



2023 Income Tax Return

**ST JOSEPH'S HEALTH SYSTEM SUBORDINATE
GROUP RETURN**

PUBLIC DISCLOSURE COPY

Form **8879-TE**

IRS E-file Signature Authorization for a Tax Exempt Entity

OMB No. 1545-0047

For calendar year 2023, or fiscal year beginning _____, 2023, and ending _____, 20____

2023

Department of the Treasury
Internal Revenue Service

Do not send to the IRS. Keep for your records.
Go to www.irs.gov/Form8879TE for the latest information.

Name of filer **ST JOSEPH'S HEALTH SYSTEM SUBORDINATE**
GROUP RETURN

EIN or SSN
27-1344467

Name and title of officer or person subject to tax **CHRISTOPHER CAULFIELD**
AUTHORIZED SIGNER

Part I Type of Return and Return Information

Check the box for the return for which you are using this Form 8879-TE and enter the applicable amount, if any, from the return. Form 8038-CP and Form 5330 filers may enter dollars and cents. For all other forms, enter whole dollars only. If you check the box on line 1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 9a, or 10a below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, 5b, 6b, 7b, 8b, 9b, or 10b, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a	Form 990 check here	<input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	1,025,839,175.
2a	Form 990-EZ check here	<input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here	<input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here	<input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part V, line 5)	4b	
5a	Form 8868 check here	<input type="checkbox"/>	b Balance due (Form 8868, line 3c)	5b	
6a	Form 990-T check here	<input type="checkbox"/>	b Total tax (Form 990-T, Part III, line 4)	6b	
7a	Form 4720 check here	<input type="checkbox"/>	b Total tax (Form 4720, Part III, line 1)	7b	
8a	Form 5227 check here	<input type="checkbox"/>	b FMV of assets at end of tax year (Form 5227, Item D)	8b	
9a	Form 5330 check here	<input type="checkbox"/>	b Tax due (Form 5330, Part II, line 19)	9b	
10a	Form 8038-CP check here	<input type="checkbox"/>	b Amount of credit payment requested (Form 8038-CP, Part III, line 22)	10b	

Part II Declaration and Signature Authorization of Officer or Person Subject to Tax

Under penalties of perjury, I declare that I am an officer of the above entity or I am a person subject to tax with respect to (name of entity) _____, (EIN) _____ and that I have examined a copy of the 2023 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the electronic return and, if applicable, the consent to electronic funds withdrawal.

PIN: check one box only

I authorize KPMG LLP to enter my PIN 23654
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the tax year 2023 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer or person subject to tax with respect to the entity, I will enter my PIN as my signature on the tax year 2023 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Signature of officer or person subject to tax

Christopher Caulfield

Date 11/15/2024

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

23056513556

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2023 electronically filed return indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature

[Handwritten Signature]

Date 11/15/2024

ERO Must Retain This Form - See Instructions
Do Not Submit This Form to the IRS Unless Requested To Do So

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

Form **8879-TE** (2023)

LHA 302521 01-05-24

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form 990

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

2023

Open to Public Inspection

A For the **2023** calendar year, or tax year beginning and ending

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	C Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN		D Employer identification number 27-1344467
	Doing business as		E Telephone number 973-754-2000
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	703 MAIN STREET		G Gross receipts \$ 1,095,028,721.
	City or town, state or province, country, and ZIP or foreign postal code PATERSON, NJ 07503-2621		
F Name and address of principal officer: KEVIN J. SLAVIN SAME AS C ABOVE		H(a) Is this a group return STMT 1 for subordinates? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No H(b) Are all subordinates included? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions H(c) Group exemption number 5557	

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

J Website: WWW.STJOSEPHSHEALTH.ORG

K Form of organization: Corporation Trust Association Other **L** Year of formation: **M** State of legal domicile:

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: TO PROVIDE QUALITY HEALTHCARE WITH SPECIAL CONCERN FOR THE POOR AND UNDERSERVED.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	66
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	53
	5 Total number of individuals employed in calendar year 2023 (Part V, line 2a)	5	6284
	6 Total number of volunteers (estimate if necessary)	6	125
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	643,469.
b Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	499,493.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	32,301,757.	60,459,261.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	858,575,596.	898,066,573.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	20,209,787.	32,922,933.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	54,991,872.	34,390,408.
		966,079,012.	1,025,839,175.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	6,470,578.	3,593,810.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	552,508,931.	545,655,684.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25)	2,161,634.	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	382,305,834.	459,220,373.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	941,285,343.	1,008,469,867.	
19 Revenue less expenses. Subtract line 18 from line 12	24,793,669.	17,369,308.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	1,077,399,043.	1,093,548,879.
	22 Net assets or fund balances. Subtract line 21 from line 20	736,624,537.	723,080,667.
	340,774,506.	370,468,212.	

Part II Signature Block

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

Sign Here	Signature of officer		Date		
	CHRISTOPHER CAULFIELD, AUTHORIZED SIGNER				
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN
	EVAN W. SEEKAMP		11/15/24		P01907071
Preparer Use Only	Firm's name	Firm's EIN		Phone no.	
	KPMG LLP 345 PARK AVENUE NEW YORK, NY 10154-0102	13-5565207		212-758-9700	

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

**Application for Extension of Time To File an Exempt Organization
Return or Excise Taxes Related to Employee Benefit Plans**

Department of the Treasury
Internal Revenue Service

File a separate application for each return.
Go to www.irs.gov/Form8868 for the latest information.

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

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.

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.

Part I - Identification

Type or Print	Name of exempt organization, employer, or other filer, see instructions. ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Taxpayer identification number (TIN) 27-1344467
File by the due date for filing your return. See instructions.	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 4720 (other than individual)	09
Form 4720 (individual)	03	Form 5227	10
Form 990-PF	04	Form 6069	11
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 8870	12
Form 990-T (trust other than above)	06	Form 5330 (individual)	13
Form 990-T (corporation)	07	Form 5330 (other than individual)	14
Form 1041-A	08		

• After you enter your Return Code, complete either Part II or Part III. Part III, including signature, is applicable only for an extension of time to file Form 5330.

• If this application is for an extension of time to file Form 5330, you must enter the following information.

Plan Name _____
 Plan Number _____
 Plan Year Ending (MM/DD/YYYY) _____

Part II - Automatic Extension of Time To File for Exempt Organizations (see instructions)

The books are in the care of CHRISTOPHER CAULFIELD
703 MAIN STREET - PATERSON, NJ 07503-2621

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, 20 24, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 calendar year 20 23 or
 tax year beginning _____, 20 _____, and ending _____, 20 _____

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

3a If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a	\$	0.
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.	3b	\$	0.
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c	\$	0.

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

Part III Statement of Program Service Accomplishments

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

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 [X] No

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

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 \$ 899,194,697. including grants of \$ 3,593,810.) (Revenue \$ 915,474,917.) ACUTE CARE MEDICAL SERVICES: 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. 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 899,194,697.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

	Yes	No
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	X	
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26 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>		X
27 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>		X
28 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):		
a A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i>	X	
b A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV</i>		X
c 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>		X
29 Did the organization receive more than \$25,000 in noncash contributions? <i>If "Yes," complete Schedule M</i>	X	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 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>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	X	
34 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>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38 Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19?	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
1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable		
b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable		
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	X	

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

Table with columns for question number, question text, and Yes/No columns. Includes questions 2a through 17 regarding employee counts, tax returns, business income, foreign accounts, prohibited transactions, and charitable contributions.

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
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.		
	1a 66		
b	Enter the number of voting members included on line 1a, above, who are independent		
	1b 53		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		X
3	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?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	X	
b	Each committee with authority to act on behalf of the governing body?	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O		X

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

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
b	Describe on Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done	X	
13	Did the organization have a written whistleblower policy?	X	
14	Did the organization have a written document retention and destruction policy?	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a	The organization's CEO, Executive Director, or top management official	X	
b	Other officers or key employees of the organization	X	
	If "Yes" to line 15a or 15b, describe the process on Schedule O. See instructions.		
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	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 07503-2621

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See 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, box 6 of 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) KEVIN J. SLAVIN PRESIDENT/CEO	53.00 2.00	X		X				2,572,548.	0.	14,281.
(2) MARK W. CONNOLLY, MD CHAIRMAN, DEPT. OF SURGERY	55.00 0.00					X		2,309,037.	0.	14,804.
(3) BLADI ZAKU, MD MEDICAL DOCTOR	55.00 0.00					X		1,399,223.	0.	14,232.
(4) YANA CAVANAGH, MD MEDICAL DOCTOR	55.00 0.00					X		1,332,057.	0.	16,674.
(5) JOHN DANKS, MD MEDICAL DOCTOR	55.00 0.00					X		1,228,873.	0.	16,683.
(6) TOGHRUL TALISHINSKY, MD MEDICAL DOCTOR	55.00 0.00					X		1,202,431.	0.	19,257.
(7) TODD C. BROWER SVP, GENERAL COUNSEL (THRU 5/31/23)	55.00 0.00				X			985,221.	0.	11,315.
(8) CASWELL SAMMS SVP/CFO	55.00 0.00	X		X				926,228.	0.	13,462.
(9) JENNIFER MENDRZYCKI SVP & CHIEF OPERATING OFFICER	53.00 2.00			X				809,838.	0.	20,324.
(10) JOSPEH DUFFY, MD CO-CHAIR	2.00 0.00	X		X				802,609.	0.	8,250.
(11) LINDA A. REED SVP, CHIEF INFORMATION OFFICER	55.00 0.00				X			716,006.	0.	18,036.
(12) LISA SCHMITTGALL SVP & CHIEF STRATEGY OFFICER	55.00 0.00				X			695,869.	0.	17,013.
(13) MICHAEL ALWELL VP REVENUE CYCLE	55.00 0.00				X			635,747.	0.	16,882.
(14) CHRISTOPHER TROTZ, MD CO-CHAIR	2.00 0.00	X		X				608,456.	0.	14,343.
(15) PIA HOUSE WALKER SENIOR VP OF HUMAN RESOURCES	55.00 0.00				X			570,722.	0.	15,599.
(16) MICHAEL LAMACCHIA, MD TREASURER/SECRETARY	2.00 0.00	X		X				548,070.	0.	21,108.
(17) ROBERTO SOLIS, MD TRUSTEE	2.00 0.00	X						553,870.	0.	11,175.

