) 2021

27-1344467

Page 4

## Part IV Supporting Organizations

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

### Section A. All Supporting Organizations

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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule A (Form 990) 2021

27-1344467

Page 5

**Part IV Supporting Organizations** *(continued)*

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

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

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

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

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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule A (Form 990) 2021

27-1344467

Page 6

**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 <b>Adjusted Net Income</b> (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 <b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e <b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
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 0.015 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 0.035.	6	
7 Recoveries of prior-year distributions	7	
8 <b>Minimum Asset Amount</b> (add line 7 to line 6)	8	

Section C - Distributable Amount	(A) Prior Year	(B) Current Year (optional)
1 Adjusted net income for prior year (from Section A, line 8, column A)	1	Current Year
2 Enter 0.85 of line 1.	2	
3 Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4 Enter greater of line 2 or line 3.	4	
5 Income tax imposed in prior year	5	
6 <b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Schedule A (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule A (Form 990) 2021

27-1344467

Page 7

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

Section D - Distributions	Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>
<b>4</b> Amounts paid to acquire exempt-use assets	<b>4</b>
<b>5</b> Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )	<b>5</b>
<b>6</b> Other distributions ( <i>describe in Part VI</i> ). See instructions.	<b>6</b>
<b>7 Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions.	<b>8</b>
<b>9</b> Distributable amount for 2021 from Section C, line 6	<b>9</b>
<b>10</b> Line 8 amount divided by line 9 amount	<b>10</b>

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2021	(iii) Distributable Amount for 2021
<b>1</b> Distributable amount for 2021 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2021 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2021			
<b>a</b> From 2016			
<b>b</b> From 2017			
<b>c</b> From 2018			
<b>d</b> From 2019			
<b>e</b> From 2020			
<b>f Total</b> of lines 3a through 3e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2021 distributable amount			
<b>i</b> Carryover from 2016 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2021 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2021 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2021, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b> Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7 Excess distributions carryover to 2022.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2017			
<b>b</b> Excess from 2018			
<b>c</b> Excess from 2019			
<b>d</b> Excess from 2020			
<b>e</b> Excess from 2021			

Schedule A (Form 990) 2021



PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule A (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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:

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER IS A HOSPITAL DESCRIBED IN

SECTION 170(B)(1)(A)(III).

THE FOLLOWING ORGANIZATIONS ARE 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 HOSPITAL & MEDICAL CENTER FOUNDATION,

- HARBOR HOUSE, INC.

- 200 HOSPITAL PLAZA

- ST. JOSEPH'S EMERGENCY PHYSICIANS, INC.

- ST. JOSEPH'S FACULTY PHYSICIANS, INC.

- ST. JOSEPH'S PHYSICIANS, INC.

- ST. JOSEPH'S PHYSICIANS HEALTHCARE GROUP, INC.

- ST. JOSEPH'S SUBSPECIALTY PHYSICIANS, INC.

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

GROUP RETURN.

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule A (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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.)

HARBOR HOUSE, INC. IS ORGANIZED TO PROVIDE ELDERLY OR DISABLED PERSONS

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 ST JOSEPHS HEALTH,

INC. ("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.

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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule A (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

**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.)

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.

Schedule B (Form 990)

Department of the Treasury Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2021

Table with 2 columns: Name of the organization (ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN) and Employer identification number (27-1344467)

Organization type (check one):

Filers of:

Section:

- Form 990 or 990-EZ: [X] 501(c)(3) organization, [ ] 4947(a)(1) trust, [ ] 527 political organization
Form 990-PF: [ ] 501(c)(3) exempt foundation, [ ] 4947(a)(1) trust, [ ] 501(c)(3) taxable 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...

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...
[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor...
[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor...

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990), but it must answer "No" on Part IV, line 2, of its Form 990...

# PUBLIC INSPECTION COPY

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 <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	_____	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	_____	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	_____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b>  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 <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8		\$ 9,860.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9		\$ 31,210.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11		\$ 18,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16		\$ 23,835.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17		\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18		\$ 50,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

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		\$ 15,090.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20		\$ 121,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21		\$ 8,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24		\$ 45,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28		\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29		\$ 53,000.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 55,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32		\$ 19,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33		\$ 9,404.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35		\$ 90,399.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b>  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		\$ 37,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38		\$ 7,550.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39		\$ 11,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41		\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44		\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47		\$ 31,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48		\$ 21,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 8,330.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51		\$ 40,613.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52		\$ 5,153.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58		\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59		\$ 450,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63		\$ 11,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64		\$ 9,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65		\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66		\$ 13,375.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68		\$ 5,625.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
69		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
70		\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



# PUBLIC INSPECTION COPY

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		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
74		\$ 7,735.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
75		\$ 14,075.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
76		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
77		\$ 5,373.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
78		\$ 10,025.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 27,965.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
80		\$ 24,140.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
81		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
82		\$ 21,950.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
83		\$ 13,202.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
84		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

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		\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
86		\$ 31,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
87		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
88		\$ 7,100.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
89		\$ 21,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
90		\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 8,846.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
92		\$ 17,775.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
93		\$ 150,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
94		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
95		\$ 18,700.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
96		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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	_____ _____ _____	\$ _____ 35,225.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
98	_____ _____ _____	\$ _____ 81,457.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
99	_____ _____ _____	\$ _____ 260,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
100	_____ _____ _____	\$ _____ 9,971.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
101	_____ _____ _____	\$ _____ 116,213.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
102	_____ _____ _____	\$ _____ 190,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

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		\$ 11,623.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
104		\$ 40,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
105		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
106		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
107		\$ 19,192.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
108		\$ 120,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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		\$ 300,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
110		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
111		\$ 479,395.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
112		\$ 70,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
113		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
114		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b>  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
115		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
116		\$ 12,291.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
117		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
118		\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
119		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
120		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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
121		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
122		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
123		\$ 239,357.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
124		\$ 10,000.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
125		\$ 18,948.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
126		\$ 3,665,314.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

# PUBLIC INSPECTION COPY

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	<b>Employer identification number</b> 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
124	G&Y ANTIBACTERIAL WIPES _____ _____ _____	\$ 10,000.	01/28/21
125	PPE AND MEDICAL EQUIPMENT _____ _____ _____	\$ 18,948.	03/28/21
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____

# PUBLIC INSPECTION COPY

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 info. once.) ▶ \$ \_\_\_\_\_  
 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	

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GR

27-1344467

FORM 990

LINE H(B) - LIST OF AFFILIATED  
ORGANIZATIONS INCLUDED IN GROUP RETURN

STATEMENT 1

<u>NAME OF ORGANIZATION</u>	<u>ORGANIZATION'S ADDRESS</u>	<u>EMPLOYER ID</u>
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER INC.	703 MAIN STREET - PATERSON, NJ 07503	22-1487602
HARBOR HOUSE, INC.	703 MAIN STREET - PATERSON, NJ 07503	22-2354611
ST. JOSEPH'S HOSPITAL & MEDICAL CENTER FOUNDATION INC.	703 MAIN STREET - PATERSON, NJ 07503	22-2448138
ST. JOSEPH'S HEALTHCARE INC.	703 MAIN STREET - PATERSON, NJ 07503	22-2810004
200 HOSPITAL PLAZA CORPORATION	703 MAIN STREET - PATERSON, NJ 07503	22-3061067
ST. JOSEPH'S SUBSPECIALTY PHYSICIANS	703 MAIN STREET - PATERSON, NJ 07503	27-0806126
ST. JOSEPH'S PHYSICIANS INC.	703 MAIN STREET - PATERSON, NJ 07503	27-0806417
ST. JOSEPH'S EMERGENCY PHYSICIANS INC.	703 MAIN STREET - PATERSON, NJ 07503	27-0806549
ST. JOSEPH'S FACULTY PHYSICIANS INC.	703 MAIN STREET - PATERSON, NJ 07503	27-0806980
ST. JOSEPH'S PHYSICIANS HEALTHCARE GR	703 MAIN STREET - PATERSON, NJ 07503	27-3906409

SCHEDULE C (Form 990)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

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.

Table with 2 columns: Name of organization (ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN) and Employer identification number (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.
2 Political campaign activity expenditures \$
3 Volunteer hours for political campaign activities

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.

Table with 5 columns: (a) Name, (b) Address, (c) EIN, (d) Amount paid from filing organization's funds, (e) Amount of political contributions received and promptly and directly delivered to a separate political organization.

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule C (Form 990) 2021

LHA

132041 11-03-21

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule C (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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												
<b>1a</b> Total lobbying expenditures to influence public opinion (grassroots lobbying) .....														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....														
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....														
<b>d</b> Other exempt purpose expenditures .....														
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....														
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 70%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	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.		
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.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....														
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....														
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....														
<b>j</b> 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? .....		<input type="checkbox"/> Yes <input type="checkbox"/> 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) 2018	(b) 2019	(c) 2020	(d) 2021	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

Schedule C (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule C (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

**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)).**

	(a)		(b)
	Yes	No	Amount
<i>For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.</i>			
<b>1</b> During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
<b>a</b> Volunteers? .....		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..		X	
<b>c</b> Media advertisements? .....		X	
<b>d</b> Mailings to members, legislators, or the public? .....		X	
<b>e</b> Publications, or published or broadcast statements? .....		X	
<b>f</b> Grants to other organizations for lobbying purposes? .....		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body? .....		X	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		X	
<b>i</b> Other activities? .....	X		259,949.
<b>j</b> Total. Add lines 1c through 1i .....			259,949.
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? .....			

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

		Yes	No
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members? .....	1		
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less? .....	2		
<b>3</b> 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."**

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

**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.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

LOBBYING ACTIVITIES

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 2021, THE HOSPITAL

PAID WASHINGTON STRATEGIC CONSULTING, INC. \$67,500 FOR THEIR EFFORTS.

Schedule C (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule C (Form 990) 2021

GROUP RETURN

27-1344467

Page 4

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

THE HOSPITAL PAID MEMBERSHIP DUES TO CATHOLIC HEALTH ASSOCIATION (CHA),

NJHA, HOSPITAL ALLIANCE NJ., AND TO AMERICA ESSENTIALS HOSPITALS. A

PORTION OF THESE DUES WERE USED FOR LOBBYING ACTIVITIES.



SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

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.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two yes/no questions about donor property and grant fund usage.

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include purpose of easements, completion of lines 2a-2d, number of easements modified, states where located, monitoring policy, staff hours, expenses, and requirements of section 170(h)(4)(B)(i).

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.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include reporting requirements for art and historical treasures, and amounts required to be reported under FASB ASC 958.

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule D (Form 990) 2021

GROUP RETURN

27-1344467

Page **2**

**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 make significant use of its collection items (check all that apply):

- |   |  |
|---|--|
| <p><b>a</b> <input type="checkbox"/> Public exhibition</p> <p><b>b</b> <input type="checkbox"/> Scholarly research</p> <p><b>c</b> <input type="checkbox"/> Preservation for future generations</p> | <p><b>d</b> <input type="checkbox"/> Loan or exchange program</p> <p><b>e</b> <input type="checkbox"/> Other _____</p> |
|---|--|

**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
<b>c</b> Beginning balance .....	<b>1c</b>
<b>d</b> Additions during the year .....	<b>1d</b>
<b>e</b> Distributions during the year .....	<b>1e</b>
<b>f</b> Ending balance .....	<b>1f</b>

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

**b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided 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
<b>1a</b> Beginning of year balance .....	123,142.	123,142.	123,142.	123,142.	291,432.
<b>b</b> Contributions .....					
<b>c</b> Net investment earnings, gains, and losses .....	47.	39.	3,500.	1,792.	637.
<b>d</b> Grants or scholarships .....					
<b>e</b> Other expenditures for facilities and programs .....	47.	39.	3,500.	1,792.	
<b>f</b> Administrative expenses .....					
<b>g</b> End of year balance .....	123,142.	123,142.	123,142.	123,142.	292,069.

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

- a** Board designated or quasi-endowment ▶ \_\_\_\_\_ %
- b** Permanent endowment ▶ 100 %
- c** Term endowment ▶ \_\_\_\_\_ %

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

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

- (i)** Unrelated organizations .....
- (ii)** Related organizations .....

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land .....		12,510,942.		12,510,942.
<b>b</b> Buildings .....		506,603,424.	286,875,939.	219,727,485.
<b>c</b> Leasehold improvements .....		18,971,222.	14,793,926.	4,177,296.
<b>d</b> Equipment .....		414,963,420.	288,325,422.	126,637,998.
<b>e</b> Other .....		9,851,483.		9,851,483.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				372,905,204.

Schedule D (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule D (Form 990) 2021

GROUP RETURN

27-1344467

Page **3**

**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	1,581,427.	END-OF-YEAR MARKET VALUE
(B) CORPORATE OBLIGATIONS	327,288,664.	END-OF-YEAR MARKET VALUE
(C) MUTUAL FUNDS	5,144,790.	END-OF-YEAR MARKET VALUE
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	334,014,881.	

**Part VIII Investments - Program Related.**

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Col. (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	30,928,500.
(2) OTHER ASSETS	5,716,102.
(3) BENEFICIAL INTEREST IN TRUST	6,931,903.
(4) OPERATING RIGHT OF USE ASSETS	24,595,556.
(5) ASSETS HELD BY RELATED ORGANIZATIONS	25,217,668.
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	93,389,729.

**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	89,351,524.
(3) ACCRUED PENSION LIABILITY	45,495,077.
(4) ACCRUED MALPRACTICE INSURANCE	10,839,616.
(5) OTHER LONG TERM DEBT	10,039,860.
(6) OPERATING RIGHT TO USE ASSETS	24,596,045.
(7) OTHER LIABILITIES	18,671,892.
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	198,994,014.

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 FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII ...

Schedule D (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule D (Form 990) 2021

GROUP RETURN

27-1344467

Page **4**

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

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

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

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

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

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

**Part XIII Supplemental Information.**

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

PART V, LINE 4:

THE FOUNDATION MAINTAINS A DONOR-RESTRICTED FUND WHOSE PURPOSE IS TO  
 PROVIDE FOR THE CARE AND TREATMENT OF PATIENTS AFFLICTED WITH CANCER. IN  
 CLASSIFYING SUCH FUND FOR FINANCIAL STATEMENT PURPOSES AS EITHER NET  
 ASSETS WITH OR WITHOUT DONOR RESTRICTIONS, THE BOARD OF TRUSTEES LOOKS TO  
 THE EXPLICIT DIRECTIONS OF THE DONOR WHERE APPLICABLE AND THE PROVISIONS  
 OF THE LAWS OF THE STATE OF NEW JERSEY. THE BOARD HAS DETERMINED THAT,  
 ABSENT DONOR STIPULATIONS TO THE CONTRARY, THE PROVISIONS OF NEW JERSEY  
 STATE LAW DO NOT IMPOSE EITHER RESTRICTION ON THE INCOME OR CAPITAL  
 APPRECIATION DERIVED FROM THE ORIGINAL GIFT.











PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule F (Form 990) 2021 GROUP RETURN

27-1344467

Page 4

Part IV Foreign Forms

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

Schedule F (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule F (Form 990) 2021 GROUP RETURN

27-1344467

Page 5

## 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.



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule G (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))
		GOLF OUTING (event type)	GALA (event type)	2 (total number)	
Revenue	<b>1</b> Gross receipts .....	359,813.	195,910.	221,581.	777,304.
	<b>2</b> Less: Contributions .....	150,679.	130,372.	90,664.	371,715.
	<b>3</b> Gross income (line 1 minus line 2) .....	209,134.	65,538.	130,917.	405,589.
Direct Expenses	<b>4</b> Cash prizes .....				
	<b>5</b> Noncash prizes .....				
	<b>6</b> Rent/facility costs .....			406.	406.
	<b>7</b> Food and beverages .....	92,775.	9,040.	76,399.	178,214.
	<b>8</b> Entertainment .....	6,829.		3,659.	10,488.
	<b>9</b> Other direct expenses .....	17,733.	6,354.	10,311.	34,398.
	<b>10</b> Direct expense summary. Add lines 4 through 9 in column (d) .....				223,506.
<b>11</b> Net income summary. Subtract line 10 from line 3, column (d) .....				182,083.	

**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	<b>1</b> Gross revenue .....			35,780.	35,780.
	<b>2</b> Cash prizes .....			8,850.	8,850.
Direct Expenses	<b>3</b> Noncash prizes .....				
	<b>4</b> Rent/facility costs .....				
	<b>5</b> Other direct expenses .....				
<b>6</b> Volunteer labor .....	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input checked="" type="checkbox"/> No		
<b>7</b> Direct expense summary. Add lines 2 through 5 in column (d) .....					8,850.
<b>8</b> Net gaming income summary. Subtract line 7 from line 1, column (d) .....					26,930.

**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: \_\_\_\_\_

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule G (Form 990) 2021

27-1344467

Page 3

- 11 Does the organization conduct gaming activities with nonmembers?  Yes  No
- 12 Is the organization a grantor, beneficiary or trustee of a trust, or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13 Indicate the percentage of gaming activity conducted in:
- |                               |     |          |
|-------------------------------|-----|----------|
| a The organization's facility | 13a | %        |
| b An outside facility         | 13b | 100.00 % |
- 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 - PATTERSON, NJ 07053

- 15a Does the organization have a contract with a third party from whom the organization receives gaming revenue?  Yes  No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_
- c If "Yes," enter name and address of the third party:

Name ▶ \_\_\_\_\_

Address ▶ \_\_\_\_\_

16 Gaming manager information:

Name ▶ PATRICIA PAOLUCCI 703 MAIN STREET, PATERSON NJ 07053

Gaming manager compensation ▶ \$ 1,000.

Description of services provided ▶ PLAN AND EXECUTE GAMING ACTIVITIES

Director/officer  Employee  Independent contractor

17 Mandatory distributions:

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

b Enter the amount of distributions required under state law 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 explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PUBLIC INSPECTION COPY

SCHEDULE H  
(Form 990)

Hospitals

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ 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.

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	X	
b If "Yes," was it a written policy?	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. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
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: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	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: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	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"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		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?		
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	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)			51,939,377.	43,362,734.	8,576,643.	.93%
b Medicaid (from Worksheet 3, column a)			233,713,026.	193,699,098.	40,013,928.	4.33%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			285,652,403.	237,061,832.	48,590,571.	5.26%
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4)			5,090,503.	2,237,763.	2,852,740.	.31%
f Health professions education (from Worksheet 5)			46,184,605.	19,382,025.	26,802,580.	2.90%
g Subsidized health services (from Worksheet 6)			169,837,017.	77,775,713.	92,061,304.	9.96%
h Research (from Worksheet 7)			419,721.	0.	419,721.	.05%
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			221,531,846.	99,395,501.	122,136,345.	13.22%
k Total. Add lines 7d and 7j			507,184,249.	336,457,333.	170,726,916.	18.48%







# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 4

**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** FACILITY REPORTING GROUP - A

**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** 1, 2

		Yes	No
<b>Community Health Needs Assessment</b>			
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 <input checked="" type="checkbox"/> A definition of the community served by the hospital facility			
b <input checked="" type="checkbox"/> Demographics of the community			
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d <input checked="" type="checkbox"/> How data was obtained			
e <input checked="" type="checkbox"/> The significant health needs of the community			
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs			
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests			
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j <input type="checkbox"/> Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: <u>20 19</u>			
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 <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C</u>			
b <input type="checkbox"/> Other website (list url): _____			
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility			
d <input type="checkbox"/> 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: <u>20 19</u>			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	10	X	
a If "Yes," (list url): <u>SEE PART V, SECTION C</u>			
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? \$			

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 5

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

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>13</b>	X	
If "Yes," indicate the eligibility criteria explained in the FAP:			
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance status			
<b>g</b> <input checked="" type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>14</b>	X	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>15</b>	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):			
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>16</b>	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

Schedule H (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 6

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

**Billing and Collections**

Name of hospital facility or letter of facility reporting group FACILITY REPORTING GROUP - A

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

**Policy Relating to Emergency Medical Care**

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

Schedule H (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 7

**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 FACILITY REPORTING GROUP - A

		Yes	No
<p><b>22</b> 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.</p> <p><b>a</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period</p> <p><b>b</b> <input checked="" type="checkbox"/> 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</p> <p><b>c</b> <input type="checkbox"/> 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</p> <p><b>d</b> <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method</p>			
<p><b>23</b> 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? .....</p> <p>If "Yes," explain in Section C.</p>	<b>23</b>		x
<p><b>24</b> 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? .....</p> <p>If "Yes," explain in Section C.</p>	<b>24</b>		x

**Schedule H (Form 990) 2021**

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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.

SCHEDULE H, PART V, SECTION B. FACILITY REPORTING GROUP A

FACILITY REPORTING GROUP A CONSISTS OF:

- FACILITY 2: SJUMC DBA ST. JOSEPH'S WAYNE MED. CTR

- FACILITY 1: ST. JOSEPH'S UNIVERSITY MEDICAL CTR

FACILITY REPORTING GROUP - A

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 AS PART OF THIS PROCESS. A

LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY ST. JOSEPH'S HEALTH; 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. IN ALL, 72 COMMUNITY

STAKEHOLDERS IN SOUTHERN PASSAIC COUNTY TOOK PART IN THE ONLINE KEY

INFORMANT SURVEY, AS OUTLINED BELOW:

PHYSICIANS 10

PUBLIC HEALTH REPRESENTATIVES 2

OTHER HEALTH PROVIDERS 20

SOCIAL SERVICES PROVIDERS 10

OTHER COMMUNITY LEADERS 30

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

FINAL PARTICIPATION INCLUDED REPRESENTATIVES OF THE ORGANIZATIONS OUTLINED

BELOW.