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) KENNETH M. MORRIS, JR. VP, EXTERNAL AFFAIRS	55.00 0.00				X			460,306.	0.	24,996.
(19) NILESH PATEL, MD TRUSTEE	2.00 0.00	X						435,230.	0.	25,978.
(20) KEVIN BROWNE SVP, SENIOR NURSE EXECUTIVE	55.00 0.00				X			442,108.	0.	12,745.
(21) DEBORAH SMITH VP, CHIEF NURSING OFFICER	55.00 0.00				X			420,369.	0.	21,843.
(22) JANINE BEGASSE VP QUALITY & SAFETY	55.00 0.00				X			423,593.	0.	12,625.
(23) JUDITH PADULA FORMER KEY EMPLOYEE	0.00 0.00						X	421,398.	0.	0.
(24) TOM CASEY VP, MARKETING AND PUBLIC RELATIONS	55.00 0.00				X			408,186.	0.	10,759.
(25) ROBERT BUDELMAN, III VP, CHIEF DEVELOPMENT OFFICER	55.00 0.00				X			400,414.	0.	16,428.
(26) PADMAJA UPADYA, MD VP, CHIEF MEDICAL OFFICER, SJWMC	2.00 0.00	X						389,140.	0.	6,149.
1b Subtotal								21,697,549.	0.	394,961.
c Total from continuation sheets to Part VII, Section A								2,524,808.	0.	92,672.
d Total (add lines 1b and 1c)								24,222,357.	0.	487,633.

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 1,459

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
TOTOWA MED URBAN RENEWAL LLC, 2 BROAD STREET, 4TH FL, BLOOMFIELD, NJ 07003	RENTAL SERVICES	9,161,845.
ADVANCED CARDIOLOGY PRACTICE, LLC, 246 HAMBURG TURNPIKE, STE 201, WAYNE, NJ 07470	CARDIOLOGY	7,638,440.
NORTH AMERICAN PARTNERS IN ANESTHESIA 1305 WALT WHITMAN ROAD, MELVILLE, NY 11747	ANESTHESIOLOGY	7,477,897.
CARDIOLOGY ASSOCIATES, 999 MCBRIDE AVE, STE B204, WEST PATERSON, NJ 07424	CARDIOLOGY	6,607,771.
PASSAIC RIVER PHYSICIANS LLC PO BOX 740666, ATLANTA, GA 30374-0666	PHYSICIAN SERVICES	6,189,974.

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 49

SEE PART VII, SECTION A CONTINUATION SHEETS

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) ANTHONY TESORIERO VP, FACILITIES OPERATIONS	55.00 0.00				X			380,001.	0.	13,226.
(28) SWATI PAREKH, MD SECRETARY	2.00 0.00	X		X				354,464.	0.	17,051.
(29) MICHAEL CAIROLI VP, WAYNE SITE ADMIN.	55.00 0.00				X			348,683.	0.	15,674.
(30) JANE WHITE VP, ONCOLOGY	55.00 0.00				X			327,888.	0.	10,591.
(31) MICHAEL AGNELLI, MD TRUSTEE	2.00 0.00	X						307,225.	0.	11,867.
(32) SAMI ABDULMASSIH, MD TRUSTEE	2.00 0.00	X						247,403.	0.	11,676.
(33) VALERIE CAMPBELL VP, CHIEF COMPLIANCE OFFICER	55.00 0.00				X			238,712.	0.	12,541.
(34) DUSTIN RICCIO, MD PRESIDENT/CEO	55.00 0.00	X		X				187,970.	0.	46.
(35) VICKI CLEVINGER VP, CHIEF COMPLIANCE OFFICER	0.00 0.00						X	132,462.	0.	0.
(36) ATHANASIA KONTOS CHAIR	2.00 0.00	X		X				0.	0.	0.
(37) DEAN EMMOLO TRUSTEE	1.00 1.00	X						0.	0.	0.
(38) WILFREDO FERNANDEZ CHAIR	1.00 1.00	X		X				0.	0.	0.
(39) BERNADETTE COUNTRYMAN VICE CHAIR	1.00 1.00	X		X				0.	0.	0.
(40) DONNA M. DECANDIDO VICE CHAIR	2.00 0.00	X		X				0.	0.	0.
(41) DENNIS MARCO TREASURER/SECRETARY	2.00 0.00	X						0.	0.	0.
(42) GUALBERTO MEDINA SECRETARY	1.00 1.00	X						0.	0.	0.
(43) TALIA GRIEP TREASURER	1.00 1.00	X		X				0.	0.	0.
(44) RICHARD ABBATE TRUSTEE	2.00 0.00	X						0.	0.	0.
(45) JOSEPH AMICO TRUSTEE	2.00 0.00	X						0.	0.	0.
(46) MICHAEL J. ARMSTRONG TRUSTEE	1.00 1.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c										

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			
(47) FARHAN AYOUB, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(48) DONNA BOLES TRUSTEE	1.00 1.00	X						0.	0.	0.
(49) MARIE BREUSS TRUSTEE	2.00 0.00	X						0.	0.	0.
(50) ALBERT CANDIDO TRUSTEE	2.00 0.00	X						0.	0.	0.
(51) JOHN R. CIOLETTI TRUSTEE	2.00 0.00	X						0.	0.	0.
(52) MOIRA CONNOLLY, ESQ. TRUSTEE	2.00 0.00	X						0.	0.	0.
(53) SISTER ELLEN DAUWER TRUSTEE	2.00 0.00	X						0.	0.	0.
(54) PATRICIA DAVINO TRUSTEE	2.00 0.00	X						0.	0.	0.
(55) DANIEL DELGADO TRUSTEE	2.00 0.00	X						0.	0.	0.
(56) KATHLEEN FAGAN TRUSTEE	2.00 0.00	X						0.	0.	0.
(57) RONALD J. GARNER TRUSTEE	2.00 0.00	X						0.	0.	0.
(58) ANTHONY GRIFFO TRUSTEE	2.00 0.00	X						0.	0.	0.
(59) SISTER KAREN HELFENSTEIN TRUSTEE	1.00 1.00	X						0.	0.	0.
(60) GEORGE HUNDT TRUSTEE	2.00 0.00	X						0.	0.	0.
(61) DAVID INCORVAIA TRUSTEE	2.00 0.00	X						0.	0.	0.
(62) ROGER JOHNSON TRUSTEE	2.00 0.00	X						0.	0.	0.
(63) JAMES KRANZ TRUSTEE	1.00 0.00	X						0.	0.	0.
(64) ALFRED LEE TRUSTEE	1.00 1.00	X						0.	0.	0.
(65) CHRISTINE LEROY, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(66) GABRIELLA LOCONTE TRUSTEE	2.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c										

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			
(67) ANTHONY LOSARDO, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(68) GAMIL MAKAR, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(69) MICHAEL MAINERO, MD TRUSTEE	1.00 1.00	X						0.	0.	0.
(70) THOMAS G. MARINARO TRUSTEE (THRU 11/23)	2.00 0.00	X						0.	0.	0.
(71) SISTER MARY MORLEY TRUSTEE	1.00 1.00	X						0.	0.	0.
(72) TIMOTHY MATTESON, ESQ. TREASURER	2.00 0.00	X						0.	0.	0.
(73) CECILIA K. MCKENNEY TRUSTEE	2.00 0.00	X						0.	0.	0.
(74) MARY MEEHAN TRUSTEE	2.00 0.00	X						0.	0.	0.
(75) PATRICK MICHAEL, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(76) JOHN MORONE, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(77) DEBORAH A. NAPPI, CPA TRUSTEE	2.00 0.00	X						0.	0.	0.
(78) MARTIN NEILAN, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(79) ROMAN OBEN TRUSTEE	2.00 0.00	X						0.	0.	0.
(80) WILLIAM O' SHAUGHNESSY TRUSTEE	2.00 0.00	X						0.	0.	0.
(81) JAI PAREKH, MD, MBA, FAAO TRUSTEE	1.00 1.00	X						0.	0.	0.
(82) ROBERT PAZ TRUSTEE	1.00 1.00	X						0.	0.	0.
(83) BETH POLITO TRUSTEE	2.00 0.00	X						0.	0.	0.
(84) MANNAN RAZZAK, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(85) GENE RUBINO, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(86) BIJAL SHETH, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c										

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			
(87) SISTER ROSEMARY SMITH TRUSTEE	1.00 1.00	X						0.	0.	0.
(88) SISTER MAUREEN SULLIVAN TRUSTEE	1.00 1.00	X						0.	0.	0.
(89) JOHN SUTTER, MD TRUSTEE	2.00 0.00	X						0.	0.	0.
(90) JOSEPH VITALE JR., MD TRUSTEE	2.00 0.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c								2,524,808.	92,672.	