- ST. JOSEPH'S HEALTH
- CLIFTON HEALTH DEPARTMENT
- ACS OF PASSAIC COUNTY
- BANGLADESHI AMERICAN WOMEN'S
- DEVELOPMENT INITIATIVE
- CAREFINDERSTOTAL CARE
- CHABAD CENTER OF PASSAIC COUNTY
- CITY OF PATERSON
- CLIFTON MEDICAL CARE
- CLIFTON PUBLIC SCHOOLS
- COALITION ON AIDS IN PASSAIC COUNTY,
- COLLABORATIVE SUPPORT PROGRAMS OF NEW JERSEY
- ELMWOOD PARK SENIOR ACTIVITY CENTER OF BERGEN CO.
- FACES OF FALLEN FATHERS
- FAMILY INTERVENTION SERVICES
- FAMILY PROMISE OF BERGEN COUNTY
- HAMILTON PARTNERSHIP FOR PATERSON
- HEART AND VASCULAR MEDICAL GROUP
- HOME CARE OPTIONS
- HVA MEDICAL GROUP
- INTERNAL MEDICINE AND GERIATRIC PRACTICE
- LIGHTHOUSE PREGNANCY RESOURCE CENTER
- M&S PSYCHOTHERAPY AND COUNSELING

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

- MORE THAN FRIENDS CARES INC.

- NEW CITY KIDS: PATERSON

- NORWESCAP, INC.

- PALESTINIAN AMERICAN COMMUNITY CENTER

- PASSAIC PUBLIC SCHOOLS

- PATERSON ALLIANCE

- PATERSON COMMUNITY CLINIC

- PATERSON DIVISION OF HEALTH

- PATERSON EDUCATION FUND

- RENEW LIFE CENTER

- ST. JOSEPH'S FAMILY MEDICINE/CLIFTON

- ST. JOSEPH'S UNIVERSITY MEDICAL CENTER

- ST. PAUL'S CHURCH

- STRAIGHT AND NARROW

- TOWNSHIP OF WAYNE

- UNITED METHODIST CHURCH IN WAYNE COUNTY

- UNITED METHODIST CHURCH

- WANAQUE BOROUGH HEALTH DEPARTMENT

- WAYNE COUNSELING AND FAMILY SERVICES

- WILLIAM PATERSON UNIVERSITY

### POPULATION AND SURVEY CHARACTERISTICS:

47.9% WERE MEN; 52.1% WERE WOMEN; 41% WERE BETWEEN THE AGES OF 18 AND 39;

42.4% WERE BETWEEN THE AGES OF 40 AND 64; 16.6% WERE 65 YEARS OR OLDER;

43.5% WERE WHITE (NON-HISPANIC); 37.8% WERE HISPANIC; 10.7% WERE BLACK

(NON-HISPANIC); 8% WERE OTHER (NON-HISPANIC).



PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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.

ON OCTOBER 15, 2019, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER CONVENED A

GROUP OF 15 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). 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:

- 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.

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. DIABETES

2. NUTRITION, PHYSICAL ACTIVITY & WEIGHT

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

3. HEART DISEASE & STROKE

4. SUBSTANCE ABUSE

5. ACCESS TO HEALTHCARE

6. MENTAL HEALTH

7. TOBACCO USE

8. SEXUAL HEALTH

9. CANCER

10. HOUSING

11. INJURY & VIOLENCE

12. RESPIRATORY DISEASES

13. SEPTICEMIA

COMMUNITY STAKEHOLDERS WERE ASKED TO RATE THE DEGREE TO WHICH EACH OF 20

HEALTH ISSUES IS A PROBLEM IN THEIR OWN COMMUNITY, USING A SCALE OF "MAJOR

PROBLEM," "MODERATE PROBLEM," "MINOR PROBLEM," OR "NO PROBLEM AT ALL."

FINDINGS ALSO ARE OUTLINED THROUGHOUT THE 2019 CHNIA REPORT, ALONG WITH

THE QUALITATIVE INPUT DESCRIBING REASONS FOR THEIR CONCERNS. (NOTE THAT

THESE RATINGS ALONE DO NOT ESTABLISH PRIORITIES FOR THIS ASSESSMENT;

RATHER, THEY ARE ONE OF SEVERAL DATA INPUTS CONSIDERED FOR THE

PRIORITIZATION PROCESS DESCRIBED EARLIER.

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER WILL USE THE INFORMATION FROM THIS

COMMUNITY HEALTH NEEDS ASSESSMENT TO DEVELOP AN IMPLEMENTATION STRATEGY TO

ADDRESS THE SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY. WHILE THE HOSPITAL

WILL LIKELY NOT IMPLEMENT STRATEGIES FOR ALL OF THE HEALTH ISSUES LISTED

ABOVE, THE RESULTS OF THIS PRIORITIZATION EXERCISE WILL BE USED TO INFORM

THE DEVELOPMENT OF THE HOSPITAL'S ACTION PLAN TO GUIDE COMMUNITY HEALTH

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

IMPROVEMENT EFFORTS IN THE COMING YEARS.

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 6A: ST. JOSEPH'S WAYNE MEDICAL CENTER

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 11: THE FOLLOWING "AREAS OF OPPORTUNITY" REPRESENT

THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY, BASED ON THE INFORMATION

GATHERED THROUGH THIS COMMUNITY HEALTH NEEDS ASSESSMENT. FROM THESE DATA,

OPPORTUNITIES FOR HEALTH IMPROVEMENT EXIST IN THE AREA WITH REGARD TO THE

FOLLOWING HEALTH ISSUES:

THE AREAS OF OPPORTUNITY WERE DETERMINED AFTER CONSIDERATION OF VARIOUS

CRITERIA, INCLUDING: STANDING IN COMPARISON WITH BENCHMARK DATA

(PARTICULARLY NATIONAL DATA); IDENTIFIED TRENDS; THE PREPONDERANCE OF

SIGNIFICANT FINDINGS WITHIN TOPIC AREAS; THE MAGNITUDE OF THE ISSUE IN

TERMS OF THE NUMBER OF PERSONS AFFECTED; AND THE POTENTIAL HEALTH IMPACT

OF A GIVEN ISSUE. THESE ALSO TAKE INTO ACCOUNT THOSE ISSUES OF GREATEST

CONCERN TO THE COMMUNITY STAKEHOLDERS (KEY INFORMANTS) GIVING INPUT TO

THIS PROCESS:

- DIABETES

- NUTRITION PHYSICAL ACTIVITY AND WEIGHT

- HEART DISEASE AND STROKE

- SUBSTANCE ABUSE

- ACCESS TO HEALTHCARE

- MENTAL HEALTH

- TOBACCO USE

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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.

- SEXUAL HEALTH

- RESPIRATORY DISEASES

- SEPTICEMIA

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER CONVENED A GROUP OF 15 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). FOLLOWING THE DATA REVIEW, PRC ANSWERED ANY QUESTIONS.

FINALLY, 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?

- 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

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

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

HEALTH CONSEQUENCES).

ABILITY TO IMPACT A SECOND RATING WAS DESIGNED TO MEASURE THE PERCIEVED

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. DIABETES

2. NUTRITION, PHYSICAL ACTIVITY & WEIGHT

3. HEART DISEASE & STROKE

ST. JOSEPH'S HEALTH USED THE INFORMATION FROM THIS COMMUNITY HEALTH NEEDS

ASSESSMENT TO DEVELOP AN IMPLEMENTATION STRATEGY TO ADDRESS THE

SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY.

GOAL 1: IMPROVE THE WELLBEING OF COMMUNITY RESIDENTS THROUGH INCREASED

KNOWLEDGE ABOUT AND ACCESS TO HEALTHY FOODS AND PARTICIPATION IN PHYSICAL

ACTIVITY PROGRAMS.

A. PARTNER WITH THE PASSAIC COUNTY HEALTH COALITION AND AREA ORGANIZATIONS

TO PROMOTE HEALTH AND WELLNESS IN THE COMMUNITY RELATED TO NUTRITION,

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

### PHYSICAL AND HEALTHY WEIGHT ACTIVITIES

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

TO NUTRITION, PHYSICAL ACTIVITY AND HEALTHY WEIGHT INITIATIVES

C. CONTINUE TO OFFER NUTRITIONAL AND WELLNESS EDUCATION TO MONTHLY SUPPORT

GROUPS ACROSS SERVICE LINES, SUCH AS HEART HEALTH, STROKE AND DIABETES

SUPPORT GROUPS

D. INCREASE DIETICIAN COVERAGE TO FIVE DAYS A WEEK WITH THE EMPLOYMENT OF

ADDITIONAL DIETICIANS

GOAL 2: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE AND CARE MANAGEMENT

ACROSS THE CONTINUUM FOR HEART DISEASE AND STROKE

HEART DISEASE

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

TO HEART DISEASE PREVENTION AND RISK FACTORS THROUGH PARTNERSHIP WITH THE

AMERICAN HEART ASSOCIATION AND OTHER COMMUNITY ORGANIZATIONS

B. INCREASE AWARENESS OF LIFE-SAVING PROGRAMS IN THE COMMUNITY THROUGH

HANDS ON ONLY CPR AND AED TRAININGS

C. BECOME AN AMERICAN COLLEGE OF CARDIOLOGY PAIN ACCREDITATION CENTER

D. EXPAND CARDIAC REHAB TO BOTH HOSPITAL CAMPUSES

E. FOCUS EDUCATIONAL OUTREACH IN THE COMMUNITY BASED ON REQUESTS TO OFFER

HEART HEALTH INITIATIVES TARGETING WOMEN

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

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

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.