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	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	668,569.				
	d Related organizations	1d	3,439,683.				
	e Government grants (contributions)	1e	29,250,677.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	27,100,332.				
	g Noncash contributions included in lines 1a-1f	1g	\$ 156,588.				
	h Total. Add lines 1a-1f			60,459,261.			
Program Service Revenue	2 a NET PATIENT SRVC REV.	Business Code 621110	847,352,128.	847,352,128.			
	b PHYSICIAN BILLING	621110	50,714,445.	50,714,445.			
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			898,066,573.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		20,442,869.			20,442,869.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	6a	(i) Real	6,431,716.			
			(ii) Personal				
	b Less: rental expenses	6b	1,339,060.				
	c Rental income or (loss)	6c	5,092,656.				
	d Net rental income or (loss)			5,092,656.	540,493.	4,552,163.	
	7 a Gross amount from sales of assets other than inventory	7a	(i) Securities	59,038,559.	20,733,669.		
			(ii) Other				
	b Less: cost or other basis and sales expenses	7b	59,474,091.	7,818,073.			
	c Gain or (loss)	7c	-435,532.	12,915,596.			
d Net gain or (loss)			12,480,064.		12,480,064.		
8 a Gross income from fundraising events (not including \$ 668,569. of contributions reported on line 1c). See Part IV, line 18	8a		965,261.				
		b Less: direct expenses	8b	548,719.			
		c Net income or (loss) from fundraising events			416,542.		416,542.
9 a Gross income from gaming activities. See Part IV, line 19	9a		24,408.				
		b Less: direct expenses	9b	9,603.			
		c Net income or (loss) from gaming activities			14,805.		14,805.
10 a Gross sales of inventory, less returns and allowances	10a						
		b Less: cost of goods sold	10b				
		c Net income or (loss) from sales of inventory					
Miscellaneous Revenue	11 a PHARMACY	Business Code 456110	3,607,992.	3,607,992.			
	b PARKING	812930	3,172,198.		3,172,198.		
	c MANAGEMENT FEES	900099	2,673,551.	2,673,551.			
	d All other revenue	900099	19,412,664.	11,126,800.	102,976.	8,182,888.	
	e Total. Add lines 11a-11d			28,866,405.			
12 Total revenue. See instructions			1,025,839,175.	915,474,916.	643,469.	49,261,529.	

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 X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...	3,575,810.	3,575,810.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	18,000.	18,000.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	14,864,654.	13,232,326.	1,568,427.	63,901.
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	4,329,089.	3,853,700.	456,779.	18,610.
7 Other salaries and wages	440,093,321.	391,765,487.	46,435,932.	1,891,902.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	13,459,906.	12,128,890.	1,331,016.	
9 Other employee benefits	41,293,511.	37,033,510.	4,083,629.	176,372.
10 Payroll taxes	31,615,203.	28,488,856.	3,126,347.	
11 Fees for services (nonemployees):				
a Management				
b Legal	1,834,953.	1,653,499.	181,454.	
c Accounting	773,334.	696,861.	76,473.	
d Lobbying	335,721.	302,522.	33,199.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	855,188.	759,758.	84,581.	10,849.
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	4,256,404.	3,835,499.	420,905.	
12 Advertising and promotion	921,947.	830,778.	91,169.	
13 Office expenses	47,957,516.	43,215,119.	4,742,397.	
14 Information technology	29,001,659.	26,133,758.	2,867,901.	
15 Royalties				
16 Occupancy	94,881,317.	85,498,744.	9,382,573.	
17 Travel	436,702.	393,518.	43,184.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings				
20 Interest	14,796,335.	13,433,439.	1,362,896.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	36,124,307.	32,578,394.	3,545,913.	
23 Insurance	17,093,084.	15,402,792.	1,690,292.	
24 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.)				
a MEDICAL SUPPLIES EXP.	149,243,392.	127,205,536.	22,037,856.	
b PHYSICIAN FEES	35,905,589.	32,354,976.	3,550,613.	
c EQUIP REPAIR/MAINT.	5,844,814.	5,844,814.		
d BAD DEBT EXPENSE	529,981.	529,981.		
e All other expenses	18,428,130.	18,428,130.		
25 Total functional expenses. Add lines 1 through 24e	1,008,469,867.	899,194,697.	107,113,536.	2,161,634.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A)		(B)
		Beginning of year		End of year
Assets	1 Cash - non-interest-bearing	4,534,889.	1	22,158.
	2 Savings and temporary cash investments	17,753,308.	2	13,461,437.
	3 Pledges and grants receivable, net	22,794,764.	3	45,057,210.
	4 Accounts receivable, net	92,835,094.	4	101,916,149.
	5 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	267,544.	5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net	1,269,908.	7	2,482,995.
	8 Inventories for sale or use	24,455,734.	8	26,552,675.
	9 Prepaid expenses and deferred charges	19,642,992.	9	43,836,076.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1,006,514,840.		
	b Less: accumulated depreciation	10b 650,681,026.		
	11 Investments - publicly traded securities	374,634,654.	10c	355,833,814.
	12 Investments - other securities. See Part IV, line 11	79,016,282.	11	75,007,728.
	13 Investments - program-related. See Part IV, line 11	264,483,001.	12	264,326,835.
	14 Intangible assets		13	
	15 Other assets. See Part IV, line 11	2,110,000.	14	189,926.
16 Total assets. Add lines 1 through 15 (must equal line 33)	173,600,873.	15	164,861,876.	
	1,077,399,043.	16	1,093,548,879.	
Liabilities	17 Accounts payable and accrued expenses	208,883,870.	17	207,145,967.
	18 Grants payable		18	
	19 Deferred revenue	12,400,932.	19	3,408,031.
	20 Tax-exempt bond liabilities	302,710,633.	20	295,335,940.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 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		22	
	23 Secured mortgages and notes payable to unrelated third parties	40,600,000.	23	40,600,000.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	172,029,102.	25	176,590,729.
	26 Total liabilities. Add lines 17 through 25	736,624,537.	26	723,080,667.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	306,618,488.	27	337,376,149.
	28 Net assets with donor restrictions	34,156,018.	28	33,092,063.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	340,774,506.	32	370,468,212.
33 Total liabilities and net assets/fund balances	1,077,399,043.	33	1,093,548,879.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,025,839,175.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,008,469,867.
3	Revenue less expenses. Subtract line 2 from line 1	3	17,369,308.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	340,774,506.
5	Net unrealized gains (losses) on investments	5	14,957,160.
6	Donated services and use of facilities	6	-8,095.
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-2,624,667.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	370,468,212.

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990: <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.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
b	Were the organization's financial statements audited by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? _____ If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F? _____	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits _____	X	

Form 990 (2023)

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 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

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

(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		3,439,683.	
Total					3,439,683.	0.

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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2023 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2022 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2023. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2022. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2023. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2022. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Table with 7 columns: (a) 2019, (b) 2020, (c) 2021, (d) 2022, (e) 2023, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 8 Public support.

Section B. Total Support

Table with 7 columns: (a) 2019, (b) 2020, (c) 2021, (d) 2022, (e) 2023, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on; 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.); 13 Total support.

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

Table with 2 columns: Line number, Percentage. Row 15: Public support percentage for 2023 (line 8, column (f), divided by line 13, column (f)) 15 %; Row 16: Public support percentage from 2022 Schedule A, Part III, line 15 16 %

Section D. Computation of Investment Income Percentage

Table with 2 columns: Line number, Percentage. Row 17: Investment income percentage for 2023 (line 10c, column (f), divided by line 13, column (f)) 17 %; Row 18: Investment income percentage from 2022 Schedule A, Part III, line 17 18 %

19a 33 1/3% support tests - 2023. 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 - 2022. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked 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
1 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>		X
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <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>		X
3a 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>		X
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c 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>		
4a 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>		X
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>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <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>		
5a 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>		X
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		X
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		X
8 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>		X
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		X
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>		X
c 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>		X
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		X
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>		

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		X
b A family member of a person described on line 11a above?		X
c 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>		X

Section B. Type I Supporting Organizations

	Yes	No
1 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>	X	
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <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>		X

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (<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	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 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	Distributable Amount. 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) 2023

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	8
9	Distributable amount for 2023 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2023	(iii) Distributable Amount for 2023
1	Distributable amount for 2023 from Section C, line 6		
2	Underdistributions, if any, for years prior to 2023 (reasonable cause required - explain in Part VI). See instructions.		
3	Excess distributions carryover, if any, to 2023		
a	From 2018		
b	From 2019		
c	From 2020		
d	From 2021		
e	From 2022		
f	Total of lines 3a through 3e		
g	Applied to underdistributions of prior years		
h	Applied to 2023 distributable amount		
i	Carryover from 2018 not applied (see instructions)		
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.		
4	Distributions for 2023 from Section D, line 7: \$		
a	Applied to underdistributions of prior years		
b	Applied to 2023 distributable amount		
c	Remainder. Subtract lines 4a and 4b from line 4.		
5	Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.		
6	Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.		
7	Excess distributions carryover to 2024. Add lines 3j and 4c.		
8	Breakdown of line 7:		
a	Excess from 2019		
b	Excess from 2020		
c	Excess from 2021		
d	Excess from 2022		
e	Excess from 2023		

Schedule A (Form 990) 2023

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 EACH 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). EACH IS A TYPE I SUPPORTING ORGANIZATION THAT

DIRECTLY SUPPORTS 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 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 THE RIGHT AND POWER TO APPOINT

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.)

A GROUP RETURN.

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 A 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 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 PHYSICIANS HEALTHCARE GROUP INC.'S SOLE MEMBER IS SJUMC.

SJUMC IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S

PHYSICIANS HEALTHCARE GROUP INC.

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

ST. JOSEPH'S SUBSPECIALTY PHYSICIANS INC.'S SOLE MEMBER IS SJUMC. SJUMC

IS RESPONSIBLE FOR ELECTING THE TRUSTEES OF ST. JOSEPH'S SUBSPECIALTY

PHYSICIANS INC.

Schedule B
(Form 990)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2023

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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Organization type (check one):

Filers of:

Section:

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

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

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

General Rule

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

Special Rules

- For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year \$ _____

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

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

Schedule B (Form 990) (2023)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 56,570.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____ _____ _____	\$ _____ 56,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____ _____ _____	\$ _____ 46,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	_____ _____ _____	\$ _____ 46,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	_____ _____ _____	\$ _____ 38,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	_____ _____ _____	\$ _____ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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		\$ 31,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8		\$ 30,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
9		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10		\$ 29,885.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11		\$ 27,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 24,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	_____ _____ _____	\$ _____ 23,333.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	_____ _____ _____	\$ _____ 21,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	_____ _____ _____	\$ _____ 21,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	_____ _____ _____	\$ _____ 21,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	_____ _____ _____	\$ _____ 21,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 21,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	_____ _____ _____	\$ _____ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	_____ _____ _____	\$ _____ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	_____ _____ _____	\$ _____ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	_____ _____ _____	\$ _____ 16,850.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	_____ _____ _____	\$ _____ 16,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	_____ _____ _____	\$ _____ 13,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	_____ _____ _____	\$ _____ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	_____ _____ _____	\$ _____ 11,925.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	_____ _____ _____	\$ _____ 11,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	_____ _____ _____	\$ _____ 11,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	_____ _____ _____	\$ _____ 11,350.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	_____ _____ _____	\$ _____ 11,253.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 10,560.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	_____ _____ _____	\$ _____ 10,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	_____ _____ _____	\$ _____ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	_____ _____ _____	\$ _____ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	_____ _____ _____	\$ _____ 8,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55	_____ _____ _____	\$ 8,333.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	_____ _____ _____	\$ 8,333.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57	_____ _____ _____	\$ 8,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58	_____ _____ _____	\$ 8,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59	_____ _____ _____	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60	_____ _____ _____	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62	_____ _____ _____	\$ _____ 7,415.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63	_____ _____ _____	\$ _____ 6,850.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64	_____ _____ _____	\$ _____ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65	_____ _____ _____	\$ _____ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66	_____ _____ _____	\$ _____ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68		\$ 6,500.	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		\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71		\$ 6,462.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72		\$ 6,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 6,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
74	_____ _____ _____	\$ _____ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
75	_____ _____ _____	\$ _____ 5,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
76	_____ _____ _____	\$ _____ 5,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
77	_____ _____ _____	\$ _____ 5,560.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
78	_____ _____ _____	\$ _____ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	_____ _____ _____	\$ _____ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
80	_____ _____ _____	\$ _____ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
81	_____ _____ _____	\$ _____ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
82	_____ _____ _____	\$ _____ 5,175.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
83	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
84	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
86	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
87	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
88	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
89	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
90	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
92	<hr/> <hr/> <hr/>	\$ 72,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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
8	BOXED TREATS _____ _____ _____	\$ 3,200.	11/28/23
77	FOOD AND BEVERAGE _____ _____ _____	\$ 360.	10/28/23
92	MEDICAL EQUIPMENT _____ _____ _____	\$ 72,600.	05/28/23
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____

Name of organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

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

2023

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.

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

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

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

Schedule C (Form 990) 2023

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

- A** Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a	Total lobbying expenditures to influence public opinion (grassroots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">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.														
g	Grassroots nontaxable amount (enter 25% of line 1f)														
h	Subtract line 1g from line 1a. If zero or less, enter -0-														
i	Subtract line 1f from line 1c. If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?														

Yes No

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990) 2023

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		335,720.
j Total. Add lines 1c through 1i			335,720.
2a Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

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 2023, THE HOSPITAL PAID WASHINGTON

STRATEGIC CONSULTING, INC. \$90,750 FOR THEIR EFFORTS. THE HOSPITAL PAID

Part IV Supplemental Information *(continued)*

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)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. Attach to Form 990.

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

OMB No. 1545-0047

2023

Open to Public Inspection

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

Employer identification number 27-1344467

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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, total number and acreage, number of easements on historic structures, and monitoring expenses.

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 questions about reporting art and historical treasures for public service and financial gain.

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

Schedule D (Form 990) 2023

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).
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange program
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian, or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	123,142.	123,142.	123,142.	123,142.	123,142.
b Contributions					
c Net investment earnings, gains, and losses	2,627.	506.	47.	39.	3,500.
d Grants or scholarships					
e Other expenditures for facilities and programs	2,627.	506.	47.	39.	3,500.
f Administrative expenses					
g End of year balance	123,142.	123,142.	123,142.	123,142.	123,142.

- 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:
- | | Yes | No |
|--|-----|----|
| (i) Unrelated organizations? | X | |
| (ii) Related organizations? | | X |
| 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
1a Land		17,401,197.		17,401,197.
b Buildings		373,885,954.	206,053,745.	167,832,209.
c Leasehold improvements		550,655,078.	411,375,733.	139,279,345.
d Equipment		11,347,638.	9,318,469.	2,029,169.
e Other		53,224,973.	23,933,079.	29,291,894.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B))				355,833,814.

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	537,002.	END-OF-YEAR MARKET VALUE
(B) US BONDS/MORT. BACKED & MUTUAL FUNDS	9,546,250.	END-OF-YEAR MARKET VALUE
(C) CORPORATE OBLIGATIONS	254,243,583.	END-OF-YEAR MARKET VALUE
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, line 12, col. (B))	264,326,835.	

Part VIII Investments - Program Related.

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

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

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	29,544,168.
(2) OPERATING RIGHT USE OF ASSETS	106,983,434.
(3) OTHER ASSETS	22,530,403.
(4) BENEFICIAL INTEREST IN TRUST	5,803,871.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 15, col. (B))	164,861,876.

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) OPERATING RIGHT TO USE ASSETS	106,982,964.
(3) ESTIMATED THIRD PARTY SETTLEMENTS	10,985,873.
(4) ACCRUED PENSION LIABILITY	10,712,612.
(5) ACCRUED MALPRACTICE INSURANCE	22,102,942.
(6) OTHER	25,806,338.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 25, col. (B))	176,590,729.

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 ...

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.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and descriptions.

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.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and descriptions.

Part XIII Supplemental Information

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

PART XIII V - 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.

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

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

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

3 Enter total number of other organizations or entities

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

Part III can be duplicated if additional space is needed.

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

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 the 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 the 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 the 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 the 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 the 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 the Instructions for Form 5713; don't file with Form 990)* **Yes** **No**

Part V Supplemental Information

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

PART I, LINE 3, COLUMN (F):

THE ORGANIZATION USES THE ACCRUAL METHOD OF ACCOUNTING TO ACCOUNT FOR

ITS FOREIGN EXPENDITURES.

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))	
		2023 GALA (event type)	2023 GOLF UPPER MONTCLAIR (event type)	2 (total number)		
Revenue	1	Gross receipts	971,535.	266,437.	395,857.	1,633,829.
	2	Less: Contributions	408,170.	89,688.	170,711.	668,569.
	3	Gross income (line 1 minus line 2)	563,365.	176,749.	225,146.	965,260.
Direct Expenses	4	Cash prizes				
	5	Noncash prizes				
	6	Rent/facility costs		71,040.	31,750.	102,790.
	7	Food and beverages	117,400.	43,955.	54,521.	215,876.
	8	Entertainment	85,040.		3,500.	88,540.
	9	Other direct expenses	80,753.	20,113.	40,647.	141,513.
	10	Direct expense summary. Add lines 4 through 9 in column (d)				548,719.
11	Net income summary. Subtract line 10 from line 3, column (d)				416,541.	

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1	Gross revenue		24,408.	24,408.
	2	Cash prizes		9,603.	9,603.
Direct Expenses	3	Noncash prizes			
	4	Rent/facility costs			
	5	Other direct expenses			
6	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	
7	Direct expense summary. Add lines 2 through 5 in column (d)				9,603.
8	Net gaming income summary. Subtract line 7 from line 1, column (d)				14,805.

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

- 11 Does the organization conduct gaming activities with nonmembers? 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 07503

- 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 07503

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.

Part IV Supplemental Information *(continued)*

Multiple horizontal lines for supplemental information.

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.
Attach to Form 990.

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

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number	27-1344467
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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 <i>free</i> 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 <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input 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

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			52,136,742.	51,279,893.	856,849.	.08%
b Medicaid (from Worksheet 3, column a)			276,527,835.	242,744,968.	33,782,867.	3.35%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			328,664,577.	294,024,861.	34,639,716.	3.43%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)			45,880,471.	24,622,288.	21,258,183.	2.11%
g Subsidized health services (from Worksheet 6)			181,094,728.	52,867,513.	128,227,215.	12.72%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			226,975,199.	77,489,801.	149,485,398.	14.83%
k Total. Add lines 7d and 7j			555,639,776.	371,514,662.	184,125,114.	18.26%

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	122,297,582.
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	63,349,059.
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	260,856,577.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	297,467,419.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-36,610,842.
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 ST. JOSEPH'S SURGERY MANAGEMENT	SURGERY CENTER MANAGEMENT	62.79%		37.21%

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

Table with 3 columns: Question, Yes, No. Rows include Community Health Needs Assessment questions 1 through 12c.