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

WAYNE CAMPUS/COMMUNITY

C. FOCUS ON POST-STROKE CARE THROUGH THE ADDITION OF A NURSE NAVIGATOR AND

THE OFFERING OF A WEEKLY STROKE CLINIC TO ASSIST POST-STROKE PATIENTS IN

LOWERING THEIR READMISSION RATES

D. EDUCATE THE MEDICAL COMMUNITY ON STROKE AWARENESS THROUGH OUTREACH TO

NURSING HOMES AND PRIMARY CARE PHYSICIAN OFFICES IN ORDER TO DECREASE THE

TIME FROM THE ONSET OF A STROKE TO MEDICAL TREATMENT

GOAL 3: IMPROVE HEALTH STATUS THROUGH CHRONIC DISEASE AND CARE MANAGEMENT

ACROSS THE CONTINUUM FOR DIABETES

A. 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

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

SERVICES TO THE PATERSON COMMUNITY

C. SHARE EXPERIENCES AND LEARNINGS FROM SJHS INTERNAL DIABETES AWARENESS

AND PREVENTION PROGRAM WITH COMMUNITY PARTNERS

GOAL 4: PROMOTE BEHAVIORAL HEALTH

A. CONTINUE TO OFFER BEHAVIORAL HEALTH EDUCATION AND SCREENINGS IN THE

COMMUNITY

B. INTEGRATE BEHAVIORAL HEALTH INTO THE PRIMARY CARE SETTING

C. INCREASE POPULATION SPECIFIC PROGRAMS AND SERVICES

D. COLLABORATE WITH OTHER PROVIDERS IN CROSS-CONTINUUM INITIATIVES

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 8

## 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.

PART V, SECTION B, LINE 7A & 10A:

PLEASE FIND THE CHNA AND IMPLEMENTATION STRATEGY HERE:

[HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/PDF/2019%20SJUMC%20CHNA%20SUMMARY%20](https://stjosephshealth.org/images/pdf/2019%20SJUMC%20CHNA%20SUMMARY%20REPORT.PDF)

[REPORT.PDF](https://stjosephshealth.org/images/pdf/2019%20SJUMC%20CHNA%20SUMMARY%20REPORT.PDF)

[HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/PDF/2019%20SJWMC%20CHNA%20SUMMARY](https://www.stjosephshealth.org/images/pdf/2019%20SJWMC%20CHNA%20SUMMARY%20REPORT.PDF)

[%20REPORT.PDF](https://www.stjosephshealth.org/images/pdf/2019%20SJWMC%20CHNA%20SUMMARY%20REPORT.PDF)

[HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/IMPLEMENTATION%20STRATEGY%201.PDF](https://www.stjosephshealth.org/images/implementation%20strategy%201.pdf)

[HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/IMPLEMENTATION%20STRATEGY%201.PDF](https://www.stjosephshealth.org/images/implementation%20strategy%201.pdf)

PART V, SECTION B, LINE 16A, 16B & 16C:

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

HERE:

[HTTPS://STJOSEPHSHEALTH.ORG/IMAGES/SJH\\_FINANCIAL\\_ASSISTANCE\\_POLICY.PDF](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\\_PARTICIPATION\\_CARE\\_ASS](https://stjosephshealth.org/images/application_for_participation_care_assistance.pdf)

[ISTANCE.PDF](https://stjosephshealth.org/images/application_for_participation_care_assistance.pdf)

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

[HTTPS://WWW.STJOSEPHSHEALTH.ORG/IMAGES/SJH\\_FA\\_PLAINLANGUAGE.PDF](https://www.stjosephshealth.org/images/sjh_fa_plainlanguage.pdf)



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 9

**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? 26

	Name and address	Type of Facility (describe)
1	ST. JOSEPH'S HEALTHCARE AND REHAB CEN 315 EAST LINDSLEY ROAD CEDAR GROVE, NJ 07009	LONGER CARE AND SUBACUTE SERVICES
2	HARBOR HOUSE 645 MAIN STREET PATERSON, NJ 07503	BEHAVIORAL HEALTH
3	OUTPATIENT MENTAL HEALTH CLINIC 641 MAIN STREET PATERSON, NJ 07505	BEHAVIORAL HEALTH
4	ACCESS PROGRAM 621 MAIN STREET PATERSON, NJ 07503	BEHAVIORAL HEALTH
5	CARDIOVASCULAR CENTER AT WAYNE 246 HAMBURG TURNPIKE WAYNE, NJ 07470	CARDIOLOGY
6	CARDIOVASCULAR CENTER AT WOODLAND PAR 999 MCBRIDE AVENUE, SUITE 204 WOODLAND PARK, NJ 07424	CARDIOLOGY
7	CARDIOVASCULAR CENTER AT NUTLEY 181 FRANKLIN AVENUE, SUITE 301 NUTLEY, NJ 07110	CARDIOLOGY
8	AMBULATORY IMAGING CENTER 1135 BROAD STREET CLIFTON, NJ 07013	IMAGING
9	ST. JOSEPHS UNIVERSITY IMAGING 246 HAMBURG TURNPIKE WAYNE, NJ 07470	IMAGING
10	PED. SUBSPEC. FAC. PRACT. AT CLIFTON 1135 BROAD STREET CLIFTON, NJ 07013	PEDIATRICS

Schedule H (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 9

**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? 26

Name and address	Type of Facility (describe)
11 PED. SUBSPEC. FAC. PRACT. AT HOBOKEN 158 14TH STREET HOBOKEN, NJ 07030	PEDIATRICS
12 PED. SUBSPEC. FAC. PRACT. AT PARAMUS 30 WEST CENTURY ROAD PARAMUS, NJ 07652	PEDIATRICS
13 PED. SUBSPEC. FAC. PRACT. AT WAYNE 1350 ROUTE 23 NORTH WAYNE, NJ 07470	PEDIATRICS
14 DEPAUL AMBULATORY CENTER 11 GETTY AVENUE #275 PATERSON, NJ 07503	PRIMARY CARE
15 FAMILY HEALTH CENTER 11 GETTY AVENUE PATERSON, NJ 07501	PRIMARY CARE
16 ST. JOSEPHS FAMILY MED. AT CLIFTON 1135 BROAD STREET, SUITE 201 CLIFTON, NJ 07013	PRIMARY CARE
17 SURGERY SUBSPECIALTY FACULTY PRACTICE 1135 BROAD STREET CLIFTON, NJ 07013	SURGERY
18 SURGERY SUBSPECIALTY FACULTY PRACTICE 57 WILLOWBROOK BOULEVARD WAYNE, NJ 07470	SURGERY
19 OB/GYN SUBSPECIALTY FACULTY PRACTICE 11 GETTY AVENUE PATERSON, NJ 07503	WOMENS HEALTH
20 OB/GYN SUBSPECIALTY FACULTY PRACTICE 525 UNION BOULEVARD TOTOWA, NJ 07512	WOMENS HEALTH

Schedule H (Form 990) 2021



PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990) 2021

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information

Provide the following information.

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

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:

ST. JOSEPH'S HEALTH HAS PARTNERED WITH LOCAL DEVELOPERS AND COMMUNITY

INVESTMENT GROUPS DEVELOPING A STRONG BOND BETWEEN COMMUNITY INVESTMENT

ACTIVITIES AND HEALTHCARE TO ADDRESS NEIGHBORHOOD AND ENVIRONMENTAL

132100 11-22-21

Schedule H (Form 990) 2021

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

CONDITIONS THAT WOULD IMPROVE ACCESS TO NEEDED HEALTHCARE SERVICES, REDUCE

INEQUITIES IN HEALTH OUTCOMES, AND CONTINUE OUR MISSION OF ENSURING THAT

THE CITY'S MOST VULNERABLE RESIDENTS HAVE ACCESS TO SAFE AFFORDABLE

NEIGHBORHOODS AND HEALTHCARE. ADDITIONALLY, ST. JOSEPH'S HEALTH HAS WORKED

COLLABORATIVELY WITH LOCAL SOCIAL SERVICES AGENCIES AND COMMUNITY

STAKEHOLDERS, SUCH AS THE HEALTH COALITION OF PASSAIC COUNTY, NEW JERSEY

COMMUNITY DEVELOPMENT CORPORATION, THE CITY OF PATERSON, PASSAIC COUNTY

HEALTH DEPARTMENT, THE BOYS AND GIRLS CLUB OF PASSAIC COUNTY, THE PATERSON

HOUSING AUTHORITY, AND THE NEW JERSEY FAMILY SUCCESS CENTER TO ADDRESS

THOSE SOCIAL DETERMINANTS OF AN INDIVIDUAL'S HEALTH, SUCH AS THE ABILITY

TO ACCESS NEEDED HEALTHCARE, HOMELESSNESS, LACK OF AFFORDABLE CHILDCARE,

POVERTY, UNEMPLOYMENT, AND LIMITED PUBLIC TRANSPORTATION.

ST. JOSEPH'S HEALTH ENTERED INTO A PARTNERSHIP WITH THE NEW JERSEY HOUSING

AND MORTGAGE FINANCING AGENCY (HMFA) TO LEVERAGE THE HOSPITAL'S EQUITY IN

CONCERT WITH THE 4% LOW INCOME HOUSING CREDIT PROGRAM TO DEVELOP A 56 UNIT

AFFORDABLE HOUSING DEVELOPMENT ADJACENT TO THE HOSPITAL CAMPUS WITH A

SUPPORTIVE HOUSING SET-ASIDE OF 10-UNITS TARGETED TOWARD TENANTS WHO MEET

NEW JERSEYS CRITERIA FOR SUPPORTIVE HOUSING AND WHO ARE ALSO FREQUENT

UTILIZERS OF HOSPITAL SERVICES, PARTICULARLY THE EMERGENCY ROOM.

PART III, LINE 2:

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

INCREASED FROM 65% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2020 TO

73% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2021.

Schedule H (Form 990)

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

THE SYSTEM CALCULATED THE BAD DEBT ASSOCIATED WITH SELF PAY CASES WAS \$56,153,910. BASED ON HISTORICAL REVIEW OF THIS CATEGORY, APPROXIMATELY 62% OF THESE CASES WERE ELIGIBLE FOR CHARITY CARE OR OTHER FINANCIAL ASSISTANCE. THE 62% FACTOR WAS THEN APPLIED TO THE TOTAL SELF-PAY ACCOUNTS PLUS \$453,651 OF BAD DEBTS RELATED TO CHARITY CARE PATIENTS TO DERIVE THE \$35,555,087 OF BAD DEBT ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE.

PART III, LINE 4:

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 CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

THE MEDICAL CENTER'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

INCREASED FROM 65% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2020 TO

73% OF SELF-PAY ACCOUNTS RECEIVABLE AT DECEMBER 31, 2021. IN ADDITION, THE

MEDICAL CENTER'S SELF-PAY WRITE-OFFS NET OF RECOVERIES DECREASED FROM

\$54.9 MILLION FOR 2020 TO \$\*\*\* MILLION FOR 2021. THE MEDICAL CENTER HAS

NOT CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL

YEARS 2020 OR 2021.

PART III, LINE 8:

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 SERVICES,

SUB-SPECIALITY CARE AND INPATIENT AND LONG TERM CARE SERVICES.

PART III, LINE 9B:

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.

ALL OF OUR SELF-PAY PATIENTS ARE TREATED WITH THE SAME PROCESS. WE FIRST

SCREEN PATIENTS FOR MEDICAID/CHARITY CARE, IF THEY AGREE TO THE PROCESS.