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:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a	<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	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
c	<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>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2023

Part V Facility Information (continued)

Billing and Collections

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

	Yes	No
<p>17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?</p>	X	
<p>18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:</p> <p>a <input type="checkbox"/> Reporting to credit agency(ies)</p> <p>b <input type="checkbox"/> Selling an individual's debt to another party</p> <p>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</p> <p>d <input type="checkbox"/> Actions that require a legal or judicial process</p> <p>e <input type="checkbox"/> Other similar actions (describe in Section C)</p> <p>f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted</p>		
<p>19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?</p> <p>If "Yes," check all actions in which the hospital facility or a third party engaged:</p> <p>a <input type="checkbox"/> Reporting to credit agency(ies)</p> <p>b <input type="checkbox"/> Selling an individual's debt to another party</p> <p>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</p> <p>d <input type="checkbox"/> Actions that require a legal or judicial process</p> <p>e <input type="checkbox"/> Other similar actions (describe in Section C)</p>		X
<p>20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):</p> <p>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)</p> <p>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)</p> <p>c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)</p> <p>d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)</p> <p>e <input type="checkbox"/> Other (describe in Section C)</p> <p>f <input type="checkbox"/> None of these efforts were made</p>		

Policy Relating to Emergency Medical Care

<p>21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?</p> <p>If "No," indicate why:</p> <p>a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions</p> <p>b <input type="checkbox"/> The hospital facility's policy was not in writing</p> <p>c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)</p> <p>d <input type="checkbox"/> Other (describe in Section C)</p>	X	
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Schedule H (Form 990) 2023

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
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
a	<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		
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		
c	<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		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Schedule H (Form 990) 2023

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 1: ST. JOSEPH'S UNIVERSITY MEDICAL CTR

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

FACILITY REPORTING GROUP - A

PART V, SECTION B, LINE 5: 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, 69 COMMUNITY

STAKEHOLDERS IN SOUTHERN PASSAIC COUNTY TOOK PART IN THE ONLINE KEY

INFORMANT SURVEY, AS OUTLINED BELOW:

PHYSICIANS 15

PUBLIC HEALTH REPRESENTATIVES 3

OTHER HEALTH PROVIDERS 16

SOCIAL SERVICES PROVIDERS 17

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.

OTHER COMMUNITY LEADERS 18

FINAL PARTICIPATION INCLUDED REPRESENTATIVES OF THE ORGANIZATIONS OUTLINED

BELOW.

- 2ND BAPTIST CHURCH
- 4CS OF PASSAIC COUNTY
- BANGLADESHI AMERICAN WOMEN'S DEVELOPMENT INITIATIVE
- CAMP YDP
- CAREFINDERS TOTAL CARE LLC
- CATHOLIC CHARITIES DIOCESE OF PATERSON
- CHILDREN'S AID & FAMILY SERVICES THE CENTER FOR ALCOHOL & DRUG

RESOURCES

- CIRCLE OF CARE
- CITY GREEN
- CITY OF PATERSON
- CITY OF PATERSON FIRE DEPARTMENT
- DIVISION OF CHILD PROTECTION & PERMANENCY
- ELMWOOD PARK SENIOR CENTER
- FAMILY CARE NJ
- FAMILY SUCCESS CENTER OF PATERSON
- GREATER PATERSON OIC
- HARBOR HOUSE
- HEALTH COALITION OF PASSAIC COUNTY
- HOME CARE OPTIONS
- JOHN P. HOLLAND CHARTER SCHOOL
- MENTAL HEALTH ASSOCIATION OF PASSAIC COUNTY
- MORE THAN FRIENDS CARES INC.

Part V Facility Information *(continued)*

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

- NEW JERSEY COMMUNITY DEVELOPMENT CORP

- NORTHEAST NJ LEGAL SERVICES

- NORWESCAP

- OASIS A HAVEN FOR WOMEN AND CHILDREN

- PALESTINIAN AMERICAN COMMUNITY CENTER

- PARTNERSHIP FOR MATERNAL AND CHILD HEALTH OF NORTHERN NJ

- PASSAIC COUNTY SAFE KIDS

- PASSAIC SCHOOL DISTRICT

- PATERSON ALLIANCE

- PATERSON COMMUNITY HEALTH CENTER

- PATERSON JUDICIARY

- PATERSON PUBLIC SCHOOLS

- PATERSON SCHOOL DISTRICT

- PATERSON TASK FORCE FOR COMMUNITY ACTION

- REBUILDING TOGETHER NORTH JERSEY

- RUTGERS COOP EXTENSION

- SEMINARY BAPTIST CHURCH

- SERV BEHAVIORIAL HEALTH

- ST. PAUL'S BAPTIST CHURCH

- ST. BONAVENTURE CHURCH

- ST. JOSEPH'S HEALTH

- ST. JOSEPH'S WIC

- ST PAUL EPISCOPAL

- STAR OF HOPE MINISTRIES

- TURNING POINT

- UNITED METHODIST CHURCH, WAYNE, NJ

- WAYNE TOWNSHIP

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.

- WAYNE TOWNSHIP HEALTH DEPARTMENT

- WAYNE YMCA

- WILLIAM PATERSON UNIVERSITY-SBDC

THE FOLLOWING "AREAS OF OPPORTUNITY" REPRESENT THE SIGNIFICANT HEALTH

NEEDS OF THE COMMUNITY, BASED ON THE INFORMATION GATHERED THROUGH THE

COMMUNITY HEALTH NEEDS ASSESSMENT. FROM THIS DATA, OPPORTUNITIES 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.

1) ACCESS TO HEALTH CARE SERVICES

- LACK OF HEALTH INSURANCE

- BARRIERS TO ACCESS

- INCONVENIENT OFFICE HOURS

- COST OF PRESCRIPTIONS

- COST OF PHYSICIAN VISITS

- APPOINTMENT AVAILABILITY

- FINDING A PHYSICIAN

- LACK OF TRANSPORTATION

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.

- CULTURE/LANGUAGE

- PRIMARY CARE PHYSICIAN RATIO

- SPECIFIC SOURCE OF ONGOING MEDICAL CARE

- EMERGENCY ROOM UTILIZATION

- RATINGS OF LOCAL HEALTH CARE

2) CANCER

- LEADING CAUSE OF DEATH

- PROSTATE CANCER INCIDENCE

3) DIABETES

- PREVALENCE OF BORDERLINE/PRE-DIABETES

- PREVALENCE OF KIDNEY DISEASE

- KEY INFORMANTS: DIABETES RANKED AS A TOP CONCERN.

4) HEART DISEASE & STROKE

- LEADING CAUSE OF DEATH

- HIGH BLOOD CHOLESTEROL PREVALENCE

- OVERALL CARDIOVASCULAR RISK

5) HOUSING

- HOUSING INSECURITY

- HOUSING CONDITIONS

6) INFANT HEALTH & FAMILY PLANNING

- PRENATAL CARE

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.

7) INJURY & VIOLENCE

- UNINTENTIONAL INJURY DEATHS INCLUDING FALLS [AGE 65+] DEATHS
- KEY INFORMANTS: INJURY AND VIOLENCE RANKED AS A TOP CONCERN.

8) MENTAL HEALTH

- "FAIR/POOR" MENTAL HEALTH
- SYMPTOMS OF CHRONIC DEPRESSION
- MENTAL HEALTH PROVIDER RATIO
- KEY INFORMANTS: MENTAL HEALTH RANKED AS A TOP CONCERN.

9) NUTRITION, PHYSICAL ACTIVITY & WEIGHT

- FOOD INSECURITY
- DIFFICULTY ACCESSING FRESH PRODUCE
- FRUIT/VEGETABLE CONSUMPTION
- ACCESS TO RECREATION/FITNESS FACILITIES
- OVERWEIGHT & OBESITY [ADULTS]
- OVERWEIGHT & OBESITY [CHILDREN]
- KEY INFORMANTS: NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT RANKED AS A TOP CONCERN.

10) ORAL HEALTH

- REGULAR DENTAL CARE [ADULTS]

11) POTENTIALLY DISABLING CONDITIONS

- ALZHEIMER'S DISEASE DEATHS

12) RESPIRATORY DISEASE

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.

- LEADING CAUSE OF DEATH

- COVID-19 MORTALITY

13) SEXUAL HEALTH

- HIV MORTALITY

- HIV PREVALENCE

14) SUBSTANCE ABUSE

- CIRRHOSIS/LIVER DISEASE DEATHS

- UNINTENTIONAL DRUG-RELATED DEATHS

- KEY INFORMANTS: SUBSTANCE ABUSE RANKED AS A TOP CONCERN.

15) TOBACCO USE

- SMOKING CESSATION

- USE OF VAPING PRODUCTS

- KEY INFORMANTS: TOBACCO USE RANKED AS A TOP CONCERN

IN DECEMBER 2022, ST. JOSEPH'S HEALTH CONVENED GROUPS OF COMMUNITY

STAKEHOLDERS (REPRESENTING A CROSS-SECTION OF COMMUNITY-BASED AGENCIES AND

ORGANIZATIONS) TO EVALUATE, DISCUSS, AND PRIORITIZE HEALTH ISSUES FOR THE

COMMUNITY, BASED ON FINDINGS OF THIS COMMUNITY HEALTH NEEDS ASSESSMENT

(CHNA). AN IN-PERSON MEETING WAS HELD ON DECEMBER 1 AND AN ONLINE MEETING

WAS HELD ON DECEMBER 12. PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC)

BEGAN EACH OF THESE MEETINGS 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, PARTICIPANTS WERE PROVIDED AN OVERVIEW OF

Part V Facility Information (continued)

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

THE PRIORITIZATION EXERCISE THAT FOLLOWED.

IN ORDER TO ASSIGN PRIORITY TO THE IDENTIFIED HEALTH NEEDS (I.E., AREAS OF

OPPORTUNITY), AN ONLINE VOTING PLATFORM WAS USED IN WHICH EACH PARTICIPANT

WAS ABLE TO REGISTER HIS/HER RATINGS USING A MOBILE DEVICE OR WEB BROWSER.

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:

1. HOW MANY PEOPLE ARE AFFECTED?

2. HOW DOES THE LOCAL COMMUNITY DATA COMPARE TO STATE OR NATIONAL LEVELS,

OR HEALTHY PEOPLE 2030 TARGETS?

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

IMPAIR QUALITY OF LIFE, OR IMPACT OTHER HEALTH ISSUES?

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

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

HEALTH CONSEQUENCES).

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

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

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

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

ABILITY TO IMPACT).

INDIVIDUALS' RATINGS FOR EACH CRITERIA WERE AVERAGED FOR EACH TESTED

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.

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: ST. JOSEPH'S WAYNE MEDICAL CENTER

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

PLEASE FIND THE CHNA AND IMPLEMENTATION STRATEGY HERE:

[HTTPS://STJOSEPHSHEALTH.ORG/WP-CONTENT/UPLOADS/2024/06/2022-SJUMC-CHNA.P](https://stjosephshealth.org/wp-content/uploads/2024/06/2022-SJUMC-CHNA.P)

DF

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 PLAIN LANGUAGE SUMMARY HERE:

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

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 26

Name and address	Type of facility (describe)
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
11 PED. SUBSPEC. FAC. PRACT. AT HOBOKEN 158 14TH STREET HOBOKEN, NJ 07030	PEDIATRICS

Schedule H (Form 990) 2023

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)
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
21 OB/GYN SUBSPECIALTY FACULTY PRACTICE 57 WILLOWBROOK BOULEVARD WAYNE, NJ 07470	WOMENS HEALTH

Schedule H (Form 990) 2023

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)
22 MATERNAL FETAL MED. FACULTY PRACTICE 1 BROADWAY, SUITE 203 ELMWOOD PARK, NJ 07407	WOMENS HEALTH
23 MATERNAL FETAL MED. FACULTY PRACTICE 525 UNION BOULEVARD TOTOWA, NJ 07512	WOMENS HEALTH
24 COMPREHENSIVE CARE CENTER FOR HIV SER 11 GETTY AVENUE PATERSON, NJ 07503	HIV SERVICES
25 WILLOWBROOK AMBULATORY 57 WILLOWBROOK BOULEVARD WAYNE, NJ 07470	AMBULATORY SERVICES
26 ST. JOSEPHS CANCER CENTER 234 HAMBURG TURNPIKE WAYNE, NJ 07470	CANCER SERVICES
27 AMBULATORY SURGERY CENTER AT TOTOWA 225 MINNISINK ROAD TOTOWA, NJ 07512	AMBULATORY SERVICES

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 (for example, 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

332100 12-26-23

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 I, LINE 7:

THE COST METHODOLOGY USED TO CALCULATE THE AMOUNTS REPORTED FOR EACH LINE
 IN THE TABLE IS COST TO CHARGE RATIO PERCENTAGE.

PART III, LINE 2:

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

Part VI Supplemental Information (Continuation)

PART III, LINE 3:

THE SYSTEM CALCULATED THE BAD DEBT ASSOCIATED WITH SELF PAY/UNINSURED

CASES WAS \$103,651,957. BASED ON HISTORICAL REVIEW, APPROXIMATELY

\$62,251,547 OF THESE CASES WERE ELIGIBLE FOR CHARITY CARE OR OTHER

FINANCIAL ASSISTANCE. IN ADDITION, WE IDENTIFIED BAD DEBTS TOTALING

\$1,097,511 RELATED TO CHARITY CARE PATIENTS. THUS TOTAL BAD DEBT

ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE AMOUNTED TO

\$63,349,059.

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.

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

THE MEDICAL CENTER'S SELF-PAY WRITE-OFFS NET OF RECOVERIES INCREASED FROM \$91.2 MILLION FOR 2022 TO \$127.1 MILLION FOR 2023. THE MEDICAL CENTER HAS NOT CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL YEARS 2022 OR 2023.

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

Part VI Supplemental Information (Continuation)

THEN OFFER THEM THE FAP. NEXT, WE FOLLOW THE NORMAL SELF-PAY COLLECTION

PRACTICES FOR 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:

SEE ABOVE NEEDS ASSESSMENT:

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

Part VI Supplemental Information (Continuation)

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. 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

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

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 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:

Part VI Supplemental Information (Continuation)

KINGS DAY - CEDAR GROVE

PEDESTRIAN SAFETY EVENT

NALOXONE TRAINING AND DISTRIBUTION

STOP THE BLEED CLASS

MLK

STOP THE BLEED INSTRUCTOR COURSE

TRAUMATIC BRAIN INJURIES

HEALTH FAIR-WAFA

HEADS UP SENIORS

FIRST AID TRAINING

A WOMEN'S HEALTH SYMPOSIUMNURSING

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

Part VI Supplemental Information (Continuation)

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

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

Part VI Supplemental Information (Continuation)

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

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

Part VI Supplemental Information (Continuation)

DANGERS OF THE SUN & SKIN CARE

WAYNE DAY

SISTERS ST. ELIZABETH BAD PROM 5K

HEALTH FAIR

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

Part VI Supplemental Information (Continuation)

(THE INSURANCE CAPTIVE), AND VHS MANAGEMENT, INC. AND SUBSIDIARY (VHS).

SAINT JOSEPH'S UNIVERSITY MEDICAL CENTER (THE UNIVERSITY MEDICAL CENTER) WAS FOUNDED IN 1867 AND IS LOCATED IN PATERSON, NEW JERSEY. IT

IS AN ACUTE-CARE HOSPITAL WITH 651 LICENSED BEDS AND 30 NEWBORN

BASSINETS. THE UNIVERSITY MEDICAL CENTER IS A STATE-DESIGNATED TRAUMA

CENTER AND PROVIDES A FULL RANGE OF HEALTH CARE SERVICES. EFFECTIVE

JANUARY 1, 2010, ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. D/B/A ST.

JOSEPH'S WAYNE MEDICAL CENTER AND SUBSIDIARY (WAYNE MEDICAL CENTER) WAS

MERGED WITH THE UNIVERSITY MEDICAL CENTER AND COLLECTIVELY THE ENTITIES

ARE REFERRED TO 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.

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

Part VI Supplemental Information (Continuation)

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 ESTABLISHED TO MANAGE THE

SURGICAL SERVICES AT THE UNIVERSITY MEDICAL CENTER. IN JUNE 2023 THE

MEDICAL CENTER SOLD ITS INTEREST IN ST. JOSEPH'S SURGERY MANAGEMENT.

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 Supplemental Information (Continuation)

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

NJ

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**
Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.
Attach to Form 990.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2023

**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)	3,436,183.	0.			GENERAL SUPPORT
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER, INC. - 703 MAIN STREET - PATERSON, NJ 07503	22-1487602	501(C)(3)	19,915.	0.			PROCEEDS FROM MEDICAL CONFERENCE SUPPORT
THE VALERIE FUND 2101 MILLBURN AVENUE MAPLEWOOD, NJ 07040	22-2126867	501(C)(3)	20,000.	0.			SPONSORSHIP
NFL ALUMNI NY/NJ CHAPTER 8000 MIDLANTIC DR, SUITE 120S MOUNT LAUREL, NJ 08054	59-1782262	501(C)(3)	20,000.	0.			GOLF OUTING

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

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

Schedule I (Form 990) 2023

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	5	18,000.	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)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

OMB No. 1545-0047

2023

Open to Public
Inspection

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

Employer identification number
27-1344467

Part I Questions Regarding Compensation

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
1a		
1b		
2		
3		
4a	X	
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8	X	
9	X	