IF THEY DO NOT QUALIFY FOR EITHER, OR WISH TO NOT APPLY, WE THEN OFFER

THEM THE FAP. NEXT, WE FOLLOW THE NORMAL SELF-PAY COLLECTION PRACTICES FOR

Schedule H (Form 990)

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

THE REMAINING AMOUNTS. EVERY 30 DAYS A STATEMENT FOR THE REMAINING BALANCE

OWED WILL BE SENT TO THE GUARANTOR. IF AFTER, 120 DAYS, THERE IS NO

RESPONSE/PAYMENT, THE ACCOUNT WILL BE REFERRED TO BAD DEBT.

PART VI, LINE 2:

NEEDS ASSESSMENT:

ON OCTOBER 15, 2019, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER CONVENED A

GROUP OF 15 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). 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:

- 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.

INDIVIDUALS' RATINGS FOR EACH CRITERIA WERE AVERAGED FOR EACH TESTED

Schedule H (Form 990)



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

## Part VI Supplemental Information (Continuation)

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. DIABETES

2. NUTRITION, PHYSICAL ACTIVITY & WEIGHT

3. HEART DISEASE & STROKE

4. SUBSTANCE ABUSE

5. ACCESS TO HEALTHCARE

6. MENTAL HEALTH

7. TOBACCO USE

8. SEXUAL HEALTH

9. CANCER

10. HOUSING

11. INJURY & VIOLENCE

12. RESPIRATORY DISEASES

13. SEPTICEMIA

COMMUNITY STAKEHOLDERS WERE ASKED TO RATE THE DEGREE TO WHICH EACH OF 20

HEALTH ISSUES IS A PROBLEM IN THEIR OWN COMMUNITY, USING A SCALE OF "MAJOR

PROBLEM," "MODERATE PROBLEM," "MINOR PROBLEM," OR "NO PROBLEM AT ALL."

FINDINGS ALSO ARE OUTLINED THROUGHOUT THE 2019 CHNIA REPORT, ALONG WITH

THE QUALITATIVE INPUT DESCRIBING REASONS FOR THEIR CONCERNS. (NOTE THAT

THESE RATINGS ALONE DO NOT ESTABLISH PRIORITIES FOR THIS ASSESSMENT;

RATHER, THEY ARE ONE OF SEVERAL DATA INPUTS CONSIDERED FOR THE

PRIORITIZATION PROCESS DESCRIBED EARLIER.

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER WILL USE THE INFORMATION FROM THIS

COMMUNITY HEALTH NEEDS ASSESSMENT TO DEVELOP AN IMPLEMENTATION STRATEGY TO

Schedule H (Form 990)

132271 04-01-21

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

## Part VI Supplemental Information (Continuation)

ADDRESS THE SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY. WHILE THE HOSPITAL

WILL LIKELY NOT IMPLEMENT STRATEGIES FOR ALL OF THE HEALTH ISSUES LISTED

ABOVE, THE RESULTS OF THIS PRIORITIZATION EXERCISE WILL BE USED TO INFORM

THE DEVELOPMENT OF THE HOSPITAL'S ACTION PLAN TO GUIDE COMMUNITY HEALTH

IMPROVEMENT EFFORTS IN THE COMING YEARS.

THE ORGANIZATION BELIEVES ITS CHNA PROCESS TO BE COMPREHENSIVE, THEREFORE

ADDITIONAL ASSESSMENTS ARE NOT CONDUCTED.

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.

PART VI, LINE 4:

COMMUNITY INFORMATION:

COMPARISON AND GENERAL COMMUNITY DESCRIPTION: SOUTHERN PASSAIC COUNTY, NEW

JERSEY INCLUDES THE FOLLOWING RESIDENTIAL ZIP CODES: 07011, 07012, 07013,

07014, 07055, 07407, 07410, 07424, 07470, 07501, 07502, 07503, 07504,

07505, 07506, 07508, 07512, 07513, 07514, 07522, AND 07524. THIS COMMUNITY

DEFINITION REPRESENTS THE PRIMARY AND SECONDARY SERVICE AREAS OF ST.

JOSEPH'S UNIVERSITY MEDICAL CENTER AND INCLUDES RESIDENTIAL ZIP CODES.

ST. JOSEPH'S HEALTH (SJH) IS A NONPROFIT, INDEPENDENT HEALTHCARE SYSTEM

SPONSORED BY THE SISTERS OF CHARITY OF SAINT ELIZABETH. ST. JOSEPH'S

UNIVERSITY MEDICAL CENTER LOCATED IN PATERSON AND OUR SISTER HOSPITAL ST.

Schedule H (Form 990)

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

## Part VI Supplemental Information (Continuation)

JOSEPH'S WAYNE MEDICAL CENTER, 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.

PATERSON, IS NJ'S THIRD LARGEST CITY, WITH NEARLY 159,732 RESIDENTS. THE

MEDIAN HOUSEHOLD INCOME IS \$41,360. THE POPULATION PRIMARILY CONSISTS OF

PEOPLE OF COLOR AND ETHNIC MINORITIES: 61% OF RESIDENTS ARE

HISPANIC/LATINO, AND 26% ARE BLACK/AFRICAN AMERICAN. ALTHOUGH DIFFICULT TO

QUANTIFY USING CENSUS DATA, THERE ARE ALSO SIZEABLE COMMUNITIES OF MIDDLE

EASTERN AND SOUTHEAST ASIAN DESCENT. GIVEN THE NUMBER OF IMMIGRANT

POPULATIONS HERE, LINGUISTIC ISOLATION IS A CHALLENGE; THERE ARE MORE THAN

20 DIFFERENT LANGUAGES SPOKEN, INCLUDING THE SOUTHEAST ASIAN LANGUAGES AND

NUMEROUS DIALECTICS OF HISPANIC AND ASIAN POPULATIONS. MANY RESIDENTS ARE

ENGLISH LANGUAGE LEARNERS, WITH SPANISH AND INCREASINGLY ARABIC AS THE

MOST COMMON PRIMARY LANGUAGES SPOKEN. IMMIGRANTS IN OUR COMMUNITY OFTEN

DEPRIORITIZE HEALTHCARE NEEDS, DUE TO CONCERNS AROUND THEIR IMMIGRATION

STATUS, AFFORDABILITY, AND ACCESS; IN MANY CASES, IMMIGRANTS DO NOT ACCESS

PREVENTIVE CARE AND ONLY PRESENT TO SJUMC ONCE A MEDICAL EMERGENCY ARISES.

DESPITE PATERSON'S SIZE AND DIVERSITY OF ITS RESIDENTS, IT HAS ONE OF THE

LOWEST PER CAPITA INCOME LEVELS IN THE STATE, AND AN UNEMPLOYMENT RATE OF

AT LEAST 8%. TWENTY-SEVEN PERCENT (27%) OF THE AREA'S POPULATION LIVES IN

Schedule H (Form 990)

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

POVERTY (THREE TIMES THE STATE AVERAGE), INCLUDING 40% OF CHILDREN UNDER

AGE 18. THE POVERTY RATE IS REFLECTED BY THE NEARLY 40% OF RESIDENTS WHO

RECEIVE BENEFITS FROM THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

(SNAP). PATERSON RESIDENTS ALSO STRUGGLE TO SECURE HEALTH INSURANCE:

ESTIMATES INDICATE UP TO 20% OF RESIDENTS UNDER THE AGE OF 65 ARE

UNINSURED (U.S. CENSUS BUREAU).

REFLECTING OUR COMMUNITY DEMOGRAPHICS, NEARLY 80% OF SJUMC/SJWMC PATIENTS

ARE COVERED BY MEDICAID OR CHARITY CARE (INDIGENT PATIENTS) OR MEDICARE

(OLDER OR DISABLED PATIENTS).

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, DIVERSITY AND INCLUSION COMMITTEE OF THE PASSAIC COUNTY VICINAGE,

PATERSON TASKFORCE FOR SOCIAL ACTION AND BOTH THE PATERSON AND WAYNE

YMCAS. ACTIVITIES INCLUDE BUT ARE NOT LIMITED TO:

KINGS DAY - CEDAR GROVE

PEDESTRIAN SAFETY EVENT

NALOXONE TRAINING AND DISTRIBUTION

STOP THE BLEED CLASS

MLK

STOP THE BLEED INSTRUCTOR COURSE

TRAUMATIC BRAIN INJURIES

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

## Part VI Supplemental Information (Continuation)

HEALTH FAIR-WAFA

HEADS UP SENIORS

FIRST AID TRAINING

A WOMEN'S HEALTH SYMPOSIUM-

NURSING PRACTICE COUNCIL PRESENTATION

NALOXONE TRAINING AND KIT DISRIBUTION

HEART HEALTHY FAIR

HEALTHY LIFESTYLES

HEART HEALTH AWARENESS FOR WOMEN

HEART AWARENESS

SMOKING & DANGERS OF E-CIGS & VAPING

WOMEN'S HEART HEALTH AWARENESS

SCHOOL 12- K-2- READ ACROSS AMERICA/DR. SEUSS WK

STOP THE BLEED CLASS

HEADS UP SENIOR

PCCC WELLNESS DAY

PCCC HEALTH FAIR

SGU ORIENTATION

WOMEN'S HEART HEALTH LUNCH & LEARN AT SAX LLP

COVID-19- PCCC-MOCSI VIRTUAL PRESENTATION

PRAYER FOR SOLIDARITY & PEACE

PUBERTY & EMOTIONAL CHANGES

DEBRIEFING- COVID-10 ANXIETY

DEBRIEFING - PATERSON HOUSING AUTHORITY

DEBRIEFING POST COVID-19- PATERSON HOUSING AUTHORITY

STROKE PREVENTION & MANAGEMENT

COMMUNITY STROKE

BP HEALTH & WELLNESS

Schedule H (Form 990)

132271 04-01-21

101

16421115 150123 27-1344467

2021.05000 ST JOSEPH'S HEALTH SYSTEM 27-13441

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

**Part VI** Supplemental Information (Continuation)

WEBINAR RECORDING ENGLISH/SPANIISH

HISPANIC AFFINITY GROUP

HISPANIC AFFINITY GROUP- FOOD TASTING CAFETERIA

PRE-DIABETES PROGRAM WITH RAMAPO COLLEGE NURSING STUDENTS

PRE-DIABETES NDPP

HISPANIC AFFINITY GROUP- FOOD TASTING CAFETERIA

ST. JOSEPH'S HEALTH SUSTAINABLE MEAL COMMUNITY PROJECT

BLM'S FOOD OUTREACH PROGRAM: EVERYBODY EATS

DPP- LIFESTYLE CHANGE

PRE-DIABETES NDPP

HISPANIC AFFINITY GROUP- FOOD TASTING CAFETERIA

BREAST CANCER AWARENESS

BLM'S FOOD OUTREACH PROGRAM: EVERYBODY EATS

PRE-DIABETES NDPP

HISPANIC AFFINITY GROUP- FOOD TASTING CAFETERIA

BLM'S FOOD OUTREACH PROGRAM: EVERYBODY EATS

BLM PATERSON & ST. JOE'S FOOD DRIVE

PRE-DIABETES NDPP

INFECTION PREVENTION AWARENESS

COMMUNITY FLU VACCINATION

AWARENESS DAY - COLUMBIA BANCK

RAIN DATE - FLU FEST

BREAST CANCER AWARENESS

BLM'S FOOD OUTREACH PROGRAM: EVERYBODY EATS

PRE-DIABETES NDPP

VIRTUAL PINK POWER TEA- BREAST CANCER AWARENESS

PRE-DIABETES NDPP

VETERAN'S DAY-VIRTUAL

Schedule H (Form 990)

132271 04-01-21

102

16421115 150123 27-1344467

2021.05000 ST JOSEPH'S HEALTH SYSTEM 27-13441

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

**Part VI** Supplemental Information (Continuation)

PRE-DIABETES NDPP

PROSPECT PARK FAIR

PRE-DIABETES NDPP

BRAIN INJURY SUPPORT

PCCC WELLNESS DAY

BOYS & GIRLS CLUB- WOODLAND PARK

SPRING HEALTH FAIR-MOBILE COMMUNITY HEALTH & BHATT FOUNDATION

BAE LUNCH AND LEARN

HEALTHY KIDS DAY-WAYNE

A FAMILY WELLNESS EVENT (HISTORIC CALVARY BAPTIST CHURCH)

HEALTHY KIDS DAY-PATERSON

7TH ANNUAL EMPLOYEE HEALTH FAIR

SAX- HEART DISEASE AMONG WOMEN

BAE WELLNESS WEEK

CONTINUING EDUCATION-WPU

STROKE PRESENTATION WAYNE

STROKE PRESENTATION PATERSON

6TH ANNUAL CAREER DAY

SCHOOL 13 CAREER DAY

SCHOOL 10 CAREER DAY

AUDIENCE: STUDENTS GRADES 3 THROUGH 8

DANGERS OF THE SUN & SKIN CARE

WAYNE DAY

SISTERS ST. ELIZABETH BAD PROM 5K

HEALTH FAIR

Schedule H (Form 990)

132271 04-01-21

103

16421115 150123 27-1344467

2021.05000 ST JOSEPH'S HEALTH SYSTEM 27-13441

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

AFRICAN-AMERICAN PARADE-PASSAIC - AFRICAN-AMERICAN AFFINITY GROUP

AFRICAN-AMERICAN PARADE PATERSON - AFRICAN-AMERICAN AFFINITY GROUP

WORKSHOPS NJCDC

MEDICATION ADMINISTRATION WORKSHOP

ASTHMA YOUNG CHILDREN

DIABETES YOUNG CHILDREN

HOME SAFETY PREVENTION

HOW TO STOP SMOKING & DANGERS OF E-CIGS & VAPING

HEALTH N WELLNESS SERVICES, LLC; FSCS HEALTH CENTERS, PATERSON/

PATERSON.K12PATERSON SCHOOLS K12

WOMEN MINISTRY AT MY CHURCH CHRIST TEMPLE BAPTIST CHURCH AND OTHERS

ZAC CAMP

WELLNESS HEALTH FAIR - JUDICIARY PASSAIC VICINAGE

WAYNE TOWNSHIP'S 42ND ANNUAL HEALTH FAIR

BAE LUNCH AND LEARN

PART VI, LINE 6:

AFFILIATED HEALTH CARE:

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), 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

Schedule H (Form 990)



PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

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

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.) PROVIDE

PROPERTY-MANAGEMENT SERVICES FOR NONHOSPITAL-RELATED REAL ESTATE HOLDINGS.

-ST. JOSEPH'S HEALTHCARE PHYSICIAN HEALTHCARE GROUP, 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

HARBORVIEW

THE MEDICAL CENTER IS ALSO THE MAJORITY MEMBER OF THE FOLLOWING

CONSOLIDATED SUBSIDIARY: ST. JOSEPH'S SURGERY MANAGEMENT, LLC (SURGERY

MANAGEMENT). SURGERY MANAGEMENT IS A LIMITED LIABILITY CORPORATION

Schedule H (Form 990)

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule H (Form 990)

GROUP RETURN

27-1344467

Page 10

Part VI Supplemental Information (Continuation)

ESTABLISHED TO MANAGE THE SURGICAL SERVICES AT THE UNIVERSITY MEDICAL CENTER.

THE FOUNDATION IS A PUBLIC CHARITY 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 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.

VHSNJ AT HOME, LLC IS A JOINT VENTURE BETWEEN A SUBSIDIARY OF THE SYSTEM, ST. JOSEPH'S HOME HEALTH, LLC, AND HACKENSACK MERIDIAN HOME CARE SERVICES, INC. THE SYSTEM HOLDS 50% OWNERSHIP INTEREST IN THE VHSNJ AT HOME, LLC JOINT VENTURE.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

NJ

# PUBLIC INSPECTION COPY

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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

### 2021

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 noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. - 703 MAIN STREET - PATERSON, NJ 07503	22-1487602	501(C)(3)	3,665,314.	0.			GENERAL SUPPORT

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule I (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule I (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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 noncash assistance
SCHOLARSHIPS	10	10,000.	0.		

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

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)**

**Compensation Information**

OMB No. 1545-0047

**2021**

Open to Public Inspection

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees  
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.  
 ▶ Attach to Form 990.  
 ▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

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

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

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

**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? .....

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

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

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

- a** Receive a severance payment or change-of-control payment? .....
- b** Participate in or receive payment from a supplemental nonqualified retirement plan? .....
- c** Participate in or receive payment from an equity-based compensation arrangement? .....
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

**Only 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? .....
- b** Any related organization? .....
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization? .....
- b** Any related organization? .....
- If "Yes" on line 6a or 6b, describe in Part III.

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

**8** Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III .....

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

	Yes	No
<b>1b</b>		
<b>2</b>		
<b>4a</b>	X	
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>	X	
<b>8</b>	X	
<b>9</b>	X	

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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	(i)	(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC 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) MARK W. CONNOLLY, MD CHAIRMAN, DEPT. OF SURGERY	(i)	1,825,889.	650,000.	32,769.	3,859.	27,311.	2,539,828.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KEVIN J. SLAVIN PRESIDENT & CHIEF EXECUTIVE OFFICER	(i)	1,092,991.	586,976.	414,174.	3,943.	3,038.	2,101,122.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DENNIS ROEMER SR. VP, CFO THRU 11/20	(i)	135,076.	199,360.	788,207.	3,899.	117.	1,126,659.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JOHN M. DANKS, MD MEDICAL DOCTOR	(i)	1,076,889.	0.	21,092.	3,221.	10,468.	1,111,670.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) LISA SCHMITTGALL EXEC VP, CHIEF ADMIN. OFFICER	(i)	611,035.	281,973.	164,962.	3,238.	10,828.	1,072,036.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) ALDO D. KHOURY, MD MEDICAL DOCTOR	(i)	975,634.	0.	11,357.	3,883.	30,051.	1,020,925.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) MATTHEW A. GROSSMAN MEDICAL DOCTOR	(i)	941,120.	50,000.	1,140.	0.	27,737.	1,019,997.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) SILVIO PODDA, MD MEDICAL DOCTOR	(i)	919,756.	25,000.	7,524.	0.	26,972.	979,252.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) TODD C. BROWER SENIOR VP, GENERAL COUNSEL	(i)	519,107.	167,831.	136,131.	7,579.	20,584.	851,232.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JENNIFER MENDRZYCKI SR. VP, SITE EXEC AND OUTPATIENT SER	(i)	460,172.	145,724.	108,584.	4,211.	30,322.	749,013.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JOSEPH DUFFY, MD SR. VP, CMO	(i)	497,756.	151,283.	86,274.	3,124.	1,641.	740,078.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) CASWELL SAMMS SR. VP, CHIEF FINANCIAL OFFICER	(i)	566,001.	14,372.	104,453.	0.	27,345.	712,171.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ROBERTO SOLIS, MD TRUSTEE	(i)	637,659.	0.	24,525.	402.	0.	662,586.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) LINDA A. REED VP, CHIEF INFORMATION OFFICER	(i)	386,821.	123,574.	85,305.	7,579.	21,414.	624,693.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) MICHAEL LAMACCHIA, MD TRUSTEE	(i)	431,518.	95,500.	27,968.	0.	27,485.	582,471.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) PIA HOUSE WALKER VP, CHIEF HUMAN RESOURCES OFFICER	(i)	352,113.	107,868.	54,334.	0.	28,532.	542,847.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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	(i)	(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC 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				
(17) ROBERT C. HOOD FMR. SR. VP, POP. HEALTH	(i)	149,732.	118,645.	244,585.	8,982.	12,364.	534,308.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) MICHAEL DELISI, MD TRUSTEE/CO-CHAIR	(i)	410,779.	50,000.	27,115.	0.	19,757.	507,651.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(19) JUDITH PADULA VP, CHIEF NURSING OFFICER THRU 12/21	(i)	330,754.	101,004.	56,683.	3,826.	11,978.	504,245.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) MICHAEL ALWELL VICE PRESIDENT, REVENUE CYCLE	(i)	308,441.	92,085.	68,912.	0.	28,756.	498,194.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(21) NILESH PATEL, MD TRUSTEE	(i)	445,000.	0.	1,616.	0.	22,190.	468,806.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(22) JAMES HAYNES VP, FACILITIES OPERATIONS THRU 10/21	(i)	258,749.	74,631.	106,260.	4,699.	23,602.	467,941.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(23) JONATHAN BARKHORN FMR. VP, PHYS. SVCS. THRU 10/20	(i)	0.	0.	450,000.	0.	0.	450,000.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(24) MARJORY LANGER, MD TRUSTEE THRU 6/21	(i)	401,507.	0.	997.	0.	29,705.	432,209.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(25) KENNETH M. MORRIS, JR. VP, EXTERNAL AFFAIRS	(i)	277,703.	79,272.	43,652.	3,444.	19,867.	423,938.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(26) JAMES LABAGNARA JR., MD VP, MED. AFFAIRS THRU 12/21	(i)	247,245.	125,569.	3,079.	8,748.	1,710.	386,351.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(27) ROBERT BUDELMAN, III TRUSTEE & VP CDO	(i)	246,368.	75,115.	35,198.	0.	26,844.	383,525.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(28) SISTER PATRICIA MENNOR VP, MISSION	(i)	252,698.	76,095.	40,920.	3,781.	9,887.	383,381.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(29) PADMAJA UPADYA, MD VP, CHIEF MEDICAL OFFICER, SJWMC	(i)	246,805.	78,930.	56,492.	0.	940.	383,167.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(30) THOMAS CASEY VP, MARKETING AND PUBLIC RELATIONS	(i)	236,393.	71,642.	51,636.	0.	1,778.	361,449.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(31) SWATI PAREKH TRUSTEE	(i)	287,619.	0.	21,765.	0.	2,911.	312,295.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(32) MOIRA CONNOLLY, ESQ. VP, CHIEF COMP. OFF. THRU 9/21	(i)	195,137.	71,854.	31,427.	2,887.	415.	301,720.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