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

Schedule J (Form 990) 2023

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC 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) KEVIN J. SLAVIN PRESIDENT/CEO	(i)	1,562,957.	625,460.	384,131.	11,550.	2,731.	2,586,829.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) MARK W. CONNOLLY, MD CHAIRMAN, DEPT. OF SURGERY	(i)	518,973.	0.	1,790,064.	13,200.	1,604.	2,323,841.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) BLADI ZAKU, MD MEDICAL DOCTOR	(i)	1,398,053.	0.	1,170.	9,900.	4,332.	1,413,455.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) YANA CAVANAGH, MD MEDICAL DOCTOR	(i)	1,311,509.	0.	20,548.	11,550.	5,124.	1,348,731.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) JOHN DANKS, MD MEDICAL DOCTOR	(i)	1,203,921.	0.	24,952.	9,900.	6,783.	1,245,556.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) TOGHRUL TALISHINSKY, MD MEDICAL DOCTOR	(i)	1,201,375.	0.	1,056.	9,230.	10,027.	1,221,688.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) TODD C. BROWER SVP, GENERAL COUNSEL (THRU 5/31/23)	(i)	327,114.	170,319.	487,788.	9,360.	1,955.	996,536.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) CASWELL SAMMS SVP/CFO	(i)	731,811.	191,038.	3,379.	9,900.	3,562.	939,690.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) JENNIFER MENDRZYCKI SVP & CHIEF OPERATING OFFICER	(i)	600,572.	160,200.	49,066.	11,550.	8,774.	830,162.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JOSPEH DUFFY, MD CO-CHAIR	(i)	583,910.	153,525.	65,174.	8,250.	0.	810,859.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) LINDA A. REED SVP, CHIEF INFORMATION OFFICER	(i)	483,278.	127,914.	104,814.	11,550.	6,486.	734,042.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) LISA SCHMITTGALL SVP & CHIEF STRATEGY OFFICER	(i)	509,342.	126,825.	59,702.	11,550.	5,463.	712,882.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) MICHAEL ALWELL VP REVENUE CYCLE	(i)	482,168.	130,163.	23,416.	11,550.	5,332.	652,629.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) CHRISTOPHER TROTZ, MD CO-CHAIR	(i)	477,998.	126,825.	3,633.	9,900.	4,443.	622,799.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) PIA HOUSE WALKER SENIOR VP OF HUMAN RESOURCES	(i)	449,081.	118,224.	3,417.	9,900.	5,699.	586,321.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) MICHAEL LAMACCHIA, MD TREASURER/SECRETARY	(i)	517,001.	0.	31,069.	12,884.	8,224.	569,178.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC 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) ROBERTO SOLIS, MD TRUSTEE	(i)	526,315.	0.	27,555.	11,175.	0.	565,045.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) KENNETH M. MORRIS, JR. VP, EXTERNAL AFFAIRS	(i)	326,327.	86,775.	47,204.	21,450.	3,546.	485,302.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(19) NILESH PATEL, MD TRUSTEE	(i)	433,180.	0.	2,050.	12,138.	13,840.	461,208.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) KEVIN BROWNE SVP, SENIOR NURSE EXECUTIVE	(i)	302,535.	120,150.	19,423.	9,637.	3,108.	454,853.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(21) DEBORAH SMITH VP, CHIEF NURSING OFFICER	(i)	358,311.	59,605.	2,453.	18,150.	3,693.	442,212.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(22) JANINE BEGASSE VP QUALITY & SAFETY	(i)	358,469.	61,616.	3,508.	9,900.	2,725.	436,218.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(23) JUDITH PADULA FORMER KEY EMPLOYEE	(i)	0.	0.	421,398.	0.	0.	421,398.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(24) TOM CASEY VP, MARKETING AND PUBLIC RELATIONS	(i)	279,662.	79,532.	48,992.	9,898.	861.	418,945.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(25) ROBERT BUDELMAN, III VP, CHIEF DEVELOPMENT OFFICER	(i)	311,577.	79,659.	9,178.	10,704.	5,724.	416,842.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(26) PADMAJA UPADYA, MD VP, CHIEF MEDICAL OFFICER, SJWMC	(i)	284,971.	80,100.	24,069.	6,149.	0.	395,289.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(27) ANTHONY TESORIERO VP, FACILITIES OPERATIONS	(i)	298,868.	80,100.	1,033.	8,633.	4,593.	393,227.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(28) SWATI PAREKH, MD SECRETARY	(i)	329,399.	0.	25,065.	13,950.	3,101.	371,515.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(29) MICHAEL CAIROLI VP, WAYNE SITE ADMIN.	(i)	278,960.	67,997.	1,726.	11,362.	4,312.	364,357.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(30) JANE WHITE VP, ONCOLOGY	(i)	255,727.	67,856.	4,305.	7,757.	2,834.	338,479.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(31) MICHAEL AGNELLI, MD TRUSTEE	(i)	306,731.	0.	494.	7,873.	3,994.	319,092.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(32) SAMI ABDULMASSIH, MD TRUSTEE	(i)	246,881.	0.	522.	7,682.	3,994.	259,079.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC 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) VALERIE CAMPBELL VP, CHIEF COMPLIANCE OFFICER	(i)	232,667.	0.	6,045.	7,270.	5,271.	251,253.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(34) DUSTIN RICCIO, MD PRESIDENT/CEO	(i)	187,838.	0.	132.	0.	46.	188,016.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(35) VICKI CLEVINGER VP, CHIEF COMPLIANCE OFFICER	(i)	0.	0.	132,462.	0.	0.	132,462.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINES 4A-B:

SEVERANCE PAYMENTS WERE MADE IN 2023 TO THE FOLLOWING INDIVIDUALS:

MARK CONNOLLY, MD - \$1,762,563

JUDITH PADULA - \$421,398

TODD BROWER - \$363,112

VICKI CLEVINGER - \$132,462

MICHAEL DELISI, MD - \$107,725

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 2023, CERTAIN

EXECUTIVES PARTICIPATED IN THE 457F (SERP) PROGRAM. THE FOLLOWING

CONTRIBUTIONS WERE MADE IN 2023:

LINDA A. REED - \$77,006

CASWELL SAMMS - \$ 110,526

JENNIFER MENDRZYCKI - \$95,045

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 - \$ 36,383

KENNETH M. MORRIS - \$39,701

KEVIN J. SLAVIN - \$401,191

JOSEPH DUFFY, MD - \$79,778

MICHAEL CAIROLI - \$34,204

TODD C. BROWER - \$23,921

ROBERT BUDLEMAN, III - \$38,152

MICHAEL ALWELL - \$58,500

CHRISTOPHER TROTZ, MD - \$58,023

PIA HOUSE WALKER - \$68,396

PADMAJA UPADYA, MD - \$36,429

LISA SCHMITTGALL - \$80,814

JANE WHITE - \$31,045

KEVIN BROWNE - \$34,269

ANTHONY TESORIERO - \$36,429

JANINE BEGASSE - \$45,000

DEBORAH SMITH - \$40,101

VALERIE CAMPBELL - \$28,327

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 7:

THE ST. JOSEPH'S HEALTH SYSTEM HAS A MANAGEMENT INCENTIVE PLAN IN PLACE

ACHIEVING DEFINED OBJECTIVES THAT ARE SUPPORTIVE OF ST. JOSEPH'S

PROVIDE A MAXIMUM INCENTIVE OPPORTUNITY TO PARTICIPANTS WHOM ACHIEVE

PARTICIPANTS SHALL BE THOSE INCUMBENTS IN MANAGEMENT POSITIONS IN WHICH

THAT IS INTENDED TO ENCOURAGE AND REWARD ELIGIBLE PLAN PARTICIPANTS FOR

HEALTHCARE SYSTEM'S MISSION AND STRATEGY. THE PROGRAM IS DESIGNED TO

THE MAXIMUM PERFORMANCE AND EXPECTATIONS IN MEASUREABLE AREAS. ELIGIBLE

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.

PART I, LINE 8:

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.

DURING 2023, 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).

Supplemental Information on Tax-Exempt Bonds
Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions,
explanations, and any additional information in Part VI.
Attach to Form 990. Go to www.irs.gov/Form990 for instructions and the latest information.

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

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A NJHCFFA 2016 THE PASSAIC COUNTY IMPROVEMENT	22-2845542	645790CB0	08/24/16	274,348,264.	REFUND 2008 & CONSTRUCTION		X		X		X
B AUTHORITY SERIES 2017	05-0569671	702754CY6	12/29/17	26,760,514.	REFUND 2010 BONDS & CONSTRUCTION		X		X		X
C NJHCFFA 2022	22-2845542	645790RE8	02/25/22	40,812,166.	REIMBURSEMENT OF CAPITAL EXPENDITURES		X		X		X
D											

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired	29,570,000.		4,325,000.		790,000.					
2 Amount of bonds legally defeased										
3 Total proceeds of issue	274,352,050.		26,855,039.		40,812,166.					
4 Gross proceeds in reserve funds										
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows										
7 Issuance costs from proceeds	2,842,983.		504,287.		651,873.					
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds	50,003,786.				35,365,738.					
11 Other spent proceeds	221,505,281.		26,350,752.		4,794,555.					
12 Other unspent proceeds										
13 Year of substantial completion	2017		2017		2022					
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X		X				
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	X		X		X					
16 Has the final allocation of proceeds been made?	X		X			X				
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X					

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

Part III Private Business Use

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

Part IV Arbitrage

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

Part IV Arbitrage (continued)

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

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

BOND C, COLUMN (F): DESCRIPTION OF PURPOSE: EQUIPMENT, REFUNDING OF A TAXABLE BOND ISSUE

PART II, LINE 3:

THE DIFFERENCE BETWEEN THE ISSUE PRICE PROVIDED IN PART I, COLUMN (E)

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

AND THE TOTAL PROCEEDS IN PART II, LINE 3 FOR BOND A AND BOND B RESULTS FROM INVESTMENT EARNINGS.

SCHEDULE K, PART IV, LINE 2C:

THE COMPUTATION FOR THE BOND ISSUED ON 2017 WAS COMPUTED IN APRIL 16, 2023.

SCHEDULE K, PART V, PRIVATE BUSINESS USE, LINE 3:

THE SYSTEM HAS SERVICE CONTRACTS THAT MAY RESULT IN PRIVATE BUSINESS USE. THESE AMOUNTS WERE DETERMINED TO BE WITHIN THE PERMITTED LEVELS OVER THE LIFE OF EACH BOND, THEREFORE, A PERCENTAGE WAS NOT DISCLOSED.

SCHEDULE K, POST-ISSUANCE COMPLIANCE WRITTEN PROCEDURES

THE SYSTEM IS IN THE PROCESS OF PUTTING IN PLACE WRITTEN POST ISSUANCE COMPLIANCE PROCEDURES BY NOVEMBER 15TH, 2025 BEFORE FILING 2024 FORM 990.

SCHEDULE L
(Form 990)

Transactions With Interested Persons

OMB No. 1545-0047

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.

2023

Attach to Form 990 or Form 990-EZ.

Open to Public Inspection

Go to 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
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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
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 \$ _____
- 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization \$ _____

Part II Loans to and/or From Interested Persons

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(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
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
Total						\$						

Part III Grants or Assistance Benefiting Interested Persons

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990) 2023

Part IV Business Transactions Involving Interested Persons

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) CONTRIBUTOR #15	SUBSTANTIAL CONTRIB	7,477,900.	SERVICE PRO		X
(2) CONTRIBUTOR #17	SUBSTANTIAL CONTRIB	6,607,770.	SERVICE PRO		X
(3) CONTRIBUTOR #36	SUBSTANTIAL CONTRIB	2,956,380.	SERVICE PRO		X
(4) CONTRIBUTOR #51	SUBSTANTIAL CONTRIB	2,709,470.	SERVICE PRO		X
(5) CONTRIBUTOR #35	SUBSTANTIAL CONTRIB	2,499,290.	SERVICE PRO		X
(6) CONTRIBUTOR #47	SUBSTANTIAL CONTRIB	1,739,370.	SERVICE PRO		X
(7) CONTRIBUTOR #39	SUBSTANTIAL CONTRIB	986,523.	SERVICE PRO		X
(8) CONTRIBUTOR #46	SUBSTANTIAL CONTRIB	812,950.	SERVICE PRO		X
(9) CONTRIBUTOR #13	SUBSTANTIAL CONTRIB	168,895.	SERVICE PRO		X
(10) CONTRIBUTOR #1	SUBSTANTIAL CONTRIB	147,146.	SERVICE PRO		X

Part V Supplemental Information

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: CONTRIBUTOR #15

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #17

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #36

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #51

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(A) NAME OF PERSON: CONTRIBUTOR #35

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #47

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #39

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #46

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #13

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

(A) NAME OF PERSON: CONTRIBUTOR #1

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: SERVICE PROVIDER

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

(A) NAME OF PERSON: DR. JAMES LABAGNARA

(B) RELATIONSHIP WITH ORGANIZATION: FORMER VP, MEDICAL AFFAIRS

(C) PURPOSE OF LOAN: PHYS. RECRUITMENT

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2023

Open to Public Inspection

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 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

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 (MISCELLANEOUS)	X	107,963	36. FMV	
26 Other (TOYS)	X	25,300	11. FMV	
27 Other (FOOD & BEVERAGE)	X	6,798	6. FMV	
28 Other (GIFT CARDS)	X	16,527	6. FMV	

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** 0

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 3 years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? **30a** X

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? **31** X

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? **32a** X

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

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

Schedule M (Form 990) 2023

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.

**SCHEDULE O
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2023

Open to Public
Inspection

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number	27-1344467
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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 6,284 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

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

Schedule O (Form 990) 2023

LHA 332211 11-14-23

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

HIV PATIENTS IN PATERSON, NJ

Name of the organization ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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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 HEALTH TOTOWA CAMPUS AN AMBULATORY PRIMARY CARE
FACILITY IN TOTOWA, NJ

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. SJWMC CURRENTLY OPERATES 138 BEDS
WITHIN

THE FOLLOWING 229 LICENSED BED COMPLEMENT:

MEDICAL/SURGICAL 193

INTENSIVE/CORONARY CARE 16

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

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

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number	27-1344467
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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
 FINANCE COMMITTEE OF THE BOARD OF TRUSTEES ON OCTOBER 25, 2024 BY THE
 ORGNIZATION'S TAX RETURN PREPARERS, KPMG 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
 ST JOSEPH'S HEALTH SYSTEM SUBORDINATE CONFLICTS. THE ANNUAL SOLICITATION
 AND COMPLETION OF COIDS IS CONDUCTED ELECTRONICALLY. UPON COMPLETION AND
 SUBMISSION OF COIDS BY REPORTING PARTIES, AFFIRMATIVE RESPONSES TO THESE
 QUESTIONS ARE REVIEWED BY THE GENERAL COUNSEL AND THE CHIEF COMPLIANCE
 OFFICER. ANY POTENTIAL CONFLICT DISCLOSED IS IDENTIFIED AND RESOLVED IF
 NECESSARY. ALL DISCLOSURES AND RECOMMENDATIONS FOR RESOLUTION ARE THEN
 REVIEWED BY THE AUDIT & COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES. THE

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number	27-1344467
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CHAIR OF THE AUDIT AND COMPLIANCE COMMITTEE PROVIDES A SUMMARY REPORT TO

THE SYSTEM BOARD OF TRUSTEES. IN 2023, 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 WHO

VOTED ON THE COMPENSATION, AND THE COMPARABILITY DATA THAT WAS RELIED UPON.

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

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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, MICHAEL LAMACCHIA, MD, SWATI PAREKH, MICHAEL AGNELLI, MD, SAMI ABDULMASSIH, MD, ARE RELATED TO TIME DEVOTED AS A TRUSTEE OF THE FILING ORGANIZATION.

COMPENSATION IS RELATED TO THE INDIVIDUALS' ROLES AS INDEPENDENT CONTRACTORS AND DOES NOT REPRESENT COMPENSATION FOR BOARD DUTIES.

SISTER PATRICIA MENNOR, VICE PRESIDENT, MISSION, AS A MEMBER OF A RELIGIOUS ORDER, IS EXEMPT FROM FEDERAL AND STATE INCOME TAX AND DOES NOT RECIEVE W-2 REPORTABLE COMPENSATION. THEREFORE, SISTER MENNOR IS NOT REPORTED AS A KEY EMPLOYEE ON PART VII OR SCHEDULE J.

FORM 990, PART IX, LINE 11G, OTHER FEES:

OTHER:

PROGRAM SERVICE EXPENSES	3,835,499.
MANAGEMENT AND GENERAL EXPENSES	420,905.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	4,256,404.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	4,256,404.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

NET PERIODIC PENSION BENEFIT	-19,935,311.
PENSION RELATED ADJUSTMENTS	19,386,225.

GRANT FUNDED CAPITAL ACQUISITIONS

Name of the organization	ST JOSEPH'S HEALTH SYSTEM SUBORDINATE GROUP RETURN	Employer identification number 27-1344467
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CHANGE IN NON CONTROLLING INTEREST -264,000.

TRANSFER OF ASSETS TO/FROM AFFILIATES

CHANGE IN INTEREST IN FOUNDATION -1,991,482.

DECREASE IN NET ASSETS WITH DONOR RESTRICTION

OTHER 179,901.

TOTAL TO FORM 990, PART XI, LINE 9 -2,624,667.

FORM 990, PART XII, LINE 2C:

THE PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.

SJH HOUSING, LLC - 168(H)(6)(F)(II) ELECTION ACKNOWLEDGEMENT:

DURING FISCAL YEAR ENDING MAY 31, 2023, SJH HOUSING, LLC, (FEIN:

85-4276345; 703 MAIN STREET, PATERSON, NJ 07503) MADE AN ELECTION UNDER

IRC SECTION 168(H)(F)(II) SO IT WILL NOT BE TREATED AS A TAX-EXEMPT

ENTITY FOR PURPOSES OF 168(H)(6)(F)(I), AND ACKNOWLEDGES THAT ANY GAIN

RECOGNIZED ON THE DISPOSITION OF AN INTEREST IN SJH HOUSING, LLC, AND

ANY DIVIDEND OR INTEREST RECEIVED OR ACCRUED BY A TAX-EXEMPT ENTITY

FROM SJH HOUSING, LLC, WILL BE TREATED AS UNRELATED BUSINESS TAXABLE

INCOME FOR PURPOSES OF 511, WITH THE EXCEPTION OF DIVIDEND INCOME

PROPERLY ALLOCATED TO INCOME OF SJH HOUSING, LLC PREVIOUSLY SUBJECT TO

TAX.

ST. JOSEPH UNIVERSITY MEDICAL CENTER, THE SOLE MEMBER OF SJH HOUSING,

LLC, HEREBY ACKNOWLEDGES AND CONSENTS TO THIS ELECTION.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-0047

2023

**Open to Public
Inspection**

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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
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) 2023

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	1,889,072.		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		62.79%
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	435,770.	1,191,696.	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	N/A	N/A	N/A	X	
ST JOSEPH'S HOSPITAL HOUSING CORP - 22-2145893, 703 MAIN STREET, PATERSON, NJ 07503	HOUSING	NJ	SJUMC	C CORP			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	
SJH HOUSING, LLC - 85-4276345 703 MAIN STREET PATERSON, NJ 07503	REAL ESTATE	NJ	SJUMC	C CORP			100%	X	

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

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) SJHS INSURANCE LIMITED	L	11,747,043. FMV	
(2)			
(3)			
(4)			
(5)			
(6)			

Part VII Supplemental Information

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

Multiple horizontal lines for supplemental information.