Schedule J (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**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	(i)	(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC 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				
(33) MICHAEL AGNELLI, MD TRUSTEE	(i)	296,479.	0.	348.	0.	3,952.	300,779.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(34) JANE WHITE VP ONCOLOGY	(i)	223,967.	14,933.	17,484.	30,254.	10,715.	297,353.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(35) GENNARO RUBINO, MD TRUSTEE	(i)	221,421.	40,000.	14,161.	0.	17,273.	292,855.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(36) MICHAEL CAIROLI VP, WAYNE SITE ADMIN.	(i)	191,380.	35,631.	15,094.	1,450.	27,107.	270,662.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(37) CHRISTOPHER TROTZ, MD VP, PHYSICIAN SERVICES	(i)	210,325.	14,933.	31,126.	0.	10,715.	267,099.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(38) JOHN P. BRUNO FORMER VP, HUMAN RESOURCES	(i)	0.	0.	217,474.	3,236.	0.	220,710.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(39) SAMI ABDULMASSIH, MD TRUSTEE	(i)	217,131.	0.	468.	0.	3,074.	220,673.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(40) ANTHONY LOSARDO, MD TRUSTEE	(i)	171,265.	0.	0.	0.	0.	171,265.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							



PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

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.

PART I, LINES 4A-B:

SEVERANCE PAYMENTS WERE MADE IN 2021 TO THE FOLLOWING INDIVIDUALS:

JONATHAN BARKHORN - \$444,808

JOHN BRUNO - \$217,474

JAMES HAYNES - \$60,005

ROBERT HOOD - \$213,334

DENNIS ROEMER - \$787,855

PART I, LINE 4B:

PARTICIPANTS WHO ARE EMPLOYED THROUGHOUT A PLAN YEAR SHALL BE ELIGIBLE FOR

THE PLAN CONTRIBUTIONS FOR SUCH PLAN YEAR. PARTICIPANTS WHO ARE HIRED AFTER

THE START OF A PLAN YEAR OR WHO BECOME ELIGIBLE FOR PARTICIPATION DURING

THE COURSE OF A PLAN YEAR DUE TO PROMOTION SHALL BE ELIGIBLE TO RECEIVE A

PRO-RATED SERP CONTRIBUTION. IN 2021, CERTAIN EXECUTIVES PARTICPATED IN THE

457F (SERP) PROGRAM. THE FOLLOWING CONTRIBUTIONS WERE MADE IN 2021:

LINDA A. REED - \$58,764

CASWELL SAMMS - \$ 101,250

JENNIFER MENDRZYCKI - \$86,096

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

## 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.

THOMAS CASEY - \$ 34,536

KENNETH M. MORRIS - \$39,000

KEVIN J. SLAVIN - \$371,833

JOSEPH DUFFY, MD - \$78,750

SISTER PATRICIA MENNOR - \$ 34,707

MICHAEL CAIROLI - \$14,428

TODD C. BROWER - \$95,685

ROBERT BUDLEMAN, III - \$34,260

JUDITH PADULA - \$46,068

MOIRA CONNOLLY, ESQ. - \$16,386

MICHAEL ALWELL - \$45,000

CHRISTOPHER TROTZ, MD - \$30,254

JAMES HAYNE - \$17,020

PIA HOUSE WALKER - \$51,295

PADMAJA UPADYA, MD - \$36,000

LISA SCHMITTGALL - \$138,991

JANE WHITE - \$16,612

IN ADDITION, THE FOLLOWING DISTRIBUTIONS WERE MADE IN 2021:

Schedule J (Form 990) 2021

PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

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.

JAMES HAYNES - \$18,358

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 PARTICIPANTS SHALL BE THOSE INCUMBENTS IN MANAGEMENT POSITIONS IN WHICH DECISION AND ACTIONS IMPACT THE OPERATIONS OF ST. JOSEPH'S HEALTHCARE SYSTEM AND/OR ITS 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.

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule J (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

**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.

PART I, LINE 8:

DURING 2021, 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).

# PUBLIC INSPECTION COPY

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

OMB No. 1545-0047

**2021**  
**Open to Public Inspection**

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

<b>Part I Bond Issues</b>											
(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
<b>A</b> NJ HEALTH CARE FACILITIES FINANCING AUTHORITY	22-2845542	645790CB0	08/24/16	274,348,264.	SEE SCHEDULE K, PART VI		X		X		X
<b>B</b> THE PASSAIC COUNTY IMPROVEMENT AUTHORITY	05-0569671	702754CY6	12/29/17	26,760,514.	SEE SCHEDULE K, PART VI		X		X		X
<b>C</b>											
<b>D</b>											

<b>Part II Proceeds</b>										
Line	A		B		C		D			
	Yes	No	Yes	No	Yes	No	Yes	No		
<b>1</b> Amount of bonds retired	20,705,000.		2,850,000.							
<b>2</b> Amount of bonds legally defeased										
<b>3</b> Total proceeds of issue	274,352,050.		26,855,039.							
<b>4</b> Gross proceeds in reserve funds										
<b>5</b> Capitalized interest from proceeds										
<b>6</b> Proceeds in refunding escrows										
<b>7</b> Issuance costs from proceeds	2,842,983.		504,287.							
<b>8</b> Credit enhancement from proceeds										
<b>9</b> Working capital expenditures from proceeds										
<b>10</b> Capital expenditures from proceeds	50,003,786.									
<b>11</b> Other spent proceeds	221,505,281.		26,350,752.							
<b>12</b> Other unspent proceeds										
<b>13</b> Year of substantial completion	2017		2017							
<b>14</b> 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						
<b>15</b> 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							
<b>16</b> Has the final allocation of proceeds been made?		X		X						
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X							

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule K (Form 990) 2021

GROUP RETURN

27-1344467

Page 2

**Part III Private Business Use**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? .....		X		X				
<b>2</b> Are there any lease arrangements that may result in private business use of bond-financed property? .....		X	X					
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? .....		X	X					
<b>b</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					
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? .....		X		X				
<b>d</b> 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? ...								
<b>4</b> 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 .....		%		%		%		%
<b>5</b> 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 .....		%		%		%		%
<b>6</b> Total of lines 4 and 5 .....		%		%		%		%
<b>7</b> Does the bond issue meet the private security or payment test? .....		X		X				
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of .....		%		%		%		%
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? .....								
<b>9</b> 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
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? .....		X		X				
<b>2</b> If "No" to line 1, did the following apply?								
<b>a</b> Rebate not due yet? .....		X	X					
<b>b</b> Exception to rebate? .....		X		X				
<b>c</b> No rebate due? .....	X			X				
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed .....								
<b>3</b> Is the bond issue a variable rate issue? .....		X		X				

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule K (Form 990) 2021

GROUP RETURN

27-1344467

Page 3

**Part IV Arbitrage** *(continued)*

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

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:

(A) ISSUER NAME: NJ HEALTH CARE FACILITIES FINANCING AUTHORITY

DATE THE REBATE COMPUTATION WAS PERFORMED: 10/08/2021

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)**

**Transactions With Interested Persons**

OMB No. 1545-0047

**2021**

**Open To Public Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **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](http://www.irs.gov/Form990) for instructions and the latest information.**

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 section 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

2 Enter the amount of tax incurred by 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?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
DR. LABAGNARA	SEE PT V	SEE PT V		X	393,932.	268,794.		X		X	X	
<b>Total</b> .....						▶ \$	268,794.					

**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

SEE PART V FOR CONTINUATIONS



# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

GROUP RETURN

Schedule L (Form 990) 2021

27-1344467

Page 2

**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

**Part V Supplemental Information.**

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

SCHEDULE L, PART II, LOANS TO AND FROM INTERESTED PERSONS:

(A) NAME OF PERSON: DR. LABAGNARA

(B) RELATIONSHIP WITH ORGANIZATION: VP, MEDICAL AFFAIRS

(C) PURPOSE OF LOAN: PHYS. RECRUITMENT

# PUBLIC INSPECTION COPY

**SCHEDULE M  
(Form 990)**

## Noncash Contributions

OMB No. 1545-0047

# 2021

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

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

**Part I** **Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art .....				
2 Art - Historical treasures .....				
3 Art - Fractional interests .....				
4 Books and publications .....				
5 Clothing and household goods .....				
6 Cars and other vehicles .....				
7 Boats and planes .....				
8 Intellectual property .....				
9 Securities - Publicly traded .....				
10 Securities - Closely held stock .....				
11 Securities - Partnership, LLC, or trust interests .....				
12 Securities - Miscellaneous .....				
13 Qualified conservation contribution - Historic structures .....				
14 Qualified conservation contribution - Other ...				
15 Real estate - Residential .....				
16 Real estate - Commercial .....				
17 Real estate - Other .....				
18 Collectibles .....				
19 Food inventory .....				
20 Drugs and medical supplies .....				
21 Taxidermy .....				
22 Historical artifacts .....				
23 Scientific specimens .....				
24 Archeological artifacts .....				
25 Other ▶ ( PPE )	X	2	21,748. FMV	
26 Other ▶ ( MED SUPPLIES )	X	3	12,212. FMV	
27 Other ▶ ( )				
28 Other ▶ ( )				

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

- 30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? .....
- b If "Yes," describe the arrangement in Part II.
- 31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? .....
- 32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? .....
- b If "Yes," describe in Part II.
- 33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.

	Yes	No
30a		X
31	X	
32a		X

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule M (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule M (Form 990) 2021 GROUP RETURN

27-1344467

Page 2

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

SCHEDULE M, PART I, COLUMN (B):

THE AMOUNT REPORTED IN COLUMN (B) REPRESENTS THE NUMBER OF  
CONTRIBUTORS.

PUBLIC INSPECTION COPY

SCHEDULE O  
(Form 990)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE  
GROUP RETURN  
Employer identification number 27-1344467

FORM 990, PART III, LINE 4A:

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (SJUMC) PROVIDES COMPREHENSIVE

ACUTE CARE SERVICES IN PATERSON, NEW JERSEY, ST. JOSEPH'S UNIVERSITY

MEDICAL CENTER D/B/A ST. JOSEPH'S WAYNE MEDICAL CENTER (SJWMC) IN

WAYNE, NEW JERSEY, SKILLED 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, NEW JERSEY 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 REGIONAL CARDIAC SURGERY CENTER, AND A REGIONAL

PERINATAL CENTER WITH APPROXIMATELY 5,404 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 OFFERS A FULL

COMPLEMENT OF SPECIALTY AND SUBSPECIALTY SERVICES INCLUDING:

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule O (Form 990) 2021

132211 11-11-21

# PUBLIC INSPECTION COPY

Schedule O (Form 990) 2021

Page 2

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

Employer identification number  
27-1344467

11 THE HEART CENTER AT ST. JOSEPH'S

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:

1 REGIONAL CRANIOFACIAL CENTER

2 PEDIATRIC CENTER FOR FEEDING AND SWALLOWING DISORDERS

3 CHILD DEVELOPMENT CENTER

4 REGIONAL CYSTIC FIBROSIS CENTER

5 FULL SPECTRUM OF PEDIATRIC SPECIALTY AND SUBSPECIALTY SERVICES

SJUMC CURRENTLY OPERATES 559 BEDS WITHIN THE FOLLOWING

MEDICAL/SURGICAL - 315

INTENSIVE/CORONARY CARE - 62

OBSTETRICS/GYNECOLOGY - 54

PEDIATRICS - 54

PSYCHIATRY - 24

NEONATAL INTENSIVE CARE - 50

TOTAL (EXCLUDES 30 NEWBORN BASSINETS) 559

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

132212 11-11-21

Schedule O (Form 990) 2021

125

16421115 150123 27-1344467

2021.05000 ST JOSEPH'S HEALTH SYSTEM 27-13441

PUBLIC INSPECTION COPY

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
--	--

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

5. ST. JOSEPH'S UNIVERSITY MEDICAL CENTER AMBULATORY IMAGING CENTER, A  
FULL SERVICE DIAGNOSTIC AND WOMEN'S IMAGING CENTER IN CLIFTON, NJ

6. 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 ST. JOSEPH'S WAYNE  
MEDICAL CENTER (SJWMC). 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, 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.

PUBLIC INSPECTION COPY

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
---	--

CERTAIN ADDITIONAL SPACE IS CURRENTLY LEASED TO A NON-PROFIT LONG TERM

ACUTE CARE SERVICES PROVIDER. SJWMC CURRENTLY OPERATES 138 BEDS WITHIN

THE FOLLOWING 229 LICENSED BED COMPLEMENT:

MEDICAL/SURGICAL 193

INTENSIVE/CORONARY CARE 16

COMPREHENSIVE REHABILITATION 20

TOTAL 229

FORM 990, PART VI, SECTION A, LINE 6:

MEMBERS OF THE ORGANIZATION

SETON MINISTRIES, INC. IS THE SOLE MEMBER OF ST. JOSEPH'S HEALTH, INC. ST.

JOSEPH'S HEALTH, INC. IS THE SOLE MEMBER OF ST. JOSEPH'S UNIVERSITY MEDICAL

CENTER, ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER FOUNDATION, INC., AND 200

HOSPITAL PLAZA CORP.

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.

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

ELECTION OF THE GOVERNING BODY

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER SHARES A MIRROR BOARD WITH ITS

MEMBER ORGANIZATION, ST. JOSEPH'S HEALTHCARE SYSTEM (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

PUBLIC INSPECTION COPY

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
---	---

SOLE MEMBER - SETON MINISTRIES, INC.

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

DECISIONS OF THE GOVERNING BODY

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; 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 11B:

REVIEW PROCESS FOR FORM 990

A COPY OF THE FORM 990 WAS PRESENTED TO THE ST. JOSEPH'S HEALTH, INC.'S

AUDIT COMMITTEE OF THE BOARD OF TRUSTEES IN NOVEMBER 2, 2022 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.

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

CONFLICT OF INTEREST POLICY

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

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



PUBLIC INSPECTION COPY

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
---	--

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  
2020, NO MATERIAL CONFLICTS WERE IDENTIFIED.

FORM 990, PART VI, SECTION B, LINE 15:

COMPENSATION POLICY

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.

PUBLIC INSPECTION COPY

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
---	--

FORM 990, PART VI, SECTION C, LINE 19:

DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

ST. JOSEPH'S HEALTH, INC. MAKES ITS FORM 990 AND AUDITED FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC BY POSTING A COPY ON THE HOSPITAL'S WEBSITE. THE ORGANIZATION'S GOVERNING DOCUMENTS, 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 NILESH PATEL, MD, ROBERTO SOLIS, MD, ANTHONY LOSARDO, MD, JOSEPH VITALE, MD, MARJORY LANGER, MD FACEP, JAI G. PAREKH, MD, MICHAEL LAMACCHIA, MD, SWATI PAREKH, MICHAEL AGNELLI, MD, SAMI ABDULMASSIH, MD, JOSEPH VITALE JR., MD, AND MANJU GUPTA, 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 PATRICIA MENNOR & SISTER MARILYN C. THIE, AS MEMBERS OF A 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, CHANGES IN NET ASSETS:

NET PERIODIC PENSION BENEFIT	9,668,000.
PENSION RELATED ADJUSTMENTS	32,829,000.
CHANGE IN NON-CONTROLLING INTEREST IN JOINT VENTURE	-360,645.

PUBLIC INSPECTION COPY

Schedule O (Form 990) 2021

Page 2

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
--------------------------	---	--

TRANSFER OF ASSETS TO INSURANCE CAPTIVE	-6,500,000.
TRANSFER OF ASSETS TO/FROM AFFILIATES	878,000.
CHANGE IN INTEREST IN FOUNDATION	-825,300.
ADJUSTMENT TO BEGINNING OF YEAR NET ASSETS	20,304,267.
ROUNDING	-3,639.
INCREASE IN NET ASSETS WITH DONOR RESTRICTIONS	7,892,684.
DECREASE IN NON-CONTROLLING INTERESTS	-261,355.
TOTAL TO FORM 990, PART XI, LINE 9	63,621,012.

FORM 990, PART XII, LINE 2C:

THE PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.

# PUBLIC INSPECTION COPY

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

## Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
▶ Attach to Form 990.

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

OMB No. 1545-0047

2021

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
ST. JOSEPH'S HEALTH PHARMACY, LLC - 83-3649808, 703 MAIN STREET, PATERSON, NJ 07503	PHARMACY	NEW JERSEY			SJUMC

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2021

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule R (Form 990) 2021 **GROUP RETURN**

27-1344467

Page 2

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
VHSNJ AT HOME - 81-4612753 1350 CAMPUS PARKWAY NEPTUNE, NJ 07753	HEALTHCARE	NJ	SJUMC	RELATED	2,138,535.	0.		X	N/A		X	50.00%
ST. JOSEPH'S SURGERY MANAGEMENT - 46-4832908, 703 MAIN STREET, PATERSON, NJ 07503	MGMT SERVICES	NJ	N/A	RELATED				X	N/A		X	55.77%
ST. JOSEPH'S HOME HEALTH, LLC - 82-1236513, 703 MAIN STREET, PATERSON, NJ 07503	SHELL	NJ	N/A	RELATED				X	N/A		X	50.00%
WAYNE VALLEY IMAGING INC 504 VALLEY ROAD WAYNE, NJ 07470	HEALTHCARE	NJ	N/A	RELATED	391,000.	1,140,000.		X	N/A		X	50.00%

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
SJHS INSURANCE LIMITED 44 CHURCH BERMUDA BERMUDA	CAPTIVE INSURANCE	BERMUDA	N/A	C CORP					X
ST JOSEPH'S HOSPITAL HOUSING CORP. - 22-2145893, 703 MAIN STREET, PATERSON, NJ 07503	HOUSING	NJ	SJUMC	C CORP	0.	0.	100%	X	
ST. JOSEPH'S HEALTH PARTNERS, LLC - 83-2385749, P.O. BOX 22155, NEW YORK, NY 10087-2155	VALUE BASED MANAGED CARE	NY	SJ HEALTH INC.	C CORP					X

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule R (Form 990) 2021 GROUP RETURN

27-1344467

Page 3

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

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

**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

- a** Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity .....
- b** Gift, grant, or capital contribution to related organization(s) .....
- c** Gift, grant, or capital contribution from related organization(s) .....
- d** Loans or loan guarantees to or for related organization(s) .....
- e** Loans or loan guarantees by related organization(s) .....
- f** Dividends from related organization(s) .....
- g** Sale of assets to related organization(s) .....
- h** Purchase of assets from related organization(s) .....
- i** Exchange of assets with related organization(s) .....
- j** Lease of facilities, equipment, or other assets to related organization(s) .....
- k** Lease of facilities, equipment, or other assets from related organization(s) .....
- l** Performance of services or membership or fundraising solicitations for related organization(s) .....
- m** Performance of services or membership or fundraising solicitations by related organization(s) .....
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....
- o** Sharing of paid employees with related organization(s) .....
- p** Reimbursement paid to related organization(s) for expenses .....
- q** Reimbursement paid by related organization(s) for expenses .....
- r** Other transfer of cash or property to related organization(s) .....
- s** Other transfer of cash or property from related organization(s) .....

	Yes	No
<b>1a</b>		X
<b>1b</b>	X	
<b>1c</b>	X	
<b>1d</b>		X
<b>1e</b>		X
<b>1f</b>		X
<b>1g</b>		X
<b>1h</b>		X
<b>1i</b>		X
<b>1j</b>	X	
<b>1k</b>		X
<b>1l</b>	X	
<b>1m</b>	X	
<b>1n</b>		X
<b>1o</b>	X	
<b>1p</b>	X	
<b>1q</b>		X
<b>1r</b>		X
<b>1s</b>		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
<b>(1)</b> ST JOSEPH UNIVERSITY MEDICAL CENTER	C	3,665,314.	FMV
<b>(2)</b> ST JOSEPH HOSPITAL & MEDICAL CENTER FOUNDATION	B	3,665,314.	FMV
<b>(3)</b> ST JOSEPH SURGERY MGT	J	492,695.	FMV
<b>(4)</b> ST JOSEPH SURGERY MGT	J	191,760.	FMV
<b>(5)</b> SJHS LIMITED	L	9,203,326.	FMV
<b>(6)</b> ST JOSEPH UNIVERSITY MEDICAL CENTER	P	708,583.	FMV

# PUBLIC INSPECTION COPY

ST JOSEPH'S HEALTH SYSTEM SUBORDINATE

Schedule R (Form 990)

GROUP RETURN

27-1344467

**Part V** Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(7) ST JOSEPH UNIVERSITY MEDICAL CENTER	M	687,123.	FMV
(8) ST JOSEPH HOSPITAL & MEDICAL CENTER FOUNDATION	O	708,583.	FMV
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			